

OMB Desk Officer on or before November 2, 1987.

Dated: August 26, 1987.

By direction of the Administrator.

David A. Cox,

Associate Deputy Administrator for Management.

Reinstatement

1. Board of Veterans Appeals
2. Statement of Accredited Representative in Appealed Cases
3. VA Form 1-646
4. This form is used to ensure that the appellant's rights are protected. This information is used in the final stages of the claims process or appellate review.
5. On occasion
6. Individuals or households
7. 36,975 responses
8. 36,975 hours
9. Not applicable

[FR Doc. 87-20039 Filed 8-31-87; 8:45 am]

BILLING CODE 8320-01-M

Meeting; Career Development Committee

The Veterans Administration gives notice under Pub. L. 92-463 that a meeting of the Career Development Committee, authorized by 38 U.S.C. 4101, will be held in the State Room of the Governor's House, Rhode Island Avenue at 17th Street, NW., Washington, DC, October 4 through 6, 1987, starting at 7 p.m., October 4. The meeting will be for the purpose of scientific review of applications for appointment to the Career Development Program in the Veterans Administration. The committee advises the Director, Medical Research Service on selection and appointment of Associate Investigators, Research Associates, Clinical Investigators, Medical Investigators, and Senior Medical Investigators.

The meeting will be open to the public up to the seating capacity of the room

from 7 p.m. to 7:30 p.m. on October 4, 1987, to discuss the general status of the program. Because of the limited seating capacity of the room, those who plan to attend should contact Mr. David D. Thomas, Executive Secretary of the Career Development Committee (151J), Veterans Administration Central Office, Washington, DC 20420 (Phone 202-233-2317) prior to September 30, 1987.

The meeting will be closed from 7:30 p.m. to 10 p.m., October 4 and from 8 a.m. to 5 p.m. on October 5 and October 6, for consideration of individual applications for positions in the Career Development Program. This necessarily requires examination of personnel files and discussion and evaluation of the qualification, competence, and potential of the several candidates, disclosure of which would constitute a clearly unwarranted invasion of personal privacy. Accordingly, closure of this portion of the meeting is permitted by section 10(d) of Pub. L. 92-463 as amended, in accordance with subsection (c)(6), 5 U.S.C. 552b.

Minutes of the meeting and rosters of the committee members may be obtained from Mr. David D. Thomas, Chief, Career Development Program, Medical Research Service (151J), Veterans Administration, Washington, DC 20420 (Phone 202-233-2317).

Dated: August 25, 1987.

By direction of the Administrator.

Rosa Marie Fontanez,

Committee Management Officer.

[FR Doc. 87-20040 Filed 8-31-87; 8:45 am]

BILLING CODE 8320-01-M

Meeting; Cooperative Studies Evaluation Committee

The Veterans Administration gives notice under Pub. L. 92-463 that a meeting of the Cooperative Studies Evaluation Committee, authorized by 38 U.S.C. 4101, will be held at the Vista International Hotel, 1400 M Street, NW., Washington, DC, on October 22, 1987.

The meeting will be for the purpose of reviewing proposed cooperative studies and advising the Veterans Administration on the relevance and feasibility of the studies, the adequacy of the protocols, and the scientific validity and propriety of technical details, including protection of human subjects. The Committee advises the Director, Medical Research Service, through the Chief of the Cooperative Studies Program on its findings.

The meeting will be open to the public up to the seating capacity of the room from 7:30 a.m. to 8 a.m. on October 22, 1987, to discuss the general status of the program. To assure adequate accommodations, those who plan to attend should contact Dr. Ping Huang, Coordinator, Cooperative Studies Evaluation Committee, Veterans Administration Central Office, Washington, DC (202-233-2861), prior to October 8, 1987.

The meeting will be closed from 8 a.m. to 3:30 p.m. on October 22, for consideration of specific proposals in accordance with provisions set forth in subsection 10(d) of Pub. L. 92-463, as amended by Pub. L. 94-409, and as cited in 5 U.S.C. 552b(c)(6) and (9)(B). During this portion of the meeting discussions and decisions will deal with qualifications of personnel conducting the studies and the medical records of patients who are study subjects, the disclosure of which would constitute clearly unwarranted invasion of personal privacy. Additionally, premature disclosure of the Committee's recommendations would likely frustrate implementation of final proposed actions.

Dated: August 25, 1987.

By direction of the Administrator.

Rosa Marie Fontanez,

Committee Management Officer.

[FR Doc. 87-20041 Filed 8-31-87; 8:45 am]

BILLING CODE 8320-01-M

Sunshine Act Meetings

Federal Register

Vol. 52, No. 169

Tuesday, September 1, 1987

This section of the FEDERAL REGISTER contains notices of meetings published under the "Government in the Sunshine Act" (Pub. L. 94-409) 5 U.S.C. 552b(e)(3).

BOARD OF GOVERNORS OF THE FEDERAL RESERVE SYSTEM

TIME AND DATE: 11:00 a.m., Tuesday, September 8, 1987.

PLACE: Marriner S. Eccles Federal Reserve Board Building, C Street entrance between 20th and 21st Streets, NW., Washington, DC 20551.

STATUS: Closed.

MATTERS TO BE CONSIDERED:

1. Personnel actions (appointments, promotions, assignments, reassignments, and salary actions) involving individual Federal Reserve System employees.

2. Any items carried forward from a previously announced meeting.

CONTACT PERSON FOR MORE INFORMATION:

Mr. Joseph R. Coyne, Assistant to the Board; (202) 452-3204. You may call (202) 452-3207, beginning

at approximately 5 p.m. two business days before this meeting, for a recorded announcement of bank and bank holding company applications scheduled for the meeting.

Date: August 28, 1987.

James McAfee,

Associate Secretary of the Board.

[FR Doc. 87-20213 Filed 8-28-87; 3:59 pm]

BILLING CODE 6210-01-M

FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION

August 26, 1987.

TIME AND DATE: 10:00 a.m., Wednesday, September 2, 1987.

PLACE: Room 600, 1730 K Street, NW., Washington, DC.

STATUS: Open.

MATTERS TO BE CONSIDERED: The Commission will consider and act upon the following:

1. *Secretary of Labor on behalf of Bushnell v. Cannelton Industries, Inc.,*

Docket No. WEVA 85-273-D. (Issues include whether the judge erred in finding the operator discriminated against the complainant for engaging in rights protected by section 105(c)(1) of the Mine Act. 30 U.S.C. 815(c)(1).)

2. *Martha Perando v. Mettiki Coal Corporation*, Docket No. YORK 85-12-D. (Issues include whether the judge erred in finding that the operator discriminated against the complainant in violation of section 105(c)(1) of the Mine Act. 30 CFR part 815(c)(1).)

Any person intending to attend this meeting who requires special accessibility features and/or auxiliary aids, such as sign language interpreters, must inform the Commission in advance of those needs. Subject to 20 CFR 2706.150(a)(3) and 2706.160(e).

CONTACT PERSON FOR MORE INFO: Jean Ellen (202) 653-5629.

Jean H. Ellen,
Agenda Clerk.

[FR Doc. 87-20093 Filed 8-28-87; 10:34 am]

BILLING CODE 6735-01-M

Corrections

Federal Register

Vol. 52, No. 169

Tuesday, September 1, 1987

This section of the FEDERAL REGISTER contains editorial corrections of previously published Presidential, Rule, Proposed Rule, and Notice documents and volumes of the Code of Federal Regulations. These corrections are prepared by the Office of the Federal Register. Agency prepared corrections are issued as signed documents and appear in the appropriate document categories elsewhere in the issue.

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Parts 795 and 799

[OPTS-42076A; FRL-3213-5]

Anthraquinone; Final Reporting and Recordkeeping Requirements and Test Rule

Correction

In rule document 87-12724 beginning on page 21018 in the issue of Thursday, June 4, 1987, make the following corrections:

§ 795.45 [Corrected]

1. On page 21027, in § 795.45(b)(1)(ii), in Table 1, in the first entry of the first column, "14-" should read "4-"

§ 799.500 [Corrected]

2. On page 21030, in the first column, in § 799.500(d)(2)(i), in the 28th line, "(b)" should read "(B)".

BILLING CODE 1505-01-D

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 799

[OPTS-42089; FRL-3221-7]

Testing Consent Order on 3,4-Dichlorobenzotrifluoride and Response to the Interagency Testing Committee

Correction

In rule document 87-14231 beginning on page 23547 in the issue of Tuesday, June 23, 1987, make the following corrections on that page:

1. In the second column, under III. Use and Exposure, in the third paragraph, in the fourth line, "Rone-Poulence" should read "Rhone-Poulenc".

2. In the third column, in the first complete paragraph, in the eighth line, "Manufactures" should read "Manufacturers".

BILLING CODE 1505-01-D

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

43 CFR Public Land Order 6653

[NM-940-07-4220-10; NM NM 52805]

Partial Revocation of Public Land Order No. 6525; New Mexico

Correction

In rule document 87-18041 beginning on page 29525 in the issue of Monday, August 10, 1987, make the following correction:

On page 29526, in the first column, in paragraph 3., in the first line, "1981" should read "1987".

BILLING CODE 1505-01-D

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

[NM-940-07-4220-11; NM NM 023643]

Continuation of Withdrawal and Reservation of Lands; New Mexico

Correction

In notice document 87-15026 beginning on page 25087 in the issue of Thursday, July 2, 1987, make the following correction:

On page 25088, in the first column, the fifth line should read "T. 10 S., R. 18W.,".

BILLING CODE 1505-01-D

Federal Register

**Tuesday
September 1, 1987**

Part II

Department of Defense

Office of the Secretary

32 CFR Part 199

**Civilian Health and Medical Program of
the Uniformed Services (CHAMPUS);
Implementation of CHAMPUS DRG-Based
Payment System; Final Rule**

DEPARTMENT OF DEFENSE

Office of the Secretary

32 CFR Part 199

[DoD Regulation 6010.8-R]

Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); Implementation of a CHAMPUS DRG-Based Payment System

AGENCY: Office of the Secretary, DoD.

ACTION: Final rule.

SUMMARY: In FR Doc. 77-7834, appearing in the Federal Register on April 4, 1977, (42 FR 17972), the Office of the Secretary of Defense published its regulation, DoD 6010.8-R, "Implementation of the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)," as Part 199 of this title. DoD Regulation 6010.8-R was reissued in the Federal Register on July 1, 1986 (51 FR 24008).

This final rule amends the comprehensive CHAMPUS regulations, DoD 6010.8-R (32 CFR Part 199), pertaining to payment for inpatient hospital services. This final rule implements a DRG-based payment system, which is modeled on the Medicare Prospective Payment System. This final rule also revises the cost-sharing requirements for beneficiaries other than dependents of active duty members. This cost-sharing change is necessary under a DRG-based payment system to ensure that cost-sharing amounts are equitable. This final rule also establishes an admission and quality review system for CHAMPUS inpatient hospital claims.

EFFECTIVE DATE: October 1, 1987. This final rule is effective for inpatient hospital admissions occurring on or after that date.

FOR FURTHER INFORMATION CONTACT: Stephen E. Isaacson, Policy Branch, OCHAMPUS, telephone (303) 361-4005.

SUPPLEMENTARY INFORMATION: On June 3, 1987, we published a proposed rule to implement a CHAMPUS DRG-based payment system. This rule proposed to change the method of payment for inpatient hospital services under CHAMPUS from a billed charge, retrospective system to a prospective payment system based on diagnosis-related groups (DRGs). We refer the reader to the proposed rule for more detailed explanations of the proposed changes to the reimbursement

procedures and the implementing regulations in 32 CFR Part 199.

We provided a 30-day comment period of the proposed rule. This final rule announces our decisions on the issues raised by commenters in response to our proposed rule.

To assist the reader in reviewing this document, we are providing the Table of Contents below.

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32 CFR Part 199

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Addendum 1—Health Program Benefit Agreement

I. Synopsis

A. Background

Paying on the basis of a fixed, prospective rate, appropriate to the particular diagnosis involved, has been shown to be an equitable, effective method of paying for hospital care. Instead of paying on the basis of billed charges, CHAMPUS is now implementing a Diagnosis Related Groups (DRG) based payment system which will assure fair payments to hospitals, reduce cost sharing requirements for beneficiaries and the government and provide for new procedures to monitor the quality of care.

B. Improvements Upon the Proposed Rule

Based on public comments, several changes are being made to improve upon the proposed rule, issued in June. Among these is an exemption for children's hospitals until a method can be incorporated that will better reflect the unique kind of care these specialty hospitals provide. Another change is authority to exempt states, such as Maryland, that are exempted by Medicare and have equally effective payment methods. Further, to assure reasonable payment amounts to hospitals in areas of generally higher costs, a wage adjustment and an urban/rural differentiation, as is used under Medicare, will be made. Also, the beneficiary cost-sharing provisions have been revised to assure that no beneficiary will pay more under the new system than under the old method of paying billed charges, and most beneficiaries will pay much less.

C. CHAMPUS DRG System Modeled After Medicare's

Established System Consistent with the Congressional intent, the proposed CHAMPUS system is modeled closely on the Medicare system. The similarities are exemplified by the fact that even though the CHAMPUS population is younger the average CHAMPUS payment amounts are roughly equal to those under Medicare. The costs of capital and indirect and direct medical education will receive the same special

treatment under CHAMPUS that they receive under Medicare. Like Medicare, long-stay or unusually costly cases will receive additional outlier payments. To assure fair payments, amounts have been calculated on the basis of actual CHAMPUS hospital claims during a recent 12-month period.

D. Fiscal Year 1988 Implementation on Schedule

Four years after Medicare's similar system was adopted, CHAMPUS is now ready to proceed with its DRG-based payment system. This interim period has given hospitals time to adjust to the DRG-based system under the government program that is some 40 times larger than CHAMPUS. During this time, CHAMPUS tested a DRG system in South Carolina and learned valuable lessons. CHAMPUS also had the opportunity to compile and analyze extensive data relating exclusively to charges for care under CHAMPUS. Also, the CHAMPUS fiscal intermediaries have had time to put in place the systems to assure smooth administration under the new payment method. In view of all of these activities, there is no need for CHAMPUS to slow down implementation. Nor is there a need to phase in national rates as Medicare did. Phasing is unnecessary because hospital operations have adjusted to the DRG payment method, now fully implemented under Medicare, and CHAMPUS, unlike Medicare, is typically a very small portion of the hospital's income.

E. Reduced Cost Shares for Beneficiaries

From the beneficiary's standpoint, the new CHAMPUS payment system will have a very positive impact. By reducing the payment amount for hospitals, the 25% cost share retired members and their dependents must pay will now be applied to a much lower amount. As a result, the average cost share per hospital stay will be reduced from about \$1135 to about \$760. To assure that cost sharing fairly reflected the value of hospital services provided to the beneficiary, the proposed rule included a new method of calculating cost sharing based on a per diem amount. The final rule continues this more equitable method, and makes a further adjustment: beneficiary cost shares will be the lesser of the per diem calculation method (the new system) or 25% of billed charges (the old system). This assures that while most beneficiaries will pay less under the new system than the old, additionally, no beneficiaries will pay more.

F. Assuring the Quality of Care

To assist in assuring the quality, reasonableness, and appropriateness of care provided CHAMPUS beneficiaries under the DRG based payment system, a new quality review requirement is being established. CHAMPUS is pursuing appropriate arrangements with the Department of Health and Human Services to undertake this important activity in conjunction with current Peer Review Organization program under Medicare. This will enable CHAMPUS to join HCFA in guarding against premature discharges and effectively monitoring the quality of care.

G. Conclusion

In accord with Congressional intent, spiraling costs will be curtailed by a CHAMPUS DRG-based payment system modeled very closely on the Medicare system. With improvements upon the proposed rule, the final rule provides for fair payments to hospitals and reduced outlays and new quality monitoring for beneficiaries. This payment system, carefully developed, will be fully implemented October 1, 1987.

II. Background

A. CHAMPUS Reimbursement—Current Procedures

Paragraph 199.6(e) of DoD 6010.8-R provides for reimbursement of hospitals and skilled nursing facilities on the basis of billed charges/set rates, cost-related reimbursement similar to that used under Title XVIII of the Social Security Act (Medicare), or prospective reimbursement. CHAMPUS has traditionally reimbursed these providers of care based on the providers' billed charges. Largely because of these procedures, CHAMPUS has been subject to rapidly increasing costs, far in excess of the general rate of inflation. This resulted not only from increases in hospitals' charges, but also from the shifting of costs as other third-party payers implemented cost-controlling reimbursement procedures.

B. Summary of Legislation

1. Department of Defense Authorization Act, 1984

The Department of Defense Authorization Act, 1984, Pub. L. 98-94 amended Title 10, section 1079(j)(2)(A) of the United States Code and provided CHAMPUS with the statutory authority to reimburse institutional providers based on diagnosis-related groups (DRGs). Specifically, it provides that payments "shall be determined to the extent practicable in accordance with the same reimbursement rules as apply

to payments to providers of services of the same type under title XVIII of the Social Security Act."

2. Consolidated Omnibus Budget Reconciliation Act, 1986

On April 7, 1986, the President signed the Consolidated Omnibus Budget Reconciliation Act, Pub. L. 99-272, which contained a provision requiring hospitals which participate in Medicare also to participate in CHAMPUS for inpatient services (see Section 1866(a)(1)(J) of the Social Security Act, 42 U.S.C. 1395cc(a)(1)(J)). Because of questions regarding the effect of this provision, the effective date in section 9122(b) of Pub. L. 99-272, which enacted section 1866(a)(1)(J), was amended by Pub. L. 99-514, section 1895(b)(6), which was signed by the President on October 22, 1986. Section 1866(a)(1)(J) requires all providers participating in Medicare also to participate in CHAMPUS for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987.

C. Summary of Proposed Amendment to Rule

In the proposed amendment to rule, we set forth new regulations for the CHAMPUS DRG-based payment system intended to apply to inpatient hospital admissions occurring on or after October 1, 1987. We described how the CHAMPUS system is modeled after the Medicare Prospective Payment System; the applicability of the system, both in terms of services and of hospitals affected; how the DRG weighting factors are calculated; how the adjusted standardized amount is calculated; how adjustments for capital and medical education costs are to be made; and how unusual cases (outliers) are to be handled. We also described changes to the cost-sharing requirements for beneficiaries other than dependents of active duty members. Additionally, we set forth procedures for an admission and quality review system for CHAMPUS inpatient hospital claims.

D. Number and Types of Public Comment

We received a total of 34 individual comments which raised a number of issues. The types and volume of commenters were as follows:

- Hospital Associations—11
- Hospitals—12
- Medical Associations—5
- Medical Review Organizations—3
- Third-party payers—1
- State Governments and Organizations—2

We received a number of general comments which do not relate to any

particular provision of the CHAMPUS DRG-based payment system, but relate to the system as a whole and our implementation plans. We will address those comments here before we respond to the comments regarding specific sections of our proposed rule.

A number of commenters suggested we delay implementation of the DRG system until at least October 1988 in order to allow hospitals time to prepare for the changes and to ensure that OCHAMPUS has adequate time to develop a comprehensive database and to consider the public comments.

We think delay in the implementation of the DRG system is unnecessary for two main reasons: first, hospitals have already adjusted to prospective payment under Medicare, and second, OCHAMPUS has developed a comprehensive database with which to develop final weights and rates.

We think that hospitals have adjusted to prospective payment under the Medicare system. As a result, the inclusion of prospective payment for CHAMPUS patients should have a minimal effect on hospital operations. The CHAMPUS prospective payment system merely will result in a marginal increase in workload for existing prospective payment-related activities in hospitals such as medical records, billing, and utilization review activities already conducted for Medicare patients. For many hospitals, the net effect of CHAMPUS DRGs on hospital operations will be positive. Instead of managing two radically different payment systems for government beneficiaries (i.e., Medicare and CHAMPUS), in many ways hospitals will have an opportunity to consolidate patient management, billing, and medical records activities to include both CHAMPUS and Medicare patients.

We disagree with the assertion that CHAMPUS has not had adequate time to develop a comprehensive database. The database used for final weight and rate calculations includes over 300,000 records of all CHAMPUS claims processed from July 1, 1986 to June 30, 1987. This represents a full-year sample of claims from the most recent period. We think that this database will provide the most accurate representation of CHAMPUS utilization. The required calculation methods necessary to derive weights and rates have been developed over the past year and tested on a smaller database. Final calculations merely required the application of these methods to the larger database.

In addition to being unnecessary, delaying implementation of the DRG-based payment system would contravene clear Congressional intent

that CHAMPUS adopt a payment method similar to that used by Medicare, an intent repeatedly and consistently expressed by Congress since Medicare's system was adopted four years ago.

Some commenters suggested that 30 days was not sufficient time to comment on the proposed rule. The comment period conforms to statutory requirements. Because of years of experience with the Medicare system, the matters discussed in the proposed rule are quite familiar to the health care community. Thus, a 30-day comment period was quite adequate to permit interested parties to consider the proposed rule and provide substantive comments. The many detailed and thorough comments we actually received confirm this. Also, we received no indication that additional comments would have been received, or additional issues raised, had the comment period been longer.

Some commenters mistakenly believe that CHAMPUS will not pay the full DRG-based amount in those cases where a hospital's charges are less than the DRG-based payment amount. Since this is a basic tenet of DRG-based reimbursement, we want to be sure that this misunderstanding is clarified. Except for those few cases which are classified as short-stay outliers, a hospital will always receive the full DRG-based payment regardless of its costs or charges.

In the proposed rule we stated that "we anticipate few, if any, changes in hospital operations as a result of our implementation of the CHAMPUS DRG-based payment system." One commenter stated that the DRG-based payment system would, indeed, affect operations, since hospitals would need more extensive internal concurrent review, additional discharge planning, and more emphasis on claims coding. We recognize these activities may increase as a result of our DRG-based payment system, but they are not required by the system. Rather they are a reaction to the system, and, more importantly, will help to ensure hospital efficiency, which is a major goal of the existing Medicare system and the new CHAMPUS system.

Several commenters expressed a concern that there could be a disruption in services to CHAMPUS patients if CHAMPUS is unable to begin the timely processing of claims on October 1. A primary concern of OCHAMPUS is that we want a smooth transition to DRG-based payments with no adverse impact on providers or beneficiaries.

We think that all CHAMPUS fiscal intermediaries are adequately prepared to process CHAMPUS claims under DRGs. Since CHAMPUS began exploring the potential for a prospective payment system, the CHAMPUS fiscal intermediaries have been consulted periodically regarding the impact of prospective payment on their current claims payment procedures. Moreover, all but one of the CHAMPUS fiscal intermediaries currently process Medicare claims, making the transition to CHAMPUS prospective payment relatively simple. And finally, since the release of the proposed rule, CHAMPUS has submitted preliminary weights, rates, cutoff thresholds, and other necessary payment procedures to the intermediaries so that they could begin revision of their payment systems. In short, we and the CHAMPUS fiscal intermediaries are confident that there will be a smooth transition from payment based on billed charges to DRGs.

One commenter suggested we allow our fiscal intermediaries to automate remittance schedules on a weekly basis rather than issuing individual checks and explanation of benefits for every claim. Under current procedures, the fiscal intermediary can combine multiple claims from the same hospital into a single remittance. This procedure will not change under the DRG-based payment system and should resolve the concern of the commenter.

Below we briefly summarize each of the major provisions of the proposed amendment of rule on which we received comments and provide an analysis of the comments and our responses. We have also provided a reference to each provision's designation in the proposed rule. Section VI of this preamble summarizes the changes we are making to the regulation as a result of the comments we received.

III. General Description of CHAMPUS DRG-Based Payment System

A. Modeled on Medicare's Prospective Payment System (PPS)

1. DRGs Used (§ 199.14(a)(1)(i)(A))

The CHAMPUS DRG-based payment system will use the same DRGs used in the most recently available grouper for the Medicare PPS.

Comment—The age breakdown in the Medicare DRG system is only shown as 17 and below. For children's hospitals it is necessary to have a more specific breakdown in ages, as the difference in levels of care between a one-year-old and a 12-year-old will vary significantly.

Response—We realize this problem may be acute for children's hospitals

and, as Medicare, we have decided to exempt children's hospitals from the CHAMPUS DRG system at this time. We intend to study the issue further and bring these hospitals into the system at a later date.

2. Assignment of Discharges to DRGs (§ 199.14(a)(1)(i)(B))

CHAMPUS will use the Health Care Financing Administration (HCFA) FY 1987 "Grouper" program to classify specific hospital discharges within DRGs, so that each discharge is assigned to a DRG based on the patient's age, sex, principal diagnosis, secondary diagnoses, procedures performed and discharge status. In addition, when the discharge data submitted by a hospital show a surgical procedure unrelated to a patient's principal diagnosis, the bill will be returned to the hospital for validation and verification.

Comment—The CHAMPUS DRG-based payment system should always use the Grouper program which is currently used under the PPS.

Response—In general, CHAMPUS intends to use the most recently available HCFA Grouper program. Currently, the most recently available program is the FY 1987 Grouper which we are using for FY 1988. For future years, HCFA revisions to its Grouper will be adopted by CHAMPUS as soon as practicable following availability of the Grouper.

Comment—It is unnecessary to verify the diagnosis and procedure codes for claims grouped into DRG 468 (unrelated operating room procedure), especially since these claims are later reviewed by the Peer Review Organization (PRO).

Response—We do not believe this is unnecessary. Since, by definition, there is something unusual about the claim data for a DRG 468, we believe it is prudent to verify the data initially to avoid payment errors. However, we have modified this requirement to make it less of a burden on hospitals. We will require only that the fiscal intermediary review such claims.

B. Beneficiary Eligibility

If a beneficiary is eligible for CHAMPUS coverage during any part of his/her inpatient confinement, the claim shall be processed as if the beneficiary were eligible for the entire stay. The beneficiary's cost-sharing status is to be determined based on his/her sponsor's status at the time of admission.

Comment—The rule should specify whether the fiscal intermediary of the PRO is responsible for determining a beneficiary's status.

Response—This determination is always the responsibility of the FI and must be made prior to payment of the claim.

C. Basis of Payment

1. Payment on a Per Discharge Basis (§ 199.14(a)(1)(i)(C)(2))

Under the CHAMPUS DRG-based payment system, hospitals are paid a predetermined amount per discharge for inpatient hospital services.

Comment—OCHAMPUS should have a provision which permits interim payments on long lengths-of-stay.

Response—In general, we have modeled the CHAMPUS DRG-based payment system on the Medicare system. Medicare intends to eliminate interim payments on long stay outliers. Therefore, we intend to follow this policy.

2. Discharges and Transfers

a. *Discharges* (§ 199.14(a)(1)(i)(C)(6)(i)). In this section we listed those actions which qualify as discharges and are eligible for full DRG-based payment.

Comment—A transfer from the care of a hospital included under the CHAMPUS DRG-based payment system to a hospital or unit that is excluded from the system is classified as a transfer, but it should be a discharge.

Response—We agree. This is a discharge under the Medicare PPS, and this was an error in our proposed rule. We have made the change to classify such actions as discharges.

b. *Payment to a hospital transferring an inpatient to another hospital* (§ 199.14(a)(1)(i)(C)(6)(iv)). In the case of a transfer, the transferring hospital is to be paid a per diem rate not to exceed the DRG-based payment that would have been paid if the patient had been discharged to another setting.

Comment—The method of reimbursement for transfers has not been addressed in a manner to assure adequate payment in the case of multiple transfers of a patient among various hospitals.

Response—We have revised the language to specifically indicate that transferring hospitals can receive additional payment for cases which meet the criteria for long-stay or cost outliers.

Comment—Transfers to military treatment facilities (MTFs) should be classified as discharges rather than as transfers.

Response—MTFs have the primary responsibility and statutory requirement to provide care to CHAMPUS

beneficiaries when space is available. Transfers to hospitals excluded from the CHAMPUS DRG-based payment system are considered discharges because the transferred patient receives subsequent care in a facility that is organized for treatment of conditions distinctly unlike treatment provided in the non-exempt acute care facility. In the case of a transfer to an MTF, however, the patient will receive continuing care comparable to that received in the non-exempt acute care transferring hospital. Therefore, transfers of this nature will be treated just as if the hospital transferred the patient to another non-exempt acute care facility. That is, the transferring hospital will be paid a DRG-specific per diem amount.

Comment—Currently, emergency room physicians must contact the MTF for permission to admit all patients in distress, but not in a life threatening status. Will there be any consideration given to reducing these emergency room transfers under DRG payment?

Response—All CHAMPUS beneficiaries who live within catchment areas of MTFs are required to first seek inpatient care in the MTF before going to a civilian hospital. That is the purpose of the requirement cited in this comment, and it will not change as a result of DRG-based reimbursement. Thus, if the MTF can treat the patient, the patient will be required to go to the MTF for inpatient services, and the civilian hospital will be reimbursed only for the emergency room services on an outpatient basis.

3. Applicability of the DRG System

a. Areas affected
(§ 199.14(a)(1)(ii)(A)). The CHAMPUS DRG-based payment system shall apply to hospitals' services in the fifty states, the District of Columbia, and Puerto Rico. There are no exemptions for services in states which have implemented a separate DRG-based payment system or similar payment system in order to control costs.

Comment—The proposed rule states that the CHAMPUS DRG-based payment system will be applicable to the six CHAMPUS Reform Initiative (CRI) demonstration states. The CRI request for proposals allows contractors to use their own reimbursement system for CHAMPUS Prime.

Response—DRG-based reimbursement will still be required in the demonstration states for all claims which are not CHAMPUS Prime, as it will apply to all standard CHAMPUS claims nationwide. Within CHAMPUS Prime, contractors can use the CHAMPUS DRG system or any other

reimbursement system, subject to the requirements of the CRI contracts.

Comment—Any state payment system granted a federal waiver for the purposes of Medicare reimbursement should be automatically exempt from the CHAMPUS system.

Response—The intent of not granting waivers to individual states was to ensure uniformity of payments throughout the country and to ensure that payments in all states would be adequately controlled. The comments we received argued persuasively that the cost controls in those states exempt from the Medicare PPS are adequate to ensure savings comparable to the CHAMPUS DRG-based payment system. Moreover, it would be disruptive if a single payer, particularly a major Federal payer, chose to exempt their beneficiaries from the state system. As a result, we have revised our position to allow states to be exempt from the CHAMPUS DRG-based payment system under the following circumstances:

1. The State must be exempt from the Medicare PPS;
2. The State must request, in writing, that it be exempt from the CHAMPUS DRG-based payment system; and
3. Payments in the State must continue to be at a level to maintain savings comparable to those which would be achieved under the CHAMPUS DRG-based payment system. This exemption is based on savings achieved under Medicare, but because of the differences in beneficiary populations between Medicare and CHAMPUS, savings under Medicare might not accrue to CHAMPUS. Thus, while a State may be initially exempt from the CHAMPUS system, we will continue to monitor reimbursement levels in the state to ensure that they do not exceed those under the CHAMPUS DRG-based payment system. If they do exceed that level, we will work with the State to resolve the problem. However, if a satisfactory solution cannot be found, OCHAMPUS will terminate the exemption after due notice has been given to the state.

At this time, it appears that at least one State, Maryland, seeks such an exemption. Such a request will be considered based on these criteria and will likely be approved.

b. Services exempt from the CHAMPUS DRG-based payment system
(§ 199.14(a)(1)(ii)(C)). In this section we provided a list of specific services which, even if provided in a hospital subject to the CHAMPUS DRG-based payment system, are exempt from the DRG system.

Comment—There is no distinction between the extremely low birth weight patient and those with a higher birth weight but who are still classified as premature. The neonatal DRGs do not have the ability to accommodate the wide variations in case mix severity.

Response—We believe that any significant classification problem with the neonate DRGs occurs primarily at Children's Hospitals which we are exempting from the CHAMPUS DRG-based payment system at this time. Neonates at other hospitals will be included in the system. We have examined the CHAMPUS data and found that the impact of neonate DRGs on hospitals other than children's hospitals is no greater, and maybe even less, than that of other DRGs. For large teaching hospitals, which have only ten percent of the CHAMPUS neonate cases outside children's hospitals, the impact is not significantly greater than for other DRGs. We will pay particular attention to the neonate issue as we analyze CHAMPUS experience under this system.

Comment—Medicare intends to implement alcohol/drug abuse DRGs and stop exempting such hospitals and units. Will OCHAMPUS do likewise?

Response—We are aware of Medicare's proposed change. However, we believe it would be premature for CHAMPUS to also implement these DRGs at this time because unlike other diagnostic categories we cannot be certain that the nature of alcohol and drug abuse treatment, and its classification, is comparable for both the CHAMPUS and Medicare beneficiary groups. Over the next few months we intend to examine the Medicare changes and evaluate them in terms of CHAMPUS beneficiaries and determine whether it would be appropriate to adopt the Medicare classification changes for the CHAMPUS population or develop a CHAMPUS-specific DRG approach.

Comment—The proposed rule implies that only hospitals may bill for services of hospital-based physicians, but it should depend on the financial arrangement between the physician and the hospital.

Response—A hospital is required to bill for services of hospital-based physicians if the physician is employed by or under contract to the hospital. This requires that the hospital pay the physician. However, if the hospital-based physician merely has an agreement with the hospital to provide services with no requirement that the hospital reimburse the physician, the physician may bill CHAMPUS for his or

her services. We will reword this section to ensure that this is clear.

Comment—The proposed rule apparently includes nurse anesthesia services within the DRG amount. This is a significant departure from the way they are reimbursed under Medicare. The rule should be amended to provide for payment for nurse anesthesia services outside of the DRG system.

Response—When we prepared the proposed rule we were unaware that Medicare had changed from its initial intention to include nurse anesthetists in the DRG payment. We will include a new section which exempts nurse anesthetists from our DRG system and permits hospitals to bill separately for their services. We are aware that Medicare intends to reimburse them as a cost passthrough until October 1989, but CHAMPUS has no comparable cost-reporting system. Therefore, we are allowing hospitals to bill separately which conforms to the procedures Medicare will use beginning in 1989.

Comment—Bone marrow transplantation and AIDs should be exempt from the CHAMPUS DRG-based payment system.

Response—Bone marrow transplantation has been an accepted medical practice for sufficient time so that procedures and charges are stabilized. Therefore, DRG-based payment amounts accurately reflect average costs. Most admissions of AIDs patients are not for treatment of AIDs itself, but rather such patients are generally admitted for a complication of AIDs which would be identifiable in our DRG system. Thus, for the present time the DRG system appears able to deal fairly and appropriately with medical care for AIDs and AIDS-related conditions. However, we will continue to monitor developments in this regard and will be ready to make revisions in the future, if appropriate.

c. Hospitals subject to the CHAMPUS DRG-based payment system (§ 199.14(a)(1)(ii)(D)). All hospitals within the fifty states, the District of Columbia, and Puerto Rico which are certified to provide services to CHAMPUS beneficiaries are subject to the DRG-based payment system except for certain types of hospitals or units which are identified.

Comment—Children's hospitals were specifically excluded from the Medicare DRG-based system due to the inadequacies of DRGs for classifying children's conditions. The DRG classification system does not distinguish the more complex and resource intensive children's conditions which are treated by children's and/or large teaching hospitals. Therefore,

including them would seriously underfund costs for treating these children. They should be exempt.

Response—We have examined CHAMPUS data relating to the charges of children's hospitals, large teaching hospitals and other short-term acute-care hospitals. Our analysis showed that when charges are adjusted for wage, teaching activity, and case mix differences, the average charge per pediatric case for children's hospitals is significantly higher than the national average. Large teaching hospitals and other acute-care hospitals' average charges, however, did not significantly vary from the national average charge per pediatric case. Therefore, we will exempt children's hospitals from the CHAMPUS DRG-based payment system because of their unique circumstances.

In order to be exempt, the hospital must be exempt under the Medicare PPS, or if it is not a Medicare provider, it must meet the same criteria required for exemption under the Medicare PPS. However, we believe the CHAMPUS DRG-based payment system can be modified to accommodate children's hospitals, and we intend to review this area so that children's hospitals can be incorporated into our DRG system in the future. We will also welcome any input from interested organizations in this regard.

Comment—How will exempt facilities be reimbursed?

Response—Hospitals or units which are exempt from the CHAMPUS DRG-based payment system will be reimbursed just as they have been in the past—that is, based on their billed charges.

IV. Determination of Payment Amounts (§ 199.14(a)(1)(iii))

The actual payment for an individual claim under the CHAMPUS DRG-based payment system is calculated by multiplying the adjusted standardized amount by a weighting factor specific to each DRG. The adjusted standardized amounts and the DRG weights shall be calculated from a database of CHAMPUS claims covering at least twelve (12) months.

We used the following procedures to develop the database. CHAMPUS used the same database to calculate both the DRG weights and the adjusted standardized amounts (ASA). The data consisted of all CHAMPUS inpatient claims processed during a 12-month period from July 1, 1986, through June 30, 1987. The data are in UB-82 record format submitted by CHAMPUS fiscal intermediaries.

The database includes only those services and hospitals that will be

subject to DRG reimbursement. Moreover, data errors were removed from the database.

Comment—It is necessary to have the final weights and rates in order to evaluate the impact of the system.

Response—In order to ensure that the final weights and rates are based on the most recent possible data, we are using a database covering July 1, 1986, through June 30, 1987. As a result, the final weights and rates were not available when the proposed rule was published. However, we did calculate preliminary weights and rates from an earlier and more abbreviated database, and we included the resultant adjusted standardized amount and a sample of weights in the proposed rule. This was certainly sufficient to give interested parties a good understanding of the impact of the proposed rule on actual payment amounts, providing additional perspective to aid in consideration of the methodology described in the rule. We also provided a complete list of the preliminary weights to anyone who requested it. The final weights and rates are attached to this final rule for information (Tables 1 and 2). Subsequent changes to the weights and rates will be published as a notice in the Federal Register.

Comment—Several commenters questioned if the data used in the database are reliable.

Response—In our view, there are three components of data reliability: The technical adequacy of the sample, the accuracy of diagnosis and procedure coding, and the reliability of the billed charge amounts on the bill.

We think that the database is technically adequate, because it consists of all CHAMPUS claims processed from July 1, 1986, through June 30, 1987.

The database used for the final weight and adjusted standardized amount (ASA) calculations also has been edited for duplicate records, total charge errors, interim bills, combined bills for mother and newborn services, and admission and discharge date errors. Moreover, all records without valid diagnoses and procedure codes were eliminated from the database. In short, the final database represents a "clean" set of records for the most recently available full year period of CHAMPUS claims. We feel that a dataset of this type will result in reliable and accurate weights and ASA.

We think that the diagnosis and procedure codes are accurate, because they are completed by medical record technicians that conduct the same coding for Medicare discharges.

Finally, we are confident that the amount recorded on the bill is the actual billed charges, because the data reflect amounts paid to hospitals, including claims adjustments.

Comment—The proposed October 1 effective date does not permit CHAMPUS to develop a comprehensive database for use in the calculation of weights and the adjusted standardized amount (ASA). Moreover, there isn't sufficient time between the end of the database period and the effective date to calculate the weights and rates.

Response—OCHAMPUS has been working on development of a DRG-based payment system since early 1984. A significant part of this effort has been to develop a comprehensive and accurate database from CHAMPUS claims which could be used to calculate the weights and ASA. We have also previously developed the programming necessary to calculate the weights and ASA. Therefore, the October 1 effective date will have no detrimental effect on the comprehensiveness of the database nor on the ability to timely calculate the weights and ASA.

Comment—Since CHAMPUS is ending the database with June 30, the database will not contain adequate data on long lengths-of-stay.

Response—The database is comprised of claims processed during the subject period and includes final bills. While long stays which are not completed as of June 30 will not be included in the database, any stays which began prior to July 1, 1986, but finished during the database period will be included. There is no reason to believe these will not be comparable. Thus, long stays will be adequately represented in the database.

A. DRG Weighting Factors

1. Calculation of DRG Weights (§ 199.14(a)(1)(iii)(A))

The 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. If there are any DRGs which have fewer than ten occurrences in the database, we will use the Medicare weight until we are able to develop a weight based on CHAMPUS data.

Comment—Use of a national average charge per discharge for the weighting denominator, rather than working on a regional or per hospital basis, will have an adverse effect.

Response—In response to the inequities resulting from other weighting methodologies, Congress required Medicare to adopt the discharge-weighted weights and rates in FY 1988

(section 1886(d)(3)(A) of the Social Security Act, as amended by section 9302(c) of Pub. L. 99-509). Similarly, CHAMPUS will discharge weight its weights and rates.

Comment—Several commenters questioned whether CHAMPUS would be able to calculate accurate weights for all DRGs, or if some DRGs would have insufficient data from which to develop a weight.

Response—We recognize this as a potential problem. In the proposed rule we proposed using the Medicare weight in those cases where there were no occurrences of a DRG in the database, and in the preliminary database this occurred only twice. However, we realize that a weight for a DRG with only a very few occurrences could be skewed. Therefore, in the calculation of the final weights we have elected to use the Medicare weight for any DRG with fewer than ten occurrences in the database. We believe this action is justified. First, it will ensure that all DRG weights are calculated from an adequate database. Second, our analysis of CHAMPUS weights compared to Medicare weights indicates that on average they are very similar. Third, we expect very few, if any, DRGs to be affected by this.

B. Calculation of the Adjusted Standardized Amount (§ 199.14(a)(1)(iii)(C))

The adjusted standardized amount (ASA) represents the adjusted average operating cost for treating all CHAMPUS beneficiaries in all DRGs during the database period. The ASA does not include any regional or hospital-specific operating cost elements, nor does it contain an urban/rural distinction.

Comment—Unlike the Medicare PPS, CHAMPUS payment amounts will not be adjusted for differences in prevailing wage levels. This is inappropriate. Wages differ significantly across Metropolitan Statistical Areas (MSAs) and states, reflecting a variety of factors beyond the control of the individual hospital.

Response—This was one of the most frequent comments. We believe that a DRG-based payment system, whose central premise is payment based on averages, should contain few, if any, adjustments to the payment amounts. Nevertheless, we recognize that wages, although by no means completely beyond the control of hospitals, constitute a large part of hospital costs and vary considerably from area to area. The final rule, therefore, in a significant change from the proposed rule, provides for use of the Medicare

area wage indexes in the CHAMPUS DRG-based payment system.

Medicare finds that after adjusting payments for differences in area wage levels, significant differences in payments still exist between urban and rural hospitals. Our analysis of CHAMPUS claims shows that after adjusting CHAMPUS DRG payments for area wages, the gap between urban and rural payments is substantially narrowed by still warrants an urban/rural differentiation in the payment system. We have, therefore, included the use of separate urban and rural adjusted standardized amounts in the final rule.

1. Apply the Cost to Charge Ratio (§ 199.14(a)(1)(iii)(C)(1))

Each charge used in the calculation of the ASA is to be reduced to a representative cost by using the Medicare cost to charge ratio which was published in the Federal Register on September 3, 1986 (p. 31523).

Comment—CHAMPUS patients will probably have a different utilization pattern than Medicare patients. Therefore, the ratio is not applicable to CHAMPUS.

Response—CHAMPUS patients have a different distribution of diagnoses than Medicare patients. CHAMPUS patients, however, due to the fact that they are a younger and healthier population than Medicare patients, require less resource intensity for the same services provided to Medicare patients. For example, hospitals generally post the same room charge for all patients. Some of the services provided in this charge include general nursing care and supervision unrelated to specific procedures. In this instance, CHAMPUS patients would require less general nursing care than a more elderly Medicare patient. Therefore, the actual cost or labor intensity required per CHAMPUS patient would be lower than that required of a Medicare patient.

The Medicare cost-to-charge ratio has been derived from extensive research and analysis of actual hospital cost reports. Additionally, diagnosis-specific cost for the CHAMPUS population are not available. We think the Medicare cost-to-charge ratio is the best measure of the relation of hospital costs to charges that is currently available.

2. Increase for Bad Debts (§ 199.14(a)(1)(iii)(C)(2))

The base standardized amount shall be increased by .01 in order to reimburse hospitals for bad debt expenses attributable to CHAMPUS beneficiaries.

Comment—Bad debt on required copayments is not uniformly distributed.

some hospitals have higher bad debt levels which should be recognized by CHAMPUS. CHAMPUS should pay actual costs or collect cost-shares themselves.

Response—In the past, CHAMPUS has not reimbursed hospitals for bad debt on beneficiary cost-sharing and deductibles. We think that the inclusion of the same add-on for bad debt to every DRG payment is generous given our past policy. Under this policy, hospitals will be paid *prospectively* for bad debt expenses for every CHAMPUS discharge through a 1 percentage point add-on to the cost-to-charge ratio.

Moreover, since the large majority of our retiree beneficiaries have either other insurance which is primary or supplemental insurance, we are confident that the allowance is fair and reasonable. Collection of beneficiary cost-shares and deductibles has traditionally been a hospital function and is done for nearly all third-party payers.

3. Preliminary Teaching Standardized Amounts (§ 199.14(a)(1)(iii)(C)(5))

A separate standardized amount shall be calculated for each teaching hospital to reimburse for indirect medical

education expenses. This will be done by using a hospital-specific indirect medical education factor calculated in accordance with Medicare procedures.

Although we received no written comments on this, we believe a change from our proposed rule is warranted. Medicare has changed its indirect medical education formula to account for an adjustment for disproportionate share hospitals. This adjustment is scheduled to end September 30, 1989. Since CHAMPUS has no disproportionate share provision, we believe immediate use of the following revised formula is proper.

$$1.5 \times \left[\left(1.0 + \frac{\text{number of interns + residents}}{\text{number of beds}} \right) .5795 - 1.0 \right]$$

Medicare has proposed that Congress reduce the indirect medical education factor in recognition of the fact that the current formula significantly overcompensates hospitals for these costs. CHAMPUS is in agreement with the Medicare proposal, but in order to remain consistent with the current Medicare program, CHAMPUS will use the above formula at this time. Should Congress adopt the Medicare proposal, CHAMPUS will revise its formula accordingly.

4. Updating the Adjusted Standardized Amount (§ 199.14(a)(1)(iii)(C)(7))

Beginning in FY 1989, the ASA will be updated by the Medicare annual update factor, unless the adjusted standardized amount is recalculated.

Comment—It is inappropriate to use the Medicare update factor. CHAMPUS should use the market basket rate of increase.

Response—We think it is important that the government promulgate a uniform DRG update factor for both DRG systems. Medicare and CHAMPUS. Congress establishes this factor each year after considering input from PROPAC, the health care industry, and HCFA. We will comply with the Congressionally-approved update factor.

C. Adjustments to the DRG-Based Payment Amounts (§ 199.14(a)(1)(iv))

Any hospital subject to the CHAMPUS DRG-based payment system can be reimbursed for allowed capital and direct medical education costs upon request. Payment for these costs will be made annually based on the ratio of CHAMPUS inpatient days to total inpatient days.

We have revised this provision in the final rule. In order to conform to the

current statutory requirements for Medicare, the calculated payment for capital costs will be reduced by 7% for FY 1988. If Medicare changes this reduction percentage in the future, CHAMPUS reserves the right to conform to the Medicare change.

Comment—Payment of capital and direct medical education costs annually is inequitable and will hurt hospitals' cash flow, since they must service their debt and pay operating bills timely.

Response—The payments for these items will be sufficiently small, particularly relative to total hospital revenues, that the administrative cost of more frequent payments is not justified. Moreover, CHAMPUS does not have hospital cost information with which to formulate accurate estimates of interim payments for capital and direct medical education.

1. Information Necessary for Payment of Capital and Direct Medical Education Costs (§ 199.14(a)(1)(iv)(C))

In order to be reimbursed for allowed capital and direct medical education costs, a hospital must submit a report of its incurred costs to the CHAMPUS fiscal intermediary. The report must cover the same period as the hospital's Medicare cost-reporting period and must be submitted within three months of the end of that period.

Comment—The CHAMPUS DRG-based payment system adds additional reporting requirements. The last thing hospitals need is a separate data gathering-monitoring-reporting system for CHAMPUS beneficiaries.

Response—Without this report there is no way for CHAMPUS to determine what capital and direct medical education costs a hospital has incurred for CHAMPUS beneficiaries. The report

itself is extremely simple and, in addition to readily available CHAMPUS demographic information, requires only a few other items which are all available from the hospital's Medicare cost report. The CHAMPUS method for reimbursing hospitals for capital and direct medical education results in equitable payments based on hospital-specific CHAMPUS information. Moreover, the reporting requirements of this method are minimal when compared to other capital payment mechanisms such as a cost-finding method.

Comment—All data reported to the FI must agree with the Medicare cost report, and the provider must report any changes. Presently, the Medicare intermediaries supply HCFA with computer tapes/diskettes of all filed cost-reports. Why not have OCHAMPUS and HCFA exchange data?

Response—This would be an enormous administrative task to identify a few changes to the capital and direct medical education payments CHAMPUS makes. In addition, we believe it is the hospital's responsibility to report accurate information to OCHAMPUS.

Comment—CHAMPUS should allow hospitals to use either the Medicare cost-finding method or the aggregate ratio of CHAMPUS PPS-related charges to total charges. A flat per diem is not sensitive to differences in the percentage of operating costs from one ancillary service to another.

Response—The proposed per diem capital payment policy provides reasonable payments for capital costs consistent with the current Medicare per diem payment methodology and results in minimal reporting requirements for hospitals. A cost-finding method similar to Medicare's cost reporting mechanism

is not in hospitals' interest, because it will burden them with extensive reporting requirements for CHAMPUS patients, a payer that generally accounts for a small percentage of each hospital's total revenues. The second alternative, capital payments based on the ratio of CHAMPUS charges to total charges is inadequate. If implemented, this policy would not be consistent with Medicare's current per diem calculation of capital costs. We recognize the fact that Medicare is proposing a revision to their current capital payment policy. CHAMPUS supports this proposal, but due to its reporting requirements on hospitals, it would be administratively infeasible for CHAMPUS to implement at this time. When the Medicare proposal is finally implemented in the Medicare system, CHAMPUS will consider it for inclusion in the CHAMPUS DRG-based payment system.

2. Outliers (§ 199.14(a)(1)(iii)(D))

CHAMPUS will adjust DRG-based payments 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.

Comment—There is no mention of a target outlier pool.

Response—The CHAMPUS DRG-based payment system does not have an outlier pool. Under the Medicare PPS, an estimated percentage of total DRG-based payments is set aside as an outlier pool, thus actually reducing the non-outlier DRG-based payments. Under the CHAMPUS DRG-based payment system, outlier payments are made over and above the basic DRG payments.

Comment—Medicare is changing their outlier policy to recognize the most expensive cases. Will CHAMPUS make similar changes?

Response—We do not intend to adopt the proposed changes until we can fully assess their impact on CHAMPUS claims and whether they produce more equitable payments.

Comment—Under the CHAMPUS DRG system, providers are at unlimited risk for extremely ill patients.

Response—Providers will not be at unlimited risk, because our system includes payments for outliers, and we believe the outlier payments are reasonable.

Comment—Will the outlier thresholds be revised to coincide with the Medicare outlier thresholds?

Response—There is no intent that the thresholds be the same. While our methodology for determining the

thresholds is the same, the actual thresholds will be derived from the CHAMPUS database and will be different. Our intent is that the thresholds reflect the service patterns for CHAMPUS beneficiaries.

a. Short-stay outliers
(§ 199.14(a)(1)(iii)(D)(i)). Any discharge with a length-of-stay (LOS) less than 1.94 standard deviations from the DRG's geometric LOS shall be classified as a short-stay outlier. 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.

Comment—Several commenters objected to our inclusion of short-stay outliers in the CHAMPUS DRG-based payment system.

Response—Short-stay outliers are fully justified. Just as an exceptionally long length-of-stay should not be considered typical for a given DRG and deserves additional payment, an exceptionally short stay should also not be considered typical and payment should be reduced. Nevertheless, we recognize that the initial days of a hospital stay are generally more expensive, so we have set the short-stay reimbursement at 200 percent of the per diem.

Comment—Many patients will have lengths-of-stay just over the short-stay outlier cutoff. This will make the process of medical review extremely expensive for both CHAMPUS and the provider.

Response—Since DRG-based payment is based on averages, we expect many stays to be shorter than the average. The short-stay outlier policy is intended to isolate those cases with a length-of-stay which is so different from the norm (in this case extraordinarily short) that it is not representative of cases within that DRG. However, the fact that cases exceed the short-stay cutoff but still are less than average will not affect the amount or extent of review to be performed.

Comment—It was indicated an average payment amount was used because some cases will cost more than others, but it will even out in total. Short-stay outliers eliminate that possibility.

Response—This is not correct. The short-stay outlier policy only eliminates those cases with such unusually short lengths-of-stay, that they are not representative of cases within the DRG. However, many cases will exceed the short-stay cutoff and still be less than the average length-of-stay. It is these cases which will allow the averaging effect. The short-stay policy is simply a counterbalance to the long-stay policy which is well accepted.

Comment—The short-stay outlier policy could result in significant financial losses in cases where a patient dies soon after admission.

Response—We recognize the fact that the initial days of a hospital stay are relatively more costly than the final days of a stay. Therefore, we will pay hospitals 200 percent of a DRG-specific per diem for short stay outlier cases. We think that this level of payment is reasonable.

V. Charges to Beneficiaries

A. Inpatient Cost-Sharing

1. Services Subject to the CHAMPUS DRG-Based Payment System (§ 199.4(f)(3)(ii)(A))

Under the proposed rule, for beneficiaries other than dependents of active-duty members the cost-share would have been a per diem amount for each day of the hospital stay, except that the day of discharge would not be counted. The per diem amount would be calculated so that total cost-sharing amounts for these beneficiaries is equivalent to 25 percent of the CHAMPUS-determined allowable costs for hospital services.

Within the Department of Defense there has been some concern that the proposed cost-sharing policy could result in some beneficiaries paying more cost-share than they would pay under current procedures. We therefore examined data which projected cost-shares under both the current and proposed procedures, and we found that approximately 30% of these beneficiaries would have greater cost-shares, although in most cases the actual increase was quite small. Even so, we found this to be an unacceptable consequence for our beneficiaries.

In order to correct this situation, the final rule modifies the cost-sharing provisions for these beneficiaries. The cost-share will be calculated at the lesser of the per diem-based amount or 25 percent of the hospital's billed charges. In this way no beneficiary will be responsible for a larger cost-share than currently required, and most will have smaller cost-shares. As a result of this change, the per diem amount has been increased slightly so that total cost-sharing amounts still equal 25% of the CHAMPUS-determined allowable amounts as required by the CHAMPUS statute.

This change in policy from the proposed rule does not in any way reduce the overall substantial cost-savings for beneficiaries as a whole. Non-active duty dependent beneficiaries will pay significantly less than they do

now. The change in policy means that none of these beneficiaries will pay any more than they do now; most will pay less; and that about half of the time they will save over \$100 per hospital stay.

Comment—What is the beneficiary cost-share if the patient dies on the day of admission?

Response—In any case in which the length-of-stay is less than 24 hours, but the stay qualifies as an inpatient stay under CHAMPUS rules, the beneficiary cost-share is to be calculated based on a one-day stay.

Comment—It will be cumbersome to calculate beneficiary cost-shares when the actual charges are less than the DRG-based payment.

Response—We have been very careful to ensure that the cost-sharing methodology would be easy for hospitals to calculate at the time of discharge. Since both length-of-stay and actual charges are known at discharge, the hospital should have no trouble calculating the beneficiary's cost-share.

B. Hospital Days Beyond that Deemed Medically Necessary (§ 199.4(f)(6))

Under current CHAMPUS procedures, as required by law, no CHAMPUS payments may be made for care provided which is not medically necessary. Although it does not occur frequently, application of this rule may result in beneficiaries being responsible for payments they hoped CHAMPUS would cover. Some media reports after publication of the proposed rule created confusion regarding application of this requirement under the DRG system.

Under the DRG-based payment system, this requirement is unchanged. In the usual case, the DRG amount will be considered full payment for all days of care. However, in the unusual cases in which the length of stay exceeds the long-stay outlier standard, additional payments will generally be made to the hospital. In these cases, it is possible that applying the requirement of medically necessary care could result in some or all of the additional payment being disallowed. In addition, as in the current program, an entire hospital admission could be determined not medically necessary, resulting in the claim being disallowed.

These possibilities, however, do not represent any change from currently required procedures. Moreover, implementation of the DRG-based payment system is not expected to result in any increase in the frequency of disallowed claims based on a lack of medical necessity.

VI. Quality of Care Review (§ 199.14(a)(1)(v))

Implementation of the Medicare DRG system generated concerns about the quality of care. In response to these concerns Congress established a Peer Review Organization (PRO) system to determine adequacy and appropriateness of care. Congressional hearings continued to be held that focused on complaints of premature discharge. Medicare revised its PRO system to concentrate further on quality of care issues. As a result of these efforts, the state of the art of process, structure, and outcome measures of the quality of care has evolved to the point where both nationally and locally developed peer review systems are widely recognized as effectively monitoring the quality of care provided.

In connection with implementing the CHAMPUS DRG system, we will piggyback on the established Federal system for monitoring the quality and appropriateness of civilian inpatient care for its beneficiaries.

CHAMPUS will implement a quality of care review program which will assure the appropriateness of care provided to beneficiaries. Every case reimbursed under the DRG system will be subject to generic quality screen reviews, admission and discharge reviews, and DRG validation. One of the objectives of these multiple reviews is to guard against episodes of premature discharge or inappropriate admission. A peer review system will use criteria which has been developed on both national and local levels to determine the adequacy and appropriateness of care. This system, which is modeled on the Medicare PRO system, will be specific to the CHAMPUS population.

Comment—The current CHAMPUS system for reviewing psychiatric and substance abuse treatment works well and ensures adequate and qualified review. Therefore, psychiatric and substance abuse services should be excluded from PRO review.

Response—The admission and quality review system set forth in this rule applies only to those services reimbursed under the CHAMPUS DRG-based payment system. Therefore, psychiatric and substance abuse services, which are exempt from DRG-based payment, will be excluded from the review system.

Comment—What are the procedures to be followed in conducting the admission and quality review?

Response—There will be two phases of review under the CHAMPUS DRG-based payment system. The permanent review system is being coordinated with

the Health Care Financing Administration. HCFA is currently in the process of recomputing its PRO contracts and the new contracts will be phased in between July and December 1988. Quality assurance reviews of CHAMPUS claims and services may be included in future PRO contracts. In the interim, CHAMPUS will conduct quality of care reviews under a separate contract. The admission and quality review section of this rule provides the basis for these review functions. Information regarding the detailed procedures will be found in the RFPs and resulting contracts for both the interim and proposed permanent review systems.

A. Areas of Review

1. Admissions (§ 199.14(a)(1)(v)(C)(I))

This section sets forth the areas which are to be reviewed to determine whether inpatient care is medically necessary and whether services are delivered in the most appropriate setting.

Comment—All transfers of CHAMPUS beneficiaries from a hospital or hospital unit subject to the CHAMPUS DRG-based payment system to another hospital or hospital unit are to be reviewed. Does this include transfers from a hospital or unit subject to the DRG system to a hospital or unit exempt from the system?

Response—We have clarified in this final rule that these cases are to be classified as discharges. This particular section applies only to those actions which are classified as transfers, so a transfer to a hospital or unit exempt from the DRG system would not be reviewed under this provision.

Comment—All CHAMPUS admissions to a hospital or unit subject to the DRG system which occur within seven calendar days of discharge from a hospital or unit subject to the DRG system are to be reviewed. Will the time periods involved in this provision be changed to coincide with Medicare's review requirement?

Response—To the extent possible, we want hospitals and PROs to be subject to only a single set of review procedures. Therefore, we will use the same time periods.

Comment—If the number of unnecessary CHAMPUS admissions for a hospital is more than 2.5 percent of the review sample or three cases (whichever is greater) for any quarter, all CHAMPUS admissions for that hospital must be reviewed during the following quarter. Will this threshold for intensified review be changed to coincide with Medicare? Can the review

organization focus on identified subsets rather than intensify an entire provider?

Response—The requirements will duplicate Medicare's.

Comment—Prepayment review is required for all CHAMPUS admissions in any DRGs which have been specifically identified by OCHAMPUS. Has OCHAMPUS identified any such DRGs?

Response—None have been identified to date. The selection of the DRGs for pre-admission or pre-procedure review will be based on data which targets known or suspected high risk topics.

2. Admission Pattern Monitoring (§ 199.14(a)(1)(v)(C)(2))

In order to ensure that discharges are appropriate, admissions for those hospitals identified as having significant increases in quarterly discharges shall be reviewed.

Comment—Medicare has determined that admission pattern monitoring was nonproductive and has eliminated it. Will CHAMPUS?

Response—As for other areas of review, we will duplicate Medicare in this respect.

3. Procedure Review (§ 199.14(a)(1)(v)(C)(5))

All claims for procedures identified by OCHAMPUS as subject to a pattern of abuse shall be reviewed.

Comment—Has OCHAMPUS identified any procedures subject to this review?

Response—Not yet. This type of review will not be implemented until the permanent review system has begun.

B. Fiscal Intermediary Actions as a Result of Review (§ 199.14(a)(1)(v)(D))

CHAMPUS intends for the FI, not the PRO, to institute corrective actions by the hospital. Therefore, this section enumerates those actions which a fiscal intermediary may take if the PRO determines that a hospital has misrepresented admission, discharge, or billing information, or has taken an action that results in the unnecessary admission of an individual entitled to benefits, unnecessary multiple admissions of an individual, or other inappropriate medical or other practices. This finding may be with regard to an individual claim or a pattern of inappropriate practices.

Comment—What procedures have been developed for this process—how is the fiscal intermediary to be notified, etc.

Response—As for other detailed information on these procedures, it will be found in the RFPs and resulting contracts for both the interim and

permanent review systems. OCHAMPUS also will issue guidance in the future on the review systems which will provide additional information.

VII. Summary of Regulations Changes

For the convenience of the reader, we are summarizing the changes we are making to the proposed rule as a result of public comments. The reader is referred to the detailed discussions above for a complete explanation of the rationale for these changes.

A. Urban/Rural Differentiation

There will be separate adjusted amounts (ASAs) calculated for urban and for rural areas. The same urban/rural designations used in the Medicare PPS will be used in the CHAMPUS DRG payment system.

B. Wage Index

Each adjusted standardized amount (ASA) which will be divided into labor and nonlabor portions. The wage index adjustments used by Medicare will be applied to the labor portions of each ASA. This amount will then be added to the nonlabor portion, and the sum will be multiplied by the DRG weight to arrive at the DRG-based payment amount.

C. State Waivers

Any state which has been exempted from the Medicare PPS can request an exemption from the CHAMPUS system.

D. Children's Hospitals

Any children's hospital which is exempt from the Medicare PPS will be exempt from the CHAMPUS system.

E. Cost-Shares

The cost-share for beneficiaries other than dependents of active duty members will be the lesser of (a) the amount based on the per diem as described in the proposed rule, or (b) 25% of the billed charge, but it can never exceed the DRG-based amount.

F. Grouper Program

The CHAMPUS system will use the most recently available Medicare Grouper program.

G. Nurse Anesthetists

Hospitals will be allowed to bill separately for nurse anesthetists' services just as they may for hospital-based physicians.

H. Capital and Direct Medical Education Payments

The capital payment for FY 1988 is to be reduced by 7% in accordance with Medicare procedures.

I. Discharges/Transfers

It is to be considered a discharge if the patient is transferred from the care of a hospital included under the CHAMPUS DRG-based payment system to a hospital or unit that is excluded from the DRG system, except for transfers to uniformed services treatment facilities.

VIII. Summary of Differences from the Medicare PPS

Although the CHAMPUS DRG-based payment system is modeled on the Medicare PPS, there are several differences. Below we have summarized the significant differences which are not addressed in the summary of public comments.

A. Services Subject to the CHAMPUS DRG-Based Payment System

The CHAMPUS DRG-based payment system exempts some services which are included in the Medicare PPS. They are: Psychiatric services in short-term hospitals; heart transplantation services; and liver transplantation services. We have exempted psychiatric services, because research has shown that psychiatric DRGs may not be a reliable measure of cost variability for psychiatric cases under CHAMPUS. We have also exempted heart and liver transplantation services for much the same reason—that is, we are concerned that the DRG-based amounts also may not be a reliable measure of their cost variability, since they occur infrequently and involve significant costs.

B. Hospitals Subject to the CHAMPUS DRG-Based Payment System

CHAMPUS has exempted certain types of hospitals from our DRG system which are subject to the Medicare PPS. Sole community hospitals are paid under special provisions under the Medicare PPS based in part on hospital-specific costs which are unavailable to CHAMPUS. Therefore, we have exempted them. Christian Science Sanitoriums are paid a predetermined fixed amount per discharge under Medicare. However, since they involve such a small number of providers and CHAMPUS claims and since some may qualify under the long-term hospital exemption anyway, we have elected to exempt all of them.

C. Updating DRG Weights

Medicare is required to update their weights annually. We plan to recalculate CHAMPUS weights annually based on a charge sample from the most recent period under CHAMPUS prospective payment. Notice of the

revised weights will be published in the **Federal Register**.

D. Inclusion of Puerto Rico

Although Puerto Rico is included in the Medicare PPS beginning in October 1987, hospitals there will be reimbursed using a blend of the national rate and the Puerto Rico discharge-weighted urban or rural standardized rate. The CHAMPUS DRG-based payment system makes no distinction for Puerto Rican hospitals.

E. Capital and Direct Medical Education Payments

These items are reimbursed as a cost passthrough under the Medicare PPS. CHAMPUS will pay for these items upon written request. CHAMPUS has no cost-reporting mechanism, but the report of these costs which is submitted to the CHAMPUS fiscal intermediary must correspond to the Medicare cost-report. We support the current Medicare proposals that revise the payment methodologies for capital and direct medical education. CHAMPUS' implementation of these proposals at this time would be administratively infeasible. However, once Medicare adopts the new methodologies, CHAMPUS will consider them for inclusion in the CHAMPUS system.

F. Bad Debt Adjustment

The adjusted standardized amount used in the CHAMPUS DRG-based payment system contains a factor to reimburse hospitals for CHAMPUS' share of their bad debts. Under the Medicare PPS, bad debts are reimbursed as a cost passthrough.

IX. Impact Analysis

A. Executive Order 12291 and the Regulatory Flexibility Act

Executive Order 12291 requires that a regulatory impact analysis be performed on any major rule. A "major rule" is defined as one which would:

Result in annual effect on the national economy of \$100 million or more;

Result in a major increase in costs or prices for consumers, any industries, any government agencies, or any geographic regions; or

Have significant adverse effects on competition, employment, investment, productivity, innovation or on the ability of U.S.-based enterprises to compete with foreign-based enterprises in domestic or import markets.

The Regulatory Flexibility Act requires that each federal agency prepare, and make available for public comment, a regulatory flexibility analysis when the agency issues regulations which would have a

significant impact on a substantial number of small entities. For purposes of the Regulatory Flexibility Act, we consider small entities to include all nonprofit and most for-profit hospitals.

Under both the Executive Order and the Regulatory Flexibility Act, such analyses must, when prepared, examine regulatory alternatives which minimize unnecessary burden or otherwise assure that regulations are cost-effective.

We are treating this final rule as a major rule under Executive Order 12291, since we anticipate that the changed reimbursement procedures required by this final rule will result in annual program savings exceeding \$100 million. The Department of Defense Authorization Act, 1984, which provides the authority for CHAMPUS to use a DRG-based payment system, allows some administrative discretion in the implementation of such a reimbursement system. Therefore, this analysis examines the major features of the system and the rationale for each.

Because of the extensive changes this final rule will cause in our methods for paying for inpatient hospital services, we are providing the following discussion which, when combined with the rest of this preamble, constitutes a regulatory impact analysis and a voluntary regulatory impact/flexibility analysis.

B. The Problem of Increased CHAMPUS Costs

The rapidly rising costs of health care have been the focus of numerous studies and have resulted in many efforts to curb the rise. Most notable of these efforts is the implementation of the Medicare Prospective Payment System (PPS) which was implemented in October 1983. Although the PPS was required to be "budget neutral" during its early years, it has had a significant impact, not only on Medicare, but also on the delivery of health care services to the public as a whole. CHAMPUS has unquestionably benefited from this in certain respects, but nevertheless our costs continue to rise at an unacceptable rate. For example, a comparison of CHAMPUS data for FY 1985 to FY 1983 shows that, while the number of admissions and the average length-of-stay have decreased, the cost per admission has increased 19.4 percent, the cost per inpatient day has increased 26.2 percent and total CHAMPUS expenditures for inpatient care increased 11.1 percent. This trend continued into FY 1986 with total hospital costs increasing 19.0 percent from FY 1985, although admissions during that year also increased by 9

percent. Average length-of-stay remained the same.

We attribute these increases to several factors. The first is inflation, but since inflation in the economy as a whole has slowed considerably, its role in the increases is minor. A second contributing factor is the absence of traditional supply and demand forces operating to curb excessive expenditures, although, like inflation, this has been checked somewhat in recent years, particularly by the Medicare PPS and other similar programs. A third factor which is significant is CHAMPUS' practice of reimbursing hospitals based on their billed charges. This creates no incentive for hospitals to control costs, and, in fact, creates the opposite incentive. This ties into the fourth factor, which is cost-shifting to billed charge payers such as CHAMPUS from other third-party payers which have placed limitations on payments.

C. A DRG-Based Payment System Represents the Best Resolution of the Problem of Increasing Costs

There can be no doubt that the Medicare PPS has significantly affected the delivery of hospital services in the United States. The CHAMPUS DRG-based payment system closely resembles the Medicare system and will benefit from the same advantages. Of particular importance, it will enable us to set our reimbursement levels to more closely equal hospitals' costs of providing services to our beneficiaries, and it will enable us to avoid the increases in charges resulting from cost-shifting which results in CHAMPUS subsidizing non-CHAMPUS patients. We fully intend to reimburse hospitals the reasonable costs of providing care to our beneficiaries, but in order to maintain the level of benefits offered by CHAMPUS under increasing budgetary constraints, it is incumbent upon us to implement steps to control our costs.

D. Quantification of Impact

In our initial impact analysis in the proposed amendment of rule we described the impacts we expect the CHAMPUS DRG-based payment system to have on hospitals, beneficiaries, and fiscal intermediaries. We also solicited comments and factual information that would enable us to describe and quantify in greater detail the effects of our DRG system. Although we received numerous comments regarding specific provisions which we have addressed earlier in this preamble, we received no specific information with regard to the economic impact.

Subsequent to publication of the proposed rule we have completed a further analysis of the impact of this change. This analysis resulted in an estimate of \$200 million savings to CHAMPUS for inpatient services provided during FY 1988. However, the effects of DRG-based payments will not actually begin until perhaps three months after implementation of the system because of actual service time, time to submit claims, and the time to process the claims. Therefore, actual CHAMPUS savings during FY 1988 would be approximately \$150 million.

E. Economic Impacts

In this section we will discuss the impact on hospitals, on our beneficiaries, and on CHAMPUS operations.

1. Hospital Impact

Since the Medicare PPS has been in operation for nearly four years, we believe hospitals have adjusted their operations to accommodate it. Therefore, we anticipate few, if any, changes in hospital operations as a result of our implementation of the CHAMPUS DRG-based payment system. Possible operational changes could be in hospitals' billing practices (if they have not already adopted Medicare billing requirements for CHAMPUS), in the need for additional medical records personnel, and perhaps in increased hospital utilization review activities. For the most part, however, these impacts should be negligible, since CHAMPUS beneficiaries constitute such a small part of most hospitals' patient loads. There may be some hospitals which serve a large number of CHAMPUS beneficiaries and relatively few Medicare beneficiaries, and the impact on these hospitals' operations may be greater, but we expect such hospitals to be very few.

Moreover, we believe some of the distinctions used during the Medicare PPS transition period, such as hospital-specific and regional differentiations, are not necessary for the CHAMPUS DRG-based payment system, because CHAMPUS charges generally represent a small percentage of each hospital's total revenues and because hospitals have already adjusted their operating practices in response to the Medicare PPS. Moreover, the end of Medicare's phase-in period which recognized the regional and hospital-specific distinctions will approximately coincide with the effective date of the CHAMPUS DRG-based payment system. However, as noted earlier in this preamble, we have included an urban/rural differentiation and a wage index

provision in the final rule in order to recognize these differences.

The primary impact of the CHAMPUS DRG-based payment system will be in the immediate reduction of total CHAMPUS payments to hospitals. It will also give us the ability to control increases in costs in the future. Because the CHAMPUS DRG-based payment system is modeled on the Medicare PPS, CHAMPUS payments for our beneficiaries will be more proportionate to Medicare payment for Medicare beneficiaries. In addition, CHAMPUS will no longer pay those amounts which have been shifted to charge payers because of payment limitations imposed by various states and other third-party payers.

The CHAMPUS DRG-based payment system includes a number of provisions and procedures which we believe help to mitigate its impact on hospitals. These include:

a. Use of Medicare cost to charge ratio. The base from which the standardized amounts are calculated is 66 percent of charges. This is the Medicare cost to charge ratio which was published in the Federal Register on September 3, 1986. This ratio excludes capital costs and direct medical education costs. Because hospitals' posted charges to third-party payers are generally consistent, this ratio provides a reasonable estimate of CHAMPUS costs relative to charges. Moreover, it represents those costs which have been identified, through statute and regulation, as reimbursable under the major government program. At the same time, this ratio is derived from claims for Medicare beneficiaries. Since our beneficiaries are considerably younger and generally healthier on average, we believe that an average CHAMPUS beneficiary would use fewer hospital resources than an average Medicare beneficiary classified under the same DRG.

b. Bad debts. In order to recognize our share of hospitals' bad debts for CHAMPUS patients (that is, unpaid cost-sharing amounts), we have increased the base amount for the standardized amounts from .66 to .67. This is an increase of about 1.5 percent which is actually more than our share of CHAMPUS bad debts.

c. Use of CHAMPUS-specific weights. We recognize that, because of the differences between our beneficiaries and Medicare's beneficiaries, their relative resource consumption in the various DRGs will be different. In order to ensure that the payment amounts used in the CHAMPUS DRG-based payment system are reasonable for our

beneficiaries, we will calculate DRG weights from CHAMPUS claims data only.

d. Wage index. We recognize that wages, although by no means completely beyond the control of hospitals, constitute a large part of hospital costs and vary considerably from area to area. We have, therefore, provided for use of the Medicare area wage indexes in the CHAMPUS DRG-based payment system. This provision is essentially budget neutral for CHAMPUS, since it will not directly affect the total amounts paid. However, it will redistribute those payments so that, rather than all hospitals being paid the same amount for the same DRG, those hospitals in high wage areas will be paid more than the average and those hospitals in low wage areas will be paid less.

e. Urban/rural differentiation. CHAMPUS data indicate that significant differences in the impact of DRG-based payments exist between urban and rural hospitals even after adjusting for area wage differences. We have, therefore, provided for development of separate urban and rural ASAs based on claims data specific to each. As for the use of wage indexes, this provision will be budget neutral.

f. Capital and direct medical education costs. In one CHAMPUS study of the largest inpatient CHAMPUS hospitals, we found that, as a percentage of total expenses, capital costs ranged from 2.4 percent to 20.5 percent. In the same study we found that direct medical education costs vary from 0 percent to 6.1 percent of total expenses. We recognize these are expenses which apply to our beneficiaries. Moreover, at present there is no equitable way to reimburse hospitals for these costs on a uniform basis which would not unduly penalize certain hospitals. The CHAMPUS DRG-based payment system, therefore, includes procedures for hospitals to report their total capital and direct medical education costs to CHAMPUS and be reimbursed CHAMPUS' share based on the ratio of CHAMPUS inpatient days to total inpatient days.

g. Psychiatric services. Most psychiatric services are exempt from DRGs under Medicare with the exception of psychiatric services provided in some acute care facilities that do not qualify for an exemption. Initially, all psychiatric services are exempt from the CHAMPUS DRG-based payment system, but OCHAMPUS is currently studying whether other prospective payment methodologies are appropriate for the provision of

psychiatric services to CHAMPUS patients.

h. Substance abuse services. Although Medicare has developed a DRG classification system for substance abuse services adequate for its beneficiary population, at this time we think that it is unclear whether this system should be applied to CHAMPUS patients because of the distinct characteristics of the CHAMPUS population. Therefore, we have elected to conduct further study on this issue. In the meantime, we will exempt substance abuse services from the CHAMPUS DRG-based payment system and continue to pay for them according to billed charges.

i. Children's hospitals. Both the comments we received, and CHAMPUS data we have examined, indicate that children's hospitals have higher costs, on average, than other hospitals. As a result, we have exempted children's hospitals from the CHAMPUS DRG-based payment system.

2. Beneficiary Impact

The CHAMPUS DRG-based payment system will benefit our beneficiaries and the procedures in this final rule contain various provisions to protect them.

a. Cost-sharing amounts. The cost-sharing provisions under the CHAMPUS DRG-based payment system are structured so that beneficiaries are still responsible on average for the same proportion of allowed costs. There will be no effect on dependents of active duty members in this regard, but on average all other beneficiaries will be required to pay smaller cost-sharing amounts, since the allowed amounts will be reduced.

b. Calculation of cost-shares for beneficiaries other than dependents of active duty members. We conducted a test of DRG-based reimbursement in South Carolina from September 1, 1984, through August 31, 1985. One of the most significant findings of that test was that the calculation of cost-shares for beneficiaries other than dependents of active duty members must be revised. Currently these beneficiaries' cost-share is 25 percent of the allowed amount which is generally nearly equal to the billed amount. During the test we found that under a DRG-based payment system the DRG-based amount sometimes greatly exceeded the hospital's billed charge, resulting in a cost-share equal to, and sometimes exceeding, the billed charge. In order to prevent this inequity, we revised the cost-sharing procedures for these beneficiaries in the proposed rule to require a standard per diem amount for services provided by hospitals subject to

the CHAMPUS DRG-based payment system. This did not entirely correct the problem, however, and some beneficiaries would still be required to pay cost-shares exceeding what would be required under current procedures. Thus, this final rule further modifies the cost-sharing requirements for these beneficiaries. The cost-share will now be the lesser of the per diem-based amount or 25 percent of the hospital's billed charges. In this way no beneficiary's cost-share will increase as a result of DRG-based payment (see Section IV.A. of this preamble).

3. Operational Impact

Fiscal intermediaries will have to make significant changes to their existing claims processing systems in order to implement the CHAMPUS DRG-based payment system. An OCHAMPUS negotiation team has been established to negotiate reimbursement of costs with the fiscal intermediaries.

F. Conclusion

We believe that this final rule meets the objectives of the Regulatory Flexibility Act.

X. Other Required Information

A. Effective Date

The procedures contained in this final rule are to be applicable to all admissions occurring on or after October 1, 1987. In the proposed amendment of rule we stated that implementation of DRG-based reimbursement in Hawaii would be delayed until April 1988. This was based on potential delays in making administrative adjustments for fiscal intermediary activities in Hawaii. These issues have now been resolved and there is no administrative reason for a delay. Thus, we no longer intend to postpone implementation in Hawaii, and DRG-based reimbursement will be implemented there on October 1, 1987.

B. Paperwork Reduction Act

This final rule contains a reporting requirement for capital and direct medical education costs which is subject to the provisions of the Paperwork Reduction Act of 1980 (44 U.S.C. 3507). As required by that Act, OCHAMPUS has requested Office of Management and Budget (OMB) approval of this requirement.

List of Subjects in 32 CFR Part 199

Claims, Handicapped, Health insurance, Military personnel.

PART 199—[AMENDED]

Accordingly, 32 CFR Part 199 is amended as follows:

1. The authority citation for Part 199 continues to read as follows:

Authority: 10 U.S.C. 1079, 1086, 5 U.S.C. 301.

2. Section 199.2(b) is amended by adding the following definitions in alphabetical order:

§ 199.2 Definitions.

CHAMPUS DRG-Based Payment System. A reimbursement system for hospitals which assigns prospectively-determined payment levels to each DRG based on the average cost of treating all CHAMPUS patients in a given DRG.

Diagnosis-Related Groups (DRGs). Diagnosis-related groups (DRGs) are a method of dividing hospital patients into clinically coherent groups based on the consumption of resources. Patients are assigned to the groups based on their principal diagnosis (the reason for admission, determined after study), secondary diagnoses, procedures performed, and the patient's age, sex, and discharge status.

3. § 199.4 is amended by revising paragraphs (d)(2), (f)(3)(ii), (f)(4)(ii), (f)(5), (g)(10), and (g)(11) and by adding paragraph (f)(6) to read as follows:

§ 199.4 Basic program benefits.

(d) * * *

(2) *Billing practices.* To be considered for benefits under this paragraph (d), covered services and supplies must be provided and billed for by an authorized provider as set forth in § 199.6 of this part. Such billing must be itemized fully and described sufficiently, even when CHAMPUS payment is determined under the CHAMPUS DRG-based payment system, so that CHAMPUS can determine whether benefits are authorized by this part. Except for claims subject to the CHAMPUS DRG-based payment system, whenever continuing charges are involved, claims should be submitted to the appropriate CHAMPUS fiscal intermediary at least every 30 days (monthly) either by the beneficiary or sponsor or directly by the provider. For claims subject to the CHAMPUS DRG-based payment system, claims may be submitted only after the beneficiary has been discharged or transferred from the hospital.

(f) * * *

(3) * * *

(ii) *Inpatient cost-sharing.* Cost-sharing amounts for inpatient services shall be as follows:

(A) *Services subject to the CHAMPUS DRG-based payment system.* The cost-share shall be the lesser of: an amount calculated by multiplying a per diem amount by the total number of days in the hospital stay except the day of discharge; or 25 percent of the hospital's billed charges. The per diem amount shall be calculated so that, in the aggregate, the total cost-sharing amounts for these beneficiaries is equivalent to 25 percent of the CHAMPUS-determined allowable costs for covered services or supplies provided on an inpatient basis by authorized providers. The per diem amount shall be published annually by OCHAMPUS.

(B) *Services exempt from the CHAMPUS DRG-based payment system and services provided by hospitals and parts of hospitals exempt from the CHAMPUS DRG-based payment system and by institutions other than hospitals.* The cost-share shall be 25 percent of the CHAMPUS-determined allowable costs or charges for otherwise covered services or supplies provided on an inpatient basis by an authorized provider.

(4) * * *

(ii) *Inpatient cost-sharing.* Eligible former spouses are responsible for the payment of cost-sharing amounts the same as those required for retirees, dependents of retirees, dependents of deceased active duty members, and dependents of deceased retirees.

(5) *Amounts over CHAMPUS-determined allowable costs or charges.* It is the responsibility of the CHAMPUS fiscal intermediary to determine allowable costs for services and supplies provided by hospitals and other institutions and allowable charges for services and supplies provided by physicians, other individual professional providers, and other providers. Such CHAMPUS-determined allowable costs or charges are made in accordance with the provisions of § 199.14. All CHAMPUS benefits, including calculation of the CHAMPUS or beneficiary cost-sharing amounts, are based on such CHAMPUS-determined allowable costs or charges. The effect on the beneficiary when the billed cost or charge is over the CHAMPUS-determined allowable amount is dependent upon whether or not the applicable claim was submitted on a participating basis on behalf of the

beneficiary or submitted directly by the beneficiary on a nonparticipating basis and on whether the claim is for inpatient hospital services subject to the CHAMPUS DRG-based payment system. This provision applies to all classes of CHAMPUS beneficiaries.

Note.—When the provider "forgives" or "waives" any beneficiary liability, such as amounts applicable to the annual fiscal year deductible for outpatient services or supplies, or the inpatient or outpatient cost-sharing as previously set forth in this section, the CHAMPUS-determined allowable charge or cost allowance (whether payable to the CHAMPUS beneficiary or sponsor, or to a participating provider) shall be reduced by the same amount.

(i) *Participating provider.* Under CHAMPUS, authorized professional providers and institutional providers other than hospitals have the option of participating on a claim-by-claim basis. Participation is required for inpatient claims only for hospitals which are Medicare-participating providers. Hospitals which are not Medicare-participating providers but which are subject to the CHAMPUS DRG-based payment system in paragraph (a)(1) of § 199.14 must sign agreements to participate on all CHAMPUS inpatient claims in order to be authorized providers under CHAMPUS. All other hospitals may elect to participate on a claim-by-claim basis. Participating providers must indicate participation by signing the appropriate space on the applicable CHAMPUS claim form and submitting it to the appropriate CHAMPUS fiscal intermediary. In the case of an institution or medical supplier, the claim must be signed by an official having such authority. This signature certifies that the provider has agreed to accept the CHAMPUS-determined allowable charge or cost as payment in full for the medical services and supplies listed on the specific claim form, and further has agreed to accept the amount paid by CHAMPUS or the CHAMPUS payment combined with the cost-sharing amount paid by or on behalf of the beneficiary as full payment for the covered medical services or supplies. Therefore, when costs or charges are submitted on a participating basis, the patient is not obligated to pay any amounts disallowed as being over the CHAMPUS-determined allowable cost or charge for authorized medical services or supplies.

(ii) *Nonparticipating providers.* Nonparticipating providers are those providers who do not agree on the CHAMPUS claim form to participate and thereby do not agree to accept the CHAMPUS-determined allowable costs or charges as the full charge. For

otherwise covered services and supplies provided by such nonparticipating CHAMPUS providers, payment is made directly to the beneficiary or sponsor and the beneficiary is liable under applicable law for any amounts over the CHAMPUS-determined allowable costs or charges. CHAMPUS shall have no responsibility for any amounts over allowable costs or charges as determined by CHAMPUS.

(6) *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 up to the long-stay outlier cutoff as described in paragraph (a)(1)(iv)(D)(1)(ii) of § 199.14. Any charges for days beyond the long-stay outlier cutoff which are deemed not medically necessary shall be the responsibility of the beneficiary.

(g) * * *

(10) *Amounts above allowable costs or charges.* Costs of services and supplies to the extent amounts billed are over the CHAMPUS determined allowable cost or charge, as provided for in § 199.14.

(11) *No legal obligation to pay, no charge would be made.* Services or supplies for which the beneficiary or sponsor has no legal obligation to pay; or for which no charge would be made if the beneficiary or sponsor was not eligible under CHAMPUS, except claims subject to the CHAMPUS DRG-based payment system where the DRG-based amount is greater than the hospital's billed charge which has been paid in full by a double coverage plan.

4. Section 199.6 is amended by revising paragraphs (a)(8) and (b)(1)(ii), by adding a new paragraph (b)(3)(v), and by removing paragraph (e) and redesignating paragraph (f) as paragraph (e) to read as follows:

§ 199.6 Authorized providers.

(a) * * *

(8) *Participating provider.* Under CHAMPUS, authorized professional providers and institutional providers other than hospitals have the option of participating on a claim-by-claim basis. Participation is required for inpatient claims only for hospitals which are Medicare-participating providers. Hospitals which are not Medicare-participating providers but which are subject to the CHAMPUS DRG-based payment system in paragraph (a)(1)(ii)(D) of § 199.14 must sign agreements to participate on all CHAMPUS inpatient claims in order to

be authorized providers under CHAMPUS. All other hospitals may elect to participate on a claim-by-claim basis. Participating providers must indicate participation by signing the appropriate space on the applicable CHAMPUS claim form and submitting it to the appropriate CHAMPUS fiscal intermediary on behalf of the beneficiary. In the case of an institution or medical supplier, the claim must be signed by an official having such authority. This certifies that the provider has agreed to accept the CHAMPUS-determined allowable charge or cost as payment in full for the medical services and supplies listed on the specific claim form; and has agreed to accept the amount paid by CHAMPUS or the CHAMPUS payment combined with the cost-sharing and deductible amounts paid by, or on behalf of, the beneficiary as full payment for the covered medical services and supplies.

(b) * * *

(1) * * *

(ii) *Billing practices.* Institutional billings must be itemized fully and sufficiently descriptive, even when CHAMPUS payment is determined under the CHAMPUS DRG-based payment system, so that CHAMPUS can make a determination of benefits. Except for claims subject to the CHAMPUS DRG-based payment system, whenever continuing charges are involved, claims should be submitted to the appropriate CHAMPUS fiscal intermediary at least every 30 days (monthly) either by the beneficiary or sponsor or directly by the provider on behalf of the beneficiary. For claims subject to the CHAMPUS DRG-based payment system, claims may be submitted only after the beneficiary has been discharged or transferred from the hospital.

(3) * * *

(v) *Participation agreements required for some hospitals which are not Medicare-participating.*

Notwithstanding the provisions of this paragraph (B)(3), a hospital which is subject to the CHAMPUS DRG-based payment system but which is not a Medicare-participating hospital must request and sign an agreement with OCHAMPUS. By signing the agreement, the hospital agrees to participate on all CHAMPUS inpatient claims and accept the requirements for a participating provider as contained in paragraph (a)(8) of § 199.6. Failure to sign such an agreement shall disqualify such hospital

as a CHAMPUS-approved institutional provider.

5. Section 199.7 is amended by revising paragraphs (B)(2)(i), (c)(2), (e)(1), and (g) and by adding a new paragraph (b)(2)(x)(C) to read as follows:

§ 199.7 Claims submissions, review, and payment.

(b) * * *

(2) * * *

(i) *Diagnosis.* All applicable diagnoses are required; standard nomenclature is acceptable. In the absence of a diagnosis, a narrative description of the definitive set of symptoms for which the medical care was rendered must be provided.

(x) * * *

(C) For hospitals subject to the CHAMPUS DRG-based payment system (see paragraph (a)(1)(ii)(D) of § 199.14), the following information is also required:

(1) The principal diagnosis (the diagnosis established, after study, to be chiefly responsible for causing the patient's admission to the hospital).

(2) All secondary diagnoses.

(3) All significant procedures performed.

(4) The discharge status of the beneficiary.

(5) The hospital's Medicare provider number.

(6) The source of the admission.

(c) * * *

(2) *Provider's signature.* A participating provider (see paragraph (a)(8) of § 199.6) is required to sign the CHAMPUS claim form.

(e) * * *

(1) *Continuing care.* Except for claims subject to the CHAMPUS DRG-based payment system, whenever medical services and supplies are being rendered on a continuing basis, an appropriate claim or claims should be submitted every 30 days (monthly) whether submitted directly by the beneficiary or sponsor or by the provider on behalf of the beneficiary. Such claims may be submitted more frequently if the beneficiary or provider so elects. The Director, OCHAMPUS, or a designee, also may require more frequent claims submission based on dollars. Examples of care that may be rendered on a continuing basis are outpatient physical therapy, private duty (special) nursing, or inpatient stays. For claims subject to the CHAMPUS DRG-based payment

system, claims may be submitted only after the beneficiary has been discharged or transferred from the hospital.

(g) *Claims review.* It is the responsibility of the CHAMPUS fiscal intermediary (or OCHAMPUS, including OCHAMPUSEUR) to review each CHAMPUS claim submitted for benefit consideration to ensure compliance with all applicable definitions, conditions, limitations, or exclusions specified or enumerated in this part. It is also required that before any CHAMPUS benefits may be extended, claims for medical services and supplies will be subject to utilization review and quality assurance standards, norms, and criteria issued by the Director, OCHAMPUS, or a designee (see paragraph (a)(1)(v) of § 199.14 for review standards for claims subject to the CHAMPUS DRG-based payment system).

6. Section 199.10 is amended by redesignating paragraph (a)(5)(iii) as paragraph (a)(5)(iv) and adding a new paragraph (a)(5)(iii) to read as follows:

§ 199.10 Appeal and hearing procedures.

(a) * * *

(5) * * *

(iii) The establishment of diagnosis-related groups (DRGs), or the methodology for the classification of inpatient discharges within the DRGs, or the weighting factors that reflect the relative hospital resources used with respect to discharges within each DRG, since each of these is established by this part.

7. A new § 199.14 is added to read as follows:

§ 199.14 Provider reimbursement methods.

(a) *Hospitals.* The CHAMPUS-determined allowable cost for reimbursement of a hospital shall be determined on the basis of one of the following methodologies.

(1) *CHAMPUS DRG-based payment system.* Under the CHAMPUS DRG-based payment system, payment for the operating costs of inpatient hospital services furnished by hospitals subject to the system (generally short-term, acute-care hospitals) is made on the basis of prospectively determined rates and applied on a per discharge basis using Diagnosis Related Groups (DRGs). Payments under this system will include an urban/rural differentiation and an adjustment for area wage differences and indirect medical education costs. Additional payments will be made for

capital costs, direct medical education costs and outlier cases.

(i) *General*—(A) *DRGs used*. The CHAMPUS DRG-based payment system will use the same DRGs used in the most recently available grouper for the Medicare Prospective Payment System.

(B) *Assignment of discharges to DRGs*. (1) The classification of a particular discharge shall be based on the patient's age, sex, principal diagnosis (that is, the diagnosis established, after study, to be chiefly responsible for causing the patient's admission to the hospital), secondary diagnoses, procedures performed and discharge status.

(2) Each discharge shall be assigned to only one DRG regardless of the number of conditions treated or services furnished during the patient's stay.

(C) *Basis of payment*—(1) *Hospital billing*. Under the CHAMPUS DRG-based payment system, hospitals are required to submit claims (including itemized charges) in accordance with paragraph (b) of § 199.7. The CHAMPUS fiscal intermediary will assign the appropriate DRG to the claim based on the information contained on the claim.

(2) *Payment on a per discharge basis*. Under the CHAMPUS DRG-based payment system, hospitals are paid a predetermined amount per discharge for inpatient hospital services furnished to CHAMPUS beneficiaries.

(3) *Claims priced as of date of discharge*. All claims reimbursed under the CHAMPUS DRG-based payment system are to be priced as of the date of discharge, regardless of when the claim is submitted.

(4) *Payment in full*. The DRG-based amount paid for inpatient hospital services is the total CHAMPUS payment for the inpatient operating costs (as described in paragraph (a)(1)(i)(C)(5) of this section) incurred in furnishing services covered by the CHAMPUS. The full prospective payment amount is payable for each stay during which there is at least one covered day of care, except as provided in paragraph (a)(1)(iv)(D)(7)(i) of this section.

(5) *Inpatient operating costs*. The CHAMPUS DRG-based payment system provides a payment amount for inpatient operating costs, including:

(i) Operating costs for routine services; such as the costs of room, board, and routine nursing services;

(ii) Operating costs for ancillary services, such as hospital radiology and laboratory services (other than physicians' services) furnished to hospital inpatients;

(iii) Special care unit operating costs; and

(iv) Malpractice insurance costs related to services furnished to inpatients.

(6) *Discharges and transfers*—(i) *Discharges*. A hospital inpatient is discharged when:

(aa) The patient is formally released from the hospital (release of the patient to another hospital as described in paragraph (a)(1)(i)(C)(6)(i) of this section, or a leave of absence from the hospital, will not be recognized as a discharge for the purpose of determining payment under the CHAMPUS DRG-based payment system);

(bb) The patient dies in the hospital; or

(cc) The patient is transferred from the care of a hospital included under the CHAMPUS DRG-based payment system to a hospital or unit that is excluded from the prospective payment system.

(ii) *Transfers*. Except as provided under paragraph (a)(1)(i)(C)(6)(i) of this section, a discharge of a hospital inpatient is not counted for purposes of the CHAMPUS DRG-based payment system when the patient is transferred:

(aa) From one patient area or unit of the hospital to another area or unit of the same hospital;

(bb) From the care of a hospital included under the CHAMPUS DRG-based payment system to the care of another hospital paid under this system;

(cc) From the care of a hospital included under the CHAMPUS DRG-based payment system to the care of another hospital that is excluded from the CHAMPUS DRG-based payment system because of participation in a statewide cost control program which is exempt from the CHAMPUS DRG-based payment system under paragraph (a)(1)(ii)(A) of this section; or

(dd) From the care of a hospital included under the CHAMPUS DRG-based payment system to the care of a uniformed services treatment facility.

(iii) *Payment in full to the discharging hospital*. The hospital discharging an inpatient shall be paid in full under the CHAMPUS DRG-based payment system.

(iv) *Payment to a hospital transferring an inpatient to another hospital*. If a hospital subject to the CHAMPUS DRG-based payment system transfers an inpatient to another such hospital, the transferring hospital shall be paid a per diem rate, as determined under instructions issued by OCHAMPUS, for each day of the patient's stay in that hospital, not to exceed the DRG-based payment that would have been paid if the patient had been discharged to another setting. However, if a discharge is classified into DRG No. 385 (Neonates, died or transferred) or DRG

No. 456 (Burns, transferred to another acute care facility), the transferring hospital shall be paid in full.

(v) *Additional payments to transferring hospitals*. A transferring hospital may qualify for an additional payment for extraordinary cases that meet the criteria for long-stay or cost outliers.

(ii) *Applicability of the DRG system*—

(A) *Areas affected*. The CHAMPUS DRG-based payment system shall apply to hospitals' services in the fifty states, the District of Columbia, and Puerto Rico, except that any State which has implemented a separate DRG-based payment system or similar payment system in order to control costs and is exempt from the Medicare Prospective Payment System may be exempt from the CHAMPUS DRG-based payment system if it requests exemption in writing, and provided payment under such system does not exceed payment which would otherwise be made under the CHAMPUS DRG-based payment system.

(B) *Services subject to the DRG-based payment system*. All normally covered inpatient hospital services furnished to CHAMPUS beneficiaries by hospitals are subject to the CHAMPUS DRG-based payment system.

(C) *Services exempt from the DRG-based payment system*. The following hospital services, even when provided in a hospital subject to the CHAMPUS DRG-based payment system, are exempt from the CHAMPUS DRG-based payment system and shall be reimbursed under the procedures in paragraph (a)(2) of this section.

(1) Services provided by hospitals exempt from the DRG-based payment system.

(2) All services which would otherwise be paid under one of the psychiatric DRGs which are numbers 424-432.

(3) All services which would otherwise be paid under one of the substance abuse DRGs which are numbers 433-438.

(4) All services related to kidney acquisition by Renal Transplantation Centers.

(5) All services related to a heart transplantation which would otherwise be paid under DRG 103.

(6) All services related to liver transplantation when the transplant is performed in a CHAMPUS-authorized liver transplantation center.

(7) All professional services provided by hospital-based physicians.

(8) All services provided by nurse anesthetists.

(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 certified to provide services to CHAMPUS beneficiaries are subject to the DRG-based payment system except for the following hospitals or hospital units which are exempt.

(1) *Psychiatric hospitals.* A psychiatric hospital which is exempt from the Medicare Prospective Payment System is also exempt from the CHAMPUS DRG-based payment system. In order for a psychiatric hospital which does not participate in Medicare to be exempt from the CHAMPUS DRG-based payment system, it must meet the same criteria (as determined by the Director, OCHAMPUS, or a designee) as required for exemption from the Medicare Prospective Payment System as contained in § 412.23 of Title 42 CFR.

(2) *Rehabilitation hospitals.* A rehabilitation hospital which is exempt from the Medicare Prospective Payment System is also exempt from the CHAMPUS DRG-based payment system. In order for a rehabilitation hospital which does not participate in Medicare to be exempt from the CHAMPUS DRG-based payment system, it must meet the same criteria (as determined by the Director, OCHAMPUS, or a designee) as required for exemption from the Medicare Prospective Payment System as contained in § 412.23 of Title 42 CFR.

(3) *Alcohol/Drug hospitals.* An alcohol/drug hospital which is exempt from the Medicare prospective payment system is also exempt from the CHAMPUS DRG-based payment system. In order for an alcohol/drug hospital which does not participate in Medicare to be exempt from the CHAMPUS DRG-based payment system, it must meet the same criteria (as determined by the Director, OCHAMPUS, or a designee) as required for exemption from the Medicare Prospective Payment System as contained in § 412.23 of Title 42 CFR.

(4) *Psychiatric, rehabilitation and alcohol/drug units (distinct parts).* A psychiatric, rehabilitation or alcohol/drug unit which is exempt from the Medicare prospective payment system is also exempt from the CHAMPUS DRG-based payment system. In order for a

distinct unit which does not participate in Medicare to be exempt from the CHAMPUS DRG-based payment system, it must meet the same criteria (as determined by the Director, OCHAMPUS, or a designee) as required for exemption from the Medicare Prospective Payment System as contained in § 412.23 of Title 42 CFR.

(5) *Long-term hospitals.* A long-term hospital which is exempt from the Medicare prospective payment system is also exempt from the CHAMPUS DRG-based payment system. In order for a long-term hospital which does not participate in Medicare to be exempt from the CHAMPUS DRG-based payment system, it must have an average length of inpatient stay greater than 25 days:

(i) As computed by dividing the number of total inpatient days (less leave or pass days) by the total number of discharges for the hospital's most recent fiscal year; or

(ii) As computed by the same method for the immediately preceding six-month period, if a change in the hospital's average length of stay is indicated.

(6) *Sole community hospitals.* Any hospital which has qualified for special treatment under the Medicare prospective payment system as a sole community hospital and has not given up that classification is exempt from the CHAMPUS DRG-based payment system. (See Subpart C of 42 CFR Part 412.)

(7) *Christian Science sanatoriums.* All Christian Science sanatoriums (as defined in paragraph (b)(4)(vii) of § 199.6) are exempt from the CHAMPUS DRG-based payment system.

(8) *Cancer hospitals.* Any hospital which qualifies as a cancer hospital under the Medicare standards and has elected to be exempt from the Medicare prospective payment system is exempt from the CHAMPUS DRG-based payment system. (See 42 CFR 412.94.)

(9) *Children's hospitals.* A children's hospital which is exempt from the Medicare Prospective Payment System is also exempt from the CHAMPUS DRG-based payment system. In order for a children's hospital which does not participate in Medicare to be exempt from the CHAMPUS DRG-based payment system, it must meet the same criteria (as determined by the Director, OCHAMPUS, or a designee) as required for exemption from the Medicare

Prospective Payment System as contained in 42 CFR 412.23.

(10) *Hospitals outside the 50 states, the District of Columbia, and Puerto Rico.* A hospital is excluded from the CHAMPUS DRG-based payment system if it is not located in one of the fifty States, the District of Columbia, or Puerto Rico.

(E) *Hospitals which do not participate in Medicare.* It is not required that a hospital be a Medicare-participating provider in order to be an authorized CHAMPUS provider. However, any hospital which is subject to the CHAMPUS DRG-based payment system and which otherwise meets CHAMPUS requirements but which is not a Medicare-participating provider (having completed a form HCFA-1514, Hospital Request for Certification in the Medicare/Medicaid Program and a form HCFA-1561, Health Insurance Benefit Agreement) must complete a participation agreement with OCHAMPUS. By completing the participation agreement, the hospital agrees to participate on all CHAMPUS inpatient claims and to accept the CHAMPUS-determined allowable amount as payment in full for these claims. Any hospital which does not participate in Medicare and does not complete a participation agreement with OCHAMPUS will not be authorized to provide services to CHAMPUS beneficiaries.

(iii) *Determination of payment amounts.* The actual payment for an individual claim under the CHAMPUS DRG-based payment system is calculated by multiplying the urban or rural adjusted standardized amounts (adjusted to account for area wage differences using the wage indexes used in the Medicare program) by a weighting factor specific to each DRG.

(A) *Calculation of DRG Weights.*

(1) *Grouping of charges.* All discharge records in the database shall be grouped by DRG.

(2) *Remove DRGs 469 and 470.* Records from DRGs 469 and 470 shall be 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:

$$1.5 \times \left[\left(1.0 + \frac{\text{number of interns + residents}}{\text{number of beds}} \right) \right] .5795 - 1.0$$

(4) *Wage level standardization.* To standardize the charge records for area wage differences, each charge record will be divided into labor-related and nonlabor-related portions, and the labor-related portion shall be divided by the most recently available Medicare wage index for the area. The labor-related and nonlabor-related portions will then be added together.

(5) *Elimination of statistical outliers.* All unusually high or low charges shall be removed from the database.

(6) *Calculation of DRG average charge.* After the standardization for indirect medical education, and area wage differences, an average charge for each DRG shall be computed by summing charges in a DRG and dividing that sum by the number of records in the DRG.

(7) *Calculation of national average charge per discharge.* A national average charge per discharge shall be calculated by summing all charges and

dividing that sum by the total number of records from all DRG categories.

(8) *DRG relative weights.* DRG relative weights shall be calculated for each DRG category by dividing each DRG average charge by the national average charge.

(B) *Empty and low-volume DRGs.* The Medicare weight shall be used for any DRG with less than ten (10) occurrences in the CHAMPUS database. The short-stay thresholds shall be set at one day for these DRGs and the long-stay thresholds shall be set at the FY 87 Medicare thresholds.

(C) *Updating DRG weights.* The CHAMPUS DRG weights shall be updated or adjusted as follows:

(1) DRG weights shall be recalculated annually using CHAMPUS charge data and the methodology described in paragraph (a)(1)(iii)(A) of this section.

(2) When a new DRG is created, CHAMPUS will, if practical, calculate a weight for it using an appropriate charge sample (if available) and the

methodology described in paragraph (a)(1)(iii)(A) of this section.

(3) In the case of any other change under Medicare to an existing DRG weight (such as in connection with technology changes), CHAMPUS shall adjust its weight for that DRG in a manner comparable to the change made by Medicare.

(D) *Calculation of the adjusted standardized amounts.* The following procedures shall be followed in calculating the CHAMPUS adjusted standardized amount.

(1) *Differentiate urban and rural charges.* All charges in the database shall be sorted into urban and rural groups. The following procedures will be applied to each group.

(2) *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:

$$1.5 \times \left[\left(1.0 + \frac{\text{number of interns + residents}}{\text{number of beds}} \right) \right] .5795 - 1.0$$

(3) *Wage level standardization.* To standardize the charge records for area wage differences, each charge record will be divided into labor-related and nonlabor-related portions, and the labor-related portion shall be divided by the most recently available Medicare wage index for the area. The labor-related and nonlabor-related portions will then be added together.

(4) *Apply the cost to charge ratio.* Each charge is to be reduced to a representative cost by using the Medicare cost to charge ratio increased by 1 percentage point in order to reimburse hospitals for bad debt expenses attributable to CHAMPUS beneficiaries. This results in an effective cost-to-charge ratio (adjusted for bad debt) of 0.67.

(5) *Preliminary base year standardized amount.* A preliminary base year standardized amount shall be calculated by summing all costs in the database applicable to the urban or rural group and dividing by the total

number of discharges in the urban or rural group.

(6) *Update for inflation.* The preliminary base year standardized amounts shall be updated using an annual update factor equal to 1.07 to produce fiscal year 1988 preliminary standardized amounts. Thereafter, development of a new standardized amount will use an inflation factor equal to the hospital market basket index used by the Health Care Financing Administration in their Prospective Payment System.

(7) The preliminary standardized amounts, updated for inflation, shall be divided by a system standardization factor so that total DRG outlays, given the database distribution across hospitals and diagnoses, are equal to the total charges reduced to costs.

(8) *Labor and nonlabor portions of the adjusted standardized amounts.* The adjusted standardized amounts shall be divided into labor and nonlabor portions in accordance with the Medicare division of labor and nonlabor portions.

(E) *Adjustments to the DRG-based payment amounts.* The following adjustments to the DRG-based amounts (the weight multiplied by the adjusted standardized amount) will be made.

(1) *Outliers.* CHAMPUS shall 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.

(i) *Length-of-stay outliers.* Length-of-stay outliers shall be identified and paid by the fiscal intermediary when the claims are processed.

(aa) *Short-stay outliers.* Any discharge with a length-of-stay (LOS) less than 1.94 standard deviations from the DRG's geometric LOS shall be classified as a short-stay outlier. Short-stay outliers shall 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 DRG amount divided by the geometric mean length-of-stay for the DRG.

(bb) *Long-stay outliers.* Any discharge which has a length-of-stay (LOS) exceeding the lesser of 1.94 standard deviations or 17 days from the DRG's geometric LOS shall be classified as a long-stay outlier. Long-stay outliers shall be 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 cutoff. The per diem rate shall equal the DRG amount divided by the geometric mean length-of-stay for the DRG.

(ii) *Cost outliers.* Any discharge which does not qualify as a length-of-stay outlier and which has standardized costs that exceed a threshold of the greater of two times the DRG-based amount or \$13,500 may be classified as a cost outlier. The standardized costs shall be calculated by multiplying the total charges by .67 and adjusting this amount for indirect medical education costs. Cost outliers shall be reimbursed the DRG-based amount plus 60 percent of all costs exceeding the threshold. Additional payment for cost outliers can be made only upon request by the hospital.

(2) *Wage Adjustment.* CHAMPUS will adjust the labor portion of the standardized amounts according to the hospital's area wage index.

(3) *Indirect Medical Education Adjustment.* The wage adjusted DRG payment will also be multiplied by 1.0 plus the hospital's indirect medical education ratio.

(F) *Updating the adjusted standardized amounts.* Beginning in FY 1989, the adjusted standardized amounts will be updated by the Medicare annual update factor, unless the adjusted standardized amounts are recalculated.

(G) *Annual Cost Pass-Throughs.*

(1) *Capital costs.* When requested in writing by a hospital, CHAMPUS shall reimburse the hospital its share of actual capital costs as reported annually to the CHAMPUS fiscal intermediary. Payment for capital costs shall be made annually based on the ratio of CHAMPUS inpatient days for those beneficiaries subject to the CHAMPUS DRG-based payment system to total inpatient days applied to the hospital's total allowable capital costs. Reductions in payments for capital costs which are required under Medicare shall also be applied to payments for capital costs under CHAMPUS.

(i) *Costs included as capital costs.* Allowable capital costs are those specified in Medicare Regulation § 413.130, as modified by § 412.72.

(ii) *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 § 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:

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

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

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

(2) *Direct medical education costs.* When requested in writing by a hospital, CHAMPUS shall reimburse the hospital its actual direct medical education costs as reported annually to the CHAMPUS fiscal intermediary. Such teaching costs must be for a teaching program approved under Medicare Regulation § 413.85. Payment for direct medical education costs shall be made annually based on the ratio of CHAMPUS inpatient days for those beneficiaries subject to the CHAMPUS DRG-based payment system to total inpatient days applied to the hospital's total allowable direct medical education costs. Allowable direct medical education costs are those specified in Medicare Regulation § 413.85.

(3) *Information necessary for payment of capital and direct medical education costs.* Any hospital subject to the CHAMPUS DRG-based payment system which wishes to be reimbursed for allowed capital and direct medical education costs must submit a report to the CHAMPUS fiscal intermediary. Such report is to be submitted within three months of the end of the hospital's Medicare cost-reporting period and shall cover the one-year period corresponding to the hospital's Medicare cost-reporting period. The first such report may cover a period of less than a full year—from the effective date of the CHAMPUS DRG-based payment system to the end of the hospital's Medicare cost-reporting period. All costs reported to the CHAMPUS fiscal intermediary must correspond to the costs reported on the hospital's Medicare cost report. (If these costs change as a result of a subsequent audit by Medicare, the revised costs are to be reported to CHAMPUS within 30 days of the date the hospital is notified of the change.) The report must be

signed by the hospital official responsible for verifying the amounts and shall contain the following information.

- (i) The hospital's name.
- (ii) The hospital's address.
- (iii) The hospital's CHAMPUS provider number.
- (iv) The hospital's Medicare provider number.
- (v) The period covered—this must correspond to the hospital's Medicare cost-reporting period.
- (vi) Total inpatient days provided.
- (vii) Total CHAMPUS inpatient days for those beneficiaries subject to the CHAMPUS DRG-based payment system provided.
- (viii) Total allowable capital costs.
- (ix) Total allowable direct medical education costs.
- (x) Total full-time equivalents for:
 - (aa) Residents.
 - (bb) Interns.
- (xi) Total inpatient beds as of the end of the cost-reporting period. If this has changed during the reporting period, an explanation of the change must be provided.

(xii) Title of official signing the report.

(xiii) Reporting date.

(xiv) The report shall contain a certification statement that any changes to the items in paragraphs (a)(1)(iii)(C)(3) (vi), (vii), (viii), (ix), or (x), which are a result of an audit of the hospital's Medicare cost-report, shall be reported to CHAMPUS within thirty (30) days of the date the hospital is notified of the change.

(iv) *Quality of care reviews.*

(A) *Objectives of review system.*

There are four required functions:

- (1) A review of the completeness, adequacy and quality of care provided;
- (2) A review of the reasonableness, necessity and appropriateness of hospital admissions under CHAMPUS DRG reimbursement;
- (3) A validation of diagnoses and procedural information that determines CHAMPUS reimbursement; and
- (4) A review of the necessity and appropriateness of care for which payment is sought on an outlier basis.

(B) *Hospital cooperation.* All hospitals which participate in CHAMPUS and submit CHAMPUS claims are required to provide all information necessary for CHAMPUS to properly process the claims. In order for CHAMPUS to be assured that services for which claims are submitted meet quality of care standards, hospitals are required to provide the peer review organization (PRO) responsible for quality review with all the information, within timeframes to be established by

OCHAMPUS, it needs to perform the review functions required by this paragraph. Additionally, all participating hospitals shall provide CHAMPUS beneficiaries, upon admission, with information about the admission and quality review system including their appeal rights. A hospital which does not cooperate in this activity shall be subject to termination as a CHAMPUS-authorized provider.

(C) *Areas of review—(1) Admissions.* The following areas shall be subject to review to determine whether inpatient care was medically appropriate and necessary, was delivered in the most appropriate setting and met acceptable standards of quality. This review may include preadmission or prepayment review when appropriate.

(i) *Transfers of CHAMPUS beneficiaries from a hospital or hospital unit subject to the CHAMPUS DRG-based payment system to another hospital or hospital unit.*

(ii) *CHAMPUS admissions to a hospital or hospital unit subject to the CHAMPUS DRG-based payment system which occur within a certain period (specified by OCHAMPUS) of discharge from a hospital or hospital unit subject to the CHAMPUS DRG-based payment system.*

(iii) *A random sample of other CHAMPUS admissions for each hospital subject to the CHAMPUS DRG-based payment system.*

(iv) *CHAMPUS admissions in any DRGs which have been specifically identified by OCHAMPUS for review or which are under review for any other reason.*

(2) *DRG validation.* The review organization responsible for quality of care reviews shall be responsible for ensuring that the diagnostic and procedural information reported by hospitals on CHAMPUS claims which is used by the fiscal intermediary to assign claims to DRGs is correct and matches the information contained in the medical records. In order to accomplish this, the following review activities shall be done.

(i) *Perform DRG validation reviews of each case under review.*

(ii) *Review of claim adjustments submitted by hospitals which result in the assignment of a higher weighted DRG.*

(iii) *Review for physician certification as to the major diagnoses and procedures and the physician's acknowledgment of annual receipt of the penalty statement as contained in the Medicare regulations at 42 CFR 412.40 and 412.46.*

(iv) *Review of a sample of claims for each hospital reimbursed under the*

CHAMPUS DRG-based payment system. Sample size shall be determined based upon the volume of claims submitted.

(3) *Outlier review.* Claims which qualify for additional payment as a long-stay outlier or as a cost-outlier shall be subject to review to ensure that the additional days or costs were medically necessary and appropriate and met all other requirements for CHAMPUS coverage. In addition, claims which qualify as short-stay outliers shall be reviewed to ensure that the admission was medically necessary and appropriate and that the discharge was not premature.

(4) *Procedure review.* Claims for procedures identified by OCHAMPUS as subject to a pattern of abuse shall be the subject of intensified quality assurance review.

(5) *Other review.* Any other cases or types of cases identified by OCHAMPUS shall be subject to focused review.

(D) *Actions as a result of review.—(1) Findings related to individual claims.* If it is determined, based upon information obtained during reviews, that a hospital has misrepresented admission, discharge, or billing information, or is found to have quality of care defects, or has taken an action that results in the unnecessary admissions of an individual entitled to benefits, unnecessary multiple admission of an individual, or other inappropriate medical or other practices with respect to beneficiaries or billing for services furnished to beneficiaries, the entity responsible for admission and quality review in conjunction with the fiscal intermediary, shall, as appropriate:

(i) *Recoup (in whole or in part) any amounts paid for the inpatient hospital services related to such an unnecessary admission or subsequent readmission and provide the hospital with a notice of appeal rights; or*

(ii) *Require the hospital to take other corrective action necessary to prevent or correct the inappropriate practice.*

(iii) *Advise the hospital and beneficiary of appeal rights, as required by § 199.10 of this part.*

(iv) *Notify OCHAMPUS of all such actions.*

(2) *Findings related to a pattern of inappropriate practices.* In all cases where a pattern of inappropriate admissions and billing practices that have the effect of circumventing the CHAMPUS DRG-based payment system is identified, OCHAMPUS shall be notified of the hospital and practice involved.

(3) *Billed charges and set rates.* The allowable costs for authorized care in

all hospitals not subject to the CHAMPUS DRG-based payment system shall be determined on the basis of billed charges or set rates. Under this procedure the allowable costs may not exceed the lower of:

(i) *The actual charge for such service made to the general public; or*

(ii) *The allowed charge applicable to the policyholders or subscribers of the CHAMPUS fiscal intermediary for comparable services under comparable circumstances, when extended to CHAMPUS beneficiaries by consent or agreement; or*

(iii) *The allowed charge applicable to the citizens of the community or state as established by local or state regulatory authority, excluding Title XIX of the Social Security Act or other welfare program, when extended to CHAMPUS beneficiaries by consent or agreement.*

(b) *Skilled Nursing Facilities (SNFs).* The CHAMPUS-determined allowable cost for reimbursement of a SNF shall be determined on the same basis as for hospitals which are not subject to the CHAMPUS DRG-based payment system.

(c) *Reimbursement for Other Than Hospitals and SNFs.* The Director, OCHAMPUS, or a designee, shall establish such other methods of determining allowable cost or charge reimbursement for those institutions, other than hospitals and SNFs, as may be required.

(d) *Reimbursement of Freestanding Ambulatory Surgical Centers.* Authorized care furnished by freestanding ambulatory surgical centers shall be reimbursed on the basis of the CHAMPUS-determined reasonable cost.

(e) *Reimbursement of Individual Health-Care Professionals and Other Non-Institutional Health-Care Providers.* The CHAMPUS-determined reasonable charge (the amount allowed by CHAMPUS) for the services of an individual health-care professional or other noninstitutional health-care provider (even if employed by or under contract to an institutional provider) shall be determined by one of the following methodologies, that is, whichever is in effect in the specific geographic location at the time covered services and supplies are provided to a CHAMPUS beneficiary.

(1) *Allowable charge method.* The allowable charge method is the preferred and primary method for reimbursement of individual health-care professionals and other noninstitutional health-care providers.

(i) *The allowable charge for authorized care shall be the lower of:*

- (A) The billed charge for the service;
- (B) The prevailing charge level that does not exceed the amount equivalent to the 80th percentile of billed charges made for similar services in the same locality during the base period.

Note.—Public Law 97-86 provides that prevailing charges are to be determined at the 90th percentile. However, DOD Appropriation Acts have limited this to the 80th percentile. Prevailing charges shall continue to be calculated in accordance with any limitations set forth in the DOD Appropriation Acts, as implemented in instructions issued by the Director, OCHAMPUS.

(1) the 80th percentile of charges shall be determined on the basis of statistical data and methodology acceptable to the Director, OCHAMPUS, or a designee.

(2) The base period shall be a period of 12 calendar months and shall be adjusted at least once a year.

(ii) A charge that exceeds the prevailing charge can be determined to be allowable only when unusual circumstances or medical complications justify the higher charge. The allowable

charge may not exceed the billed charge under any circumstances.

(2) *Alternative method.* The Director, OCHAMPUS, or a designee, may, subject to the approval of the ASD(HA), establish an alternative method of reimbursement designed to produce reasonable control over health care costs and to ensure a high level of acceptance of the CHAMPUS-determined charge by the individual health-care professionals or other noninstitutional health-care providers furnishing services and supplies to CHAMPUS beneficiaries. Alternative methods may not result in reimbursement greater than the allowable charge method above.

(f) *Outside the United States.* The Director, OCHAMPUS, or a designee, shall determine the appropriate reimbursement method or methods to be used in the extension of CHAMPUS benefits for otherwise covered medical services or supplies provided by hospitals or other institutional providers, physicians or other individual professional providers, or other providers outside the United States.

(g) *Implementing Instructions.* The Director, OCHAMPUS, or a designee, shall issue CHAMPUS policies, instructions, procedures, and guidelines, as may be necessary to implement the intent of this section.

Linda M. Lawson,

Alternate OSD Federal Register Liaison Officer, Department of Defense.

August 24, 1987.

Table 1—CHAMPUS Weight and Threshold Summary

[Editorial Note: This table will not appear in the Code of Federal Regulations]

The following summary shows the final CHAMPUS DRG weights as well as arithmetic mean lengths of stay, geometric mean lengths of stay, and outlier thresholds. For those DRGs marked with an asterisk (i.e., the low volume DRGs), we substituted Medicare weights, length of stay values, and long stay thresholds. The short stay thresholds were set at one day for these DRGs.

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CHAMPUS WEIGHT AND THRESHOLD SUMMARY

DRG NUMBER DESCRIPTION	CHAMPUS ARITHMETIC GEOMETRIC SHORT STAY LONG STAY			
	WEIGHT	MEAN LOS	MEAN LOS	THRESHOLD THRESHOLD
1 CRANIOTOMY AGE >=18 EXCEPT FOR TRAUMA	3.6060	13.3	10.2	2
2 CRANIOTOMY FOR TRAUMA AGE >=18	4.4477	14.2	9.9	1
3 CRANIOTOMY AGE <18	2.3836	9.5	6.2	1
4 SPINAL PROCEDURES	2.1411	10.7	8.7	2
5 EXTRACRANIAL VASCULAR PROCEDURES	1.7049	6.3	5.5	2
6 CARPAL TUNNEL RELEASE	0.5402	2.3	1.8	1
7 PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC AGE >=70 &/OR C.C.	2.8290	11.4	7.1	1
8 PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC AGE <70 W/O C.C.	0.8608	3.8	2.8	1
9 SPINAL DISORDERS & INJURIES	2.0299	11.4	6.4	1
10 NERVOUS SYSTEM NEOPLASMS AGE >=70 AND/OR C.C.	1.2225	8.2	5.3	1
11 NERVOUS SYSTEM NEOPLASMS AGE <70 W/O C.C.	0.8829	5.9	3.8	1
12 DEGENERATIVE NERVOUS SYSTEM DISORDERS	1.6168	12.1	6.7	1
13 MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA	0.9771	7.6	5.0	1
14 SPECIFIC CEREBROVASCULAR DISORDERS EXCEPT TIA	1.4611	8.2	5.7	1
15 TRANSIENT ISCHEMIC ATTACKS AND PRECEREAL OCCLUSIONS	0.7454	4.1	3.2	1
16 NONSPECIFIC CEREBROVASCULAR DISORDERS WITH C.C.	1.2609	6.9	4.9	1
17 NONSPECIFIC CEREBROVASCULAR DISORDERS W/O C.C.	0.7707	5.1	3.0	1
18 CRANIAL & PERIPHERAL NERVE DISORDERS AGE >=70 AND/OR C.C.	1.2039	7.9	5.5	1
19 CRANIAL & PERIPHERAL NERVE DISORDERS AGE <70 W/O C.C.	0.7152	5.4	3.8	1
20 NERVOUS SYSTEM INFECTION EXCEPT VIRAL MENINGITIS	1.3990	8.5	6.0	1
21 VIRAL MENINGITIS	0.5790	4.1	3.5	1
22 HYPERTENSIVE ENCEPHALOPATHY	0.7426	4.4	3.4	1
23 NONTRAUMATIC STUPOR & COMA	0.9647	5.5	4.0	1
24 SEIZURE & HEADACHE AGE >=70 AND/OR C.C.	0.9220	5.5	3.9	1
25 SEIZURE & HEADACHE AGE 18-69 W/O C.C.	0.5673	4.1	3.1	1
26 SEIZURE & HEADACHE AGE 0-17	0.4713	3.2	2.4	1
27 TRAUMATIC STUPOR & COMA, COMA >1 HR	1.8402	7.2	3.9	1
28 TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >=70 AND/OR C.C.	1.2596	6.1	3.5	1
29 TRAUMATIC STUPOR & COMA <1 HR AGE 18-69 W/O C.C.	0.6282	4.1	2.5	1

CHAMPUS WEIGHT AND THRESHOLD SUMMARY

DRG NUMBER DESCRIPTION	CHAMPUS ARITHMETIC GEOMETRIC SHORT STAY LONG STAY			
	WEIGHT	MEAN LOS	MEAN LOS	THRESHOLD THRESHOLD
30 TRAUMATIC STUPOR & COMA <1 HR AGE 0-17	0.4042	2.6	1.8	1 7
31 CONCUSSION AGE >=70 AND/OR C.C.	0.7241	4.1	2.6	1 15
32 CONCUSSION AGE 18-69 W/O C.C.	0.3965	2.4	1.9	1 6
33 CONCUSSION AGE 0-17	0.2338	1.6	1.3	1 3
34 OTHER DISORDERS OF NERVOUS SYSTEM AGE >=70 AND/OR C.C.	1.7484	7.9	5.0	1 21
35 OTHER DISORDERS OF NERVOUS SYSTEM AGE <70 W/O C.C.	0.6492	4.2	2.8	1 14
36 RETINAL PROCEDURES	0.8106	3.4	2.9	1 8
37 ORBITAL PROCEDURES	0.8111	3.1	2.5	1 9
38 PRIMARY IRIS PROCEDURES	0.4459	2.2	2.0	1 5
39 LENS PROCEDURES WITH OR WITHOUT VITRECTOMY	0.6959	2.0	1.7	1 4
40 EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE >=18	0.4851	1.9	1.6	1 4
41 EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE 0-17	0.4295	1.7	1.4	1 3
42 INTRAOCULAR PROCEDURES EXCEPT RETINA, IRIS & LENS	0.7921	3.0	2.5	1 7
43 HYPHEMA	0.3083	4.2	3.6	1 11
44 ACUTE MAJOR EYE INFECTIONS	0.4713	4.3	3.8	1 10
45 NEUROLOGICAL EYE DISORDERS	0.5503	3.1	2.6	1 8
46 OTHER DISORDERS OF THE EYE AGE >=18 WITH C.C.	0.6808	5.4	3.7	1 20
47 OTHER DISORDERS OF THE EYE AGE >=18 W/O C.C.	0.5982	4.4	3.0	1 15
48 OTHER DISORDERS OF THE EYE AGE 0-17	0.5002	3.8	2.6	1 12
49 MAJOR HEAD & NECK PROCEDURES	2.7560	11.6	8.6	1 25
50 SIALOADENECTOMY	0.7656	2.6	2.1	1 6
51 SALIVARY GLAND PROCEDURES EXCEPT SIALOADENECTOMY	0.6647	2.9	2.3	1 9
52 CLEFT LIP & PALATE REPAIR	0.6944	3.4	2.9	1 8
53 SINUS & MASTOID PROCEDURES AGE >=18	0.7476	2.5	1.9	1 7
54 SINUS & MASTOID PROCEDURES AGE 0-17	0.6684	2.1	1.7	1 5
55 MISCELLANEOUS EAR, NOSE & THROAT PROCEDURES	0.4973	1.6	1.4	1 3
56 RHINOPLASTY	0.4822	1.6	1.4	1 3
57 T&A PROC EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY AGE >=18	0.5202	2.5	2.0	1 6
58 T&A PROC EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY AGE 0-17	0.3662	1.3	1.2	1 2

CHAMPUS WEIGHT AND THRESHOLD SUMMARY

DRG NUMBER DESCRIPTION	CHAMPUS ARITHMETIC WEIGHT	GEOMETRIC MEAN LOS	SHORT STAY MEAN LOS	LONG STAY THRESHOLD	THRESHOLD
59 TONSILLECTOMY AND/OR ADENOIDECTOMY ONLY AGE >=18	0.3713	1.4	1.2	1	2
60 TONSILLECTOMY AND/OR ADENOIDECTOMY ONLY AGE 0-17	0.3357	1.3	1.2	1	2
61 MYRINGOTOMY WITH TUBE INSERTION AGE >=18	0.8733	2.8	1.9	1	10
62 MYRINGOTOMY WITH TUBE INSERTION AGE 0-17	0.3938	1.9	1.4	1	4
63 OTHER EAR, NOSE & THROAT O.R. PROCEDURES	0.9214	3.8	2.8	1	13
64 EAR, NOSE & THROAT MALIGNANCY	1.1117	6.2	3.9	1	20
65 DYSEQUILIBRIUM	0.5023	3.5	2.8	1	9
66 EPISTAXIS	0.5123	3.7	3.0	1	11
67 EPIGLOTTITIS	1.1043	4.3	3.6	1	12
68 OTITIS MEDIA & URI AGE >=70 AND/OR C.C.	0.6849	4.3	3.6	1	12
69 OTITIS MEDIA & URI AGE 18-69 W/O C.C.	0.4817	3.3	2.8	1	8
70 OTITIS MEDIA & URI AGE 0-17	0.4016	3.2	2.7	1	8
71 LARYNGOTRACHEITIS	0.3583	2.6	2.2	1	6
72 NASAL TRAUMA & DEFORMITY	0.3922	2.0	1.5	1	5
73 OTHER EAR, NOSE & THROAT DIAGNOSES AGE >=18	0.6875	3.7	2.6	1	12
74 OTHER EAR, NOSE & THROAT DIAGNOSES AGE 0-17	0.4760	3.0	2.1	1	9
75 MAJOR CHEST PROCEDURES	3.0582	11.4	9.6	3	26
76 OTHER RESP SYSTEM O.R.PROCEDURES WITH C.C.	3.2224	12.0	7.9	1	24
77 OTHER RESP SYSTEM O.R. PROCEDURES W/O C.C.	1.7591	7.3	5.0	1	22
78 PULMONARY EMBOLISM	1.6485	9.2	7.5	1	24
79 RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >=70 AND/OR C.C.	2.8086	11.0	8.6	1	25
80 RESPIRATORY INFECTIONS & INFLAMMATIONS AGE 18-69 W/O C.C.	1.6726	9.2	7.0	1	24
81 RESPIRATORY INFECTIONS & INFLAMMATIONS AGE 0-17	1.3621	8.0	6.5	1	23
82 RESPIRATORY NEOPLASMS	1.3537	7.4	4.9	1	21
83 MAJOR CHEST TRAUMA AGE >=70 AND/OR C.C.	2.8879	9.4	6.4	1	23
84 MAJOR CHEST TRAUMA AGE <70 W/O C.C.	0.6126	4.4	3.5	1	13
85 PLEURAL EFFUSION AGE >=70 AND/OR C.C.	1.3375	7.4	5.5	1	22
86 PLEURAL EFFUSION AGE <70 W/O C.C.	0.9337	6.1	4.1	1	21
87 PULMONARY EDEMA & RESPIRATORY FAILURE	2.6726	9.2	6.6	1	23

CHAMPUS WEIGHT AND THRESHOLD SUMMARY

DRG NUMBER DESCRIPTION	CHAMPUS WEIGHT	ARITHMETIC MEAN LOS	GEOMETRIC MEAN LOS	SHORT STAY THRESHOLD	LONG STAY THRESHOLD
88 CHRONIC OBSTRUCTIVE PULMONARY DISEASE	1.3593	6.9	5.4	1	21
89 SIMPLE PNEUMONIA & PLEURISY AGE ≥70 AND/OR C.C.	1.5290	7.5	6.3	1	20
90 SIMPLE PNEUMONIA & PLEURISY AGE 18-69 W/O C.C.	0.9350	5.5	4.7	1	14
91 SIMPLE PNEUMONIA & PLEURISY AGE 0-17	0.6261	4.3	3.6	1	10
92 INTERSTITIAL LUNG DISEASE AGE ≥70 AND/OR C.C.	1.5426	8.5	5.3	1	22
93 INTERSTITIAL LUNG DISEASE AGE <70 W/O C.C.	0.8010	4.7	3.7	1	15
94 PNEUMOTHORAX AGE ≥70 AND/OR C.C.	1.5808	8.6	6.1	1	23
95 PNEUMOTHORAX AGE <70 W/O C.C.	0.6552	5.0	4.1	1	14
96 BRONCHITIS & ASTHMA AGE ≥70 AND/OR C.C.	1.1797	6.2	5.2	1	16
97 BRONCHITIS & ASTHMA AGE 18-69 W/O C.C.	0.8014	4.8	4.1	1	12
98 BRONCHITIS & ASTHMA AGE 0-17	0.5031	3.4	2.9	1	8
99 RESPIRATORY SIGNS & SYMPTOMS AGE ≥70 AND/OR C.C.	0.9411	4.8	3.7	1	15
100 RESPIRATORY SIGNS & SYMPTOMS AGE <70 W/O C.C.	0.5788	3.3	2.5	1	9
101 OTHER RESPIRATORY DIAGNOSES AGE ≥70 AND/OR C.C.	1.3947	6.2	4.5	1	21
102 OTHER RESPIRATORY DIAGNOSES AGE <70 WITHOUT C.C.	0.7468	3.9	2.8	1	13
103 HEART TRANSPLANT	-	-	-	-	-
104 CARDIAC VALVE PROCEDURE WITH PUMP & WITH CARDIAC CATH	6.7946	12.9	11.3	3	28
105 CARDIAC VALVE PROCEDURE WITH PUMP & W/O CARDIAC CATH	5.8168	10.7	9.5	3	26
106 CORONARY BYPASS WITH CARDIAC CATH	5.8104	12.0	11.0	4	24
107 CORONARY BYPASS W/O CARDIAC CATH	4.8904	10.0	9.2	4	21
108 OTHER CARDIOTHOR OR VASCULAR PROC WITH PUMP	3.7739	10.3	8.6	2	25
109 OTHER CARDIOTHORACIC PROCEDURES W/O PUMP	4.0747	10.7	8.6	2	25
110 MAJOR RECONSTRUCTIVE VASCULAR PROCEDURES W/O PUMP AGE ≥70 AND/OR	3.7060	11.7	9.9	3	26
111 MAJOR RECONSTRUCTIVE VASCULAR PROCEDURES W/O PUMP AGE <70 W/O C.	2.7987	9.3	8.4	3	20
112 VASCULAR PROCEDURES EXCEPT MAJOR RECONSTRUCTION W/O PUMP	2.3117	6.8	5.1	1	21
113 AMPUTATION FOR CIRC SYSTEM DISORDERS EXCEPT UPPER LIMB & TOE	3.6268	19.8	15.1	3	32
114 UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS	2.0505	11.5	8.8	1	25
115 PERMANENT CARDIAC PACEMAKER IMPLANT WITH ANI, HEART FAILURE OR SH	4.7176	11.4	9.1	1	26
116 PERMANENT CARDIAC PACEMAKER IMPLANT W/O ANI, HEART FAILURE OR SHO	3.1991	6.0	5.0	1	16

CHAMPUS WEIGHT AND THRESHOLD SUMMARY

DRG NUMBER DESCRIPTION	CHAMPUS WEIGHT	ARITHMETIC MEAN LOS	GEOMETRIC MEAN LOS	SHORT STAY THRESHOLD	LONG STAY THRESHOLD
117 CARDIAC PACEMAKER REPLACE & REVIS EXC PULSE GEN REPL	1.4970	6.2	4.1	1	21
118 CARDIAC PACEMAKER PULSE GENERATOR REPLACEMENT	2.1962	2.7	2.3	1	7
119 VEIN LIGATION & STRIPPING	0.7846	3.7	3.0	1	10
120 OTHER O.R. PROCEDURES ON THE CIRCULATORY SYSTEM	2.8012	12.5	7.1	1	24
121 CIRCULATORY DISORDERS WITH AMI & C.V. COMP. DISCH. ALIVE	2.1709	8.8	6.9	1	23
122 CIRCULATORY DISORDERS WITH AMI W/O C.V. COMP. DISCH. ALIVE	1.5068	6.5	5.2	1	22
123 CIRCULATORY DISORDERS WITH AMI, EXPIRED	2.3655	4.2	2.6	1	16
124 CIRCULATORY DISORDERS EXC AMI WITH CARD CATH & COMPLEX DIAG	1.4518	4.8	3.7	1	15
125 CIRCULATORY DISORDERS EXC AMI WITH CARD CATH W/O COMPLEX DIAG	0.8694	3.0	2.3	1	8
126 ACUTE & SUBACUTE ENDOCARDITIS	3.7074	17.8	12.7	2	29
127 HEART FAILURE & SHOCK	1.2739	6.5	5.1	1	20
128 DEEP VEIN THROMBOPHLEBITIS	0.9339	7.8	6.7	2	20
129 CARDIAC ARREST, UNEXPLAINED	3.5298	10.4	4.7	1	21
130 PERIPHERAL VASCULAR DISORDERS AGE >=70 AND/OR C.C.	1.1482	7.0	4.9	1	21
131 PERIPHERAL VASCULAR DISORDERS AGE <70 W/O C.C.	0.7643	5.2	3.7	1	19
132 ATHEROSCLEROSIS AGE >=70 AND/OR C.C.	1.0702	3.6	2.8	1	10
133 ATHEROSCLEROSIS AGE <70 W/O C.C.	0.9704	3.2	2.6	1	9
134 HYPERTENSION	0.6540	4.3	3.4	1	12
135 CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >=70 AND/OR C.C.	0.9561	3.9	3.1	1	11
136 CARDIAC CONGENITAL & VALVULAR DISORDERS AGE 18-69 W/O C.C.	0.7412	3.2	2.5	1	9
137 CARDIAC CONGENITAL & VALVULAR DISORDERS AGE 0-17	0.7581	3.1	2.1	1	9
138 CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS AGE >=70 AND/OR C.C.	0.8866	4.4	3.4	1	13
139 CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS AGE <70 W/O C.C.	0.6432	3.4	2.7	1	10
140 ANGINA PECTORIS	0.8099	3.6	3.0	1	10
141 SYNCOPE & COLLAPSE AGE >=70 AND/OR C.C.	0.6900	4.0	3.1	1	12
142 SYNCOPE & COLLAPSE AGE <70 W/O C.C.	0.5358	3.0	2.4	1	8
143 CHEST PAIN	0.6394	2.9	2.4	1	7
144 OTHER CIRCULATORY DIAGNOSES WITH C.C.	1.3249	6.3	4.5	1	21
145 OTHER CIRCULATORY DIAGNOSES W/O C.C.	0.8308	4.1	3.1	1	13

CHAMPUS WEIGHT AND THRESHOLD SUMMARY

DRG NUMBER DESCRIPTION	CHAMPUS ARITHMETIC GEOMETRIC SHORT STAY LONG STAY			
	WEIGHT	MEAN LOS	MEAN LOS	THRESHOLD THRESHOLD
146 RECTAL RESECTION AGE >=70 AND/OR C.C.	3.2885	14.4	13.0	5 29
147 RECTAL RESECTION AGE <70 W/O C.C.	2.3506	10.8	10.3	5 18
148 MAJOR SMALL & LARGE BOWEL PROCEDURES AGE >=70 AND/OR C.C.	3.5614	13.9	11.9	4 28
149 MAJOR SMALL & LARGE BOWEL PROCEDURES AGE <70 W/O C.C.	2.0799	10.1	8.8	3 24
150 PERITONEAL ADHESOLYSIS AGE >=70 AND/OR C.C.	2.3009	11.1	9.8	3 25
151 PERITONEAL ADHESOLYSIS AGE <70 W/O C.C.	1.5484	8.2	7.2	2 20
152 MINOR SMALL & LARGE BOWEL PROCEDURES AGE >=70 AND/OR C.C.	2.2572	10.0	7.9	2 24
153 MINOR SMALL & LARGE BOWEL PROCEDURES AGE <70 W/O C.C.	1.3399	7.5	6.2	1 21
154 STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >=70 AND/OR C.C.	3.4536	12.3	10.0	2 26
155 STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE 18-69 W/O C.C.	2.0912	9.1	7.6	2 24
156 STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE 0-17	1.0770	5.6	4.3	1 16
157 ANAL AND STOMAL PROCEDURES AGE >=70 AND/OR C.C.	0.9817	5.6	4.5	1 17
158 ANAL AND STOMAL PROCEDURES AGE <70 W/O C.C.	0.6166	3.7	3.1	1 10
159 HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >=70 AND/OR C.C.	1.2607	6.0	5.0	1 16
160 HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE 18-69 W/O C.C.	0.8122	4.0	3.3	1 11
161 INGUINAL & FEMORAL HERNIA PROCEDURES AGE >=70 AND/OR C.C.	0.8475	3.9	3.2	1 11
162 INGUINAL & FEMORAL HERNIA PROCEDURES AGE 18-69 W/O C.C.	0.5421	2.4	2.0	1 6
163 HERNIA PROCEDURES AGE 0-17	0.4304	1.8	1.5	1 4
164 APPENDECTOMY WITH COMPLICATED PRINC. DIAG AGE >=70 AND/OR C.C.	2.3864	10.1	9.3	4 20
165 APPENDECTOMY WITH COMPLICATED PRINC. DIAG AGE <70 W/O C.C.	1.2534	6.3	5.6	2 15
166 APPENDECTOMY W/O COMPLICATED PRINC. DIAG AGE >=70 AND/OR C.C.	1.2428	5.9	5.1	1 14
167 APPENDECTOMY W/O COMPLICATED PRINC. DIAG AGE <70 W/O C.C.	0.6998	3.6	3.2	1 7
168 PROCEDURES ON THE MOUTH AGE >=70 AND/OR C.C.	1.8458	6.4	4.6	1 21
169 PROCEDURES ON THE MOUTH AGE <70 W/O C.C.	0.9303	3.2	2.7	1 8
170 OTHER DIGESTIVE SYSTEM O.R. PROCEDURES AGE >=70 AND/OR C.C.	2.9384	13.6	9.9	1 26
171 OTHER DIGESTIVE SYSTEM O.R. PROCEDURES AGE <70 W/O C.C.	1.2247	6.0	4.4	1 21
172 DIGESTIVE MALIGNANCY AGE >=70 AND/OR C.C.	1.4151	8.6	5.6	1 22
173 DIGESTIVE MALIGNANCY AGE <70 W/O C.C.	1.0248	6.2	4.1	1 21
174 G.I. HEMORRHA GE >=70 AND/OR C.C.	1.1540	5.7	4.4	1 17

CHAMPUS WEIGHT AND THRESHOLD SUMMARY

DRG NUMBER DESCRIPTION	CHAMPUS WEIGHT	ARITHMETIC MEAN LOS	GEOMETRIC MEAN LOS	SHORT STAY THRESHOLD	LONG STAY THRESHOLD
175 G.I. HEMORRHAGE AGE <70 W/O C.C.	0.7029	4.2	3.5	1	11
176 COMPLICATED PEPTIC ULCER	0.9471	5.3	4.2	1	16
177 UNCOMPLICATED PEPTIC ULCER >=70 AND/OR C.C.	0.8815	5.4	4.6	1	13
178 UNCOMPLICATED PEPTIC ULCER <70 W/O C.C.	0.6263	4.2	3.5	1	11
179 INFLAMMATORY BOWEL DISEASE	1.0332	7.0	5.3	1	22
180 G.I. OBSTRUCTION AGE >=70 AND/OR C.C.	1.0272	6.6	4.9	1	21
181 G.I. OBSTRUCTION AGE <70 W/O C.C.	0.5976	4.3	3.5	1	12
182 ESOPHAGITIS, GASTROENT. & MISC. DIGEST. DIS AGE >=70 &/OR C.C.	0.7497	4.8	3.8	1	14
183 ESOPHAGITIS, GASTROENT. & MISC. DIGEST. DIS AGE 18-69 W/O C.C.	0.5574	3.8	3.0	1	11
184 ESOPHAGITIS, GASTROENTERITIS & MISC. DIGEST. DISORDERS AGE 0-17	0.3297	2.9	2.4	1	7
185 DENTAL & ORAL DIS. EXC EXTRACTIONS & RESTORATIONS, AGE >=18	0.8997	4.8	3.3	1	17
186 DENTAL & ORAL DIS. EXC EXTRACTIONS & RESTORATIONS, AGE 0-17	0.4184	3.0	2.5	1	8
187 DENTAL EXTRACTIONS & RESTORATIONS	0.4942	2.1	1.7	1	5
188 OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >=70 AND/OR C.C.	1.0015	5.4	4.1	1	17
189 OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 18-69 W/O C.C.	0.6098	4.0	2.8	1	13
190 OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 0-17	0.4015	2.6	1.9	1	7
191 MAJOR PANCREAS, LIVER & SHUNT PROCEDURES	5.0848	16.4	13.3	3	30
192 MINOR PANCREAS, LIVER & SHUNT PROCEDURES	5.2655	18.7	12.6	2	29
193 BILIARY TRACT PROC EXC TOT CHOLECYSTECTOMY AGE >=70 &/OR C.C.	3.3429	13.7	10.7	2	27
194 BILIARY TRACT PROC EXC TOT CHOLECYSTECTOMY AGE <70 W/O C.C.	2.0402	9.6	8.4	2	24
195 TOTAL CHOLECYSTECTOMY WITH C.D.E. AGE >=70 AND/OR C.C.	2.0491	9.4	8.7	4	18
196 TOTAL CHOLECYSTECTOMY WITH C.D.E. AGE <70 W/O C.C.	1.4977	7.9	7.3	3	15
197 TOTAL CHOLECYSTECTOMY W/O C.D.E. AGE >=70 AND/OR C.C.	1.4689	7.4	6.7	2	15
198 TOTAL CHOLECYSTECTOMY W/O C.D.E. AGE <70 W/O C.C.	1.0987	5.8	5.4	2	11
199 HEPATOBIILIARY DIAGNOSTIC PROCEDURE FOR MALIGNANCY	1.9111	10.9	9.7	3	26
200 HEPATOBIILIARY DIAGNOSTIC PROCEDURE FOR NON-MALIGNANCY	2.4732	10.0	6.8	1	23
201 OTHER HEPATOBIILIARY OR PANCREAS O.R. PROCEDURES	2.7311	10.2	7.0	1	24
202 CIRRHOSIS & ALCOHOLIC HEPATITIS	1.3853	7.7	5.5	1	22
203 MALIGNANCY OF HEPATOBIILIARY SYSTEM OR PANCREAS	1.2989	7.9	5.3	1	22

CHAMPUS WEIGHT AND THRESHOLD SUMMARY

ORG NUMBER DESCRIPTION	CHAMPUS ARITHMETIC GEOMETRIC SHORT STAY LONG STAY			
	WEIGHT	MEAN LOS	MEAN LOS	THRESHOLD THRESHOLD
204 DISORDERS OF PANCREAS EXCEPT MALIGNANCY	1.0126	6.5	5.2	1 18
205 DISORDERS OF LIVER EXC MALIGN,CIRRH,ALC NEPA AGE >=70 AND/OR C.C.	1.7588	8.7	6.0	1 23
206 DISORDERS OF LIVER EXC MALIGN,CIRRH,ALC NEPA AGE <70 W/O C.C.	0.7416	5.0	3.5	1 18
207 DISORDERS OF THE BILIARY TRACT AGE >=70 AND/OR C.C.	0.9392	5.3	4.0	1 17
208 DISORDERS OF THE BILIARY TRACT AGE <70 W/O C.C.	0.6001	3.5	2.7	1 10
209 MAJOR JOINT AND LIMB REATTACHMENT PROCEDURES	2.9943	11.4	10.6	5 22
210 HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >=70 AND/OR C.C.	3.2031	14.6	11.9	3 28
211 HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 18-69 W/O C.C.	1.9295	9.8	8.3	2 25
212 HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 0-17	1.4129	8.7	5.9	1 22
213 AMPUTATIONS FOR MUSCULOSKELETAL SYSTEM & CONN. TISSUE DISORDERS	1.7263	10.7	7.8	1 24
214 BACK & NECK PROCEDURES AGE >=70 AND/OR C.C.	2.4274	11.1	9.3	3 26
215 BACK & NECK PROCEDURES AGE <70 W/O C.C.	1.5126	7.9	6.8	2 19
216 BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	1.3089	6.6	4.4	1 21
217 WND DEBRID & SKN GFT EXC HAND, FOR MUSCULOSKELETAL & CONN. TISS. DIS	2.0273	9.9	5.5	1 22
218 LOWER EXTREM & HUMER PROC EXC HIP, FOOT, FEMUR AGE >=70 &/OR C.C.	1.8658	8.8	7.1	1 24
219 LOWER EXTREM & HUMER PROC EXC HIP, FOOT, FEMUR AGE 18-69 W/O C.C.	1.0855	5.1	4.2	1 14
220 LOWER EXTREM & HUMER PROC EXC HIP, FOOT, FEMUR AGE 0-17	0.8099	3.6	2.6	1 11
221 KNEE PROCEDURES AGE >=70 AND/OR C.C.	1.9419	9.9	4.1	1 21
222 KNEE PROCEDURES AGE <70 W/O C.C.	0.8425	3.4	2.7	1 9
223 MAJOR SHOULDER/ELBOW PROC.	1.1151	4.5	3.4	1 14
224 SHOULDER, ELBOW OR FOREARM PROC, EXC MAJOR JOINT PROC, W/O CC	0.7700	2.9	2.4	1 7
225 FOOT PROCEDURES	0.7177	3.0	2.5	1 8
226 SOFT TISSUE PROCEDURES AGE >=70 AND/OR C.C.	1.0876	6.4	4.3	1 21
227 SOFT TISSUE PROCEDURES AGE <70 W/O C.C.	0.7236	3.4	2.5	1 9
228 MAJOR THUMB OR JOINT PROC, OR OTH HAND OR WRIST PROC W CC	0.8723	3.2	2.6	1 9
229 HAND OR WRIST PROC, EXCEPT MAJOR JOINT PROC W/O C.C.	0.6455	2.3	1.8	1 6
230 LOCAL EXCISION & REMOVAL OF INT FIX DEVICES OF HIP & FEMUR	0.7155	3.6	2.3	1 11
231 LOCAL EXCISION & REMOVAL OF INT FIX DEVICES EXCEPT HIP & FEMUR	0.8753	3.8	2.6	1 12
232 ARTHROSCOPY	0.6393	2.3	1.8	1 6

CHAMPUS WEIGHT AND THRESHOLD SUMMARY

DRG NUMBER DESCRIPTION	CHAMPUS ARITHMETIC GEOMETRIC SHORT STAY LONG STAY			
	WEIGHT	MEAN LOS	MEAN LOS	THRESHOLD THRESHOLD
233 OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC AGE >=70 &/OR C.C.	2.4202	9.7	7.2	1
234 OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC AGE <70 W/O C.C.	0.9855	4.7	3.7	1
235 FRACTURES OF FEMUR	1.2545	13.7	7.9	1
236 FRACTURES OF HIP & PELVIS	0.9995	8.8	6.0	1
237 SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH	0.6421	5.0	3.9	1
238 OSTEOMYELITIS	1.6239	11.9	8.6	1
239 PATHOLOGICAL FRACTURES & MUSCULOSKELETAL & CONN.TISS.MALIGNANCY	1.1907	8.7	6.0	1
240 CONNECTIVE TISSUE DISORDERS AGE >=70 AND/OR C.C.	1.4885	8.4	6.3	1
241 CONNECTIVE TISSUE DISORDERS AGE <70 W/O C.C.	0.8490	6.5	4.7	1
242 SEPTIC ARTHRITIS	1.2112	9.6	7.7	2
243 MEDICAL BACK PROBLEMS	0.7425	5.6	4.2	1
244 BONE DISEASES & SPECIFIC ARTHROPATHY AGE >=70 AND/OR C.C.	0.8232	6.0	4.6	1
245 BONE DISEASES & SPECIFIC ARTHROPATHY AGE <70 W/O C.C.	0.6544	4.8	3.5	1
246 NON-SPECIFIC ARTHROPATHIES	0.5751	3.8	3.2	1
247 SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE	0.6729	5.2	3.5	1
248 TENDONITIS, MYOSITIS & BURSTITIS	0.6042	4.3	3.3	1
249 AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	0.7924	5.4	3.1	1
250 FX, SPRNS, STRNS & DISL OF FOREARM, HAND, FOOT AGE >=70 &/OR C.C.	0.7355	5.1	3.9	1
251 FX, SPRNS, STRNS & DISL OF FOREARM, HAND, FOOT AGE 18-69 W/O C.C.	0.4550	2.7	2.0	1
252 FX, SPRNS, STRNS & DISL OF FOREARM, HAND, FOOT AGE 0-17	0.3186	1.4	1.2	1
253 FX, SPRNS, STRNS & DISL OF UPARM, LOWLEG EX FOOT AGE >=70 &/OR C.C.	0.8188	5.5	4.0	1
254 FX, SPRNS, STRNS & DISL OF UPARM, LOWLEG EX FOOT AGE 18-69 W/O C.C.	0.4732	3.4	2.6	1
255 FX, SPRNS, STRNS & DISL OF UPARM, LOWLEG EX FOOT AGE 0-17	0.3709	2.5	1.8	1
256 OTHER DIAGNOSES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	0.6606	4.1	2.9	1
257 TOTAL MASTECTOMY FOR MALIGNANCY AGE >=70 AND/OR C.C.	1.2098	6.1	5.5	2
258 TOTAL MASTECTOMY FOR MALIGNANCY AGE <70 W/O C.C.	1.0060	5.0	4.5	1
259 SUBTOTAL MASTECTOMY FOR MALIGNANCY AGE >=70 AND/OR C.C.	1.1880	7.0	4.4	1
260 SUBTOTAL MASTECTOMY FOR MALIGNANCY AGE <70 W/O C.C.	0.7876	3.2	2.4	1
261 BREAST PROC FOR NON-MALIG EXCEPT BIOPSY & LOC EXC	0.9072	3.2	2.7	1

CHAMPUS WEIGHT AND THRESHOLD SUMMARY

DRG NUMBER DESCRIPTION	CHAMPUS WEIGHT	ARITHMETIC MEAN LOS	GEOMETRIC MEAN LOS	SHORT STAY THRESHOLD	LONG STAY THRESHOLD
262 BREAST BIOPSY & LOCAL EXCISION FOR NON-MALIGNANCY	0.5166	2.1	1.8	1	5
263 SKIN GRAFTS &/OR DEBRID FOR SKIN ULCER OR CELLULITIS AGE >=70 &/O	2.9552	16.5	12.0	2	28
264 SKIN GRAFTS &/OR DEBRID FOR SKIN ULCER OR CELLULITIS AGE <70 W/O	1.8731	12.0	9.0	1	25
265 SKIN GRAFTS &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS WITH	1.7366	9.7	6.9	1	23
266 SKIN GRAFTS &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W/O	0.9241	4.7	3.3	1	16
267 PERIANAL & PILONIDAL PROCEDURES	0.4913	2.4	2.0	1	6
268 SKIN, SUBCUTANEOUS TISSUE & BREAST PLASTIC PROCEDURES	0.7085	2.9	2.4	1	8
269 OTHER SKIN, SUBCUT TISS & BREAST O.R. PROC AGE >=70 &/OR C.C.	1.5437	7.7	5.5	1	22
270 OTHER SKIN, SUBCUT TISS & BREAST O.R. PROC AGE <70 W/O C.C.	0.7451	3.6	2.5	1	12
271 SKIN ULCERS	1.1258	8.3	6.5	1	23
272 MAJOR SKIN DISORDERS AGE >=70 AND/OR C.C.	1.1249	8.3	5.7	1	22
273 MAJOR SKIN DISORDERS AGE <70 W/O C.C.	0.7077	6.1	4.4	1	21
274 MALIGNANT BREAST DISORDERS AGE >=70 AND/OR C.C.	1.2667	8.8	6.0	1	22
275 MALIGNANT BREAST DISORDERS AGE <70 W/O C.C.	0.7625	5.4	3.7	1	20
276 NON-MALIGNANT BREAST DISORDERS	0.5332	3.1	2.6	1	8
277 CELLULITIS AGE >=70 AND/OR C.C.	1.0255	6.8	5.7	1	17
278 CELLULITIS AGE 18-69 W/O C.C.	0.7518	5.3	4.5	1	14
279 CELLULITIS AGE 0-17	0.5277	4.3	3.5	1	11
280 TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >=70 &/OR C.C.	0.5775	3.7	2.7	1	12
281 TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE 18-69 W/O C.C.	0.4130	2.8	2.2	1	8
282 TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE 0-17	0.3181	2.2	1.7	1	5
283 MINOR SKIN DISORDERS AGE >=70 AND/OR C.C.	0.7153	4.9	4.1	1	13
284 MINOR SKIN DISORDERS AGE <70 W/O C.C.	0.5054	3.8	2.9	1	11
285 AMPUTATION OF LOWER LIMB FOR ENDOCRINE, NUTRITIONAL & METABOLIC D	2.3351	15.4	14.0	5	30
286 ADRENAL & PITUITARY PROCEDURES	2.8083	10.6	8.9	2	25
287 SKIN GRAFTS & WOUND DEBRIDE FOR ENDOC, NUTRIT & METAB DISORDERS	1.9411	12.4	10.0	2	27
288 O.R. PROCEDURES FOR OBESITY	1.8201	6.5	6.1	2	12
289 PARATHYROID PROCEDURES	0.9714	4.6	4.0	1	10
290 THYROID PROCEDURES	0.7745	3.2	2.8	1	7

CHAMPUS WEIGHT AND THRESHOLD SUMMARY

DRG NUMBER DESCRIPTION	CHAMPUS ARITHMETIC GEOMETRIC SHORT STAY LONG STAY			
	WEIGHT	MEAN LOS	MEAN LOS	THRESHOLD THRESHOLD
291 THYROIDAL PROCEDURES	0.4241	1.6	1.4	1 3
292 OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC AGE >70 &/OR C.C.	2.0491	9.0	7.6	2 24
293 OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC AGE <70 W/O C.C.	1.5269	6.4	4.9	1 21
294 DIABETES AGE >=36	0.7556	5.9	5.0	1 15
295 DIABETES AGE 0-35	0.6385	4.7	3.9	1 13
296 NUTRITIONAL & MISC. METABOLIC DISORDERS AGE >=70 AND/OR C.C.	1.0660	6.4	4.8	1 21
297 NUTRITIONAL & MISC. METABOLIC DISORDERS AGE 18-69 W/O C.C.	0.7334	5.2	3.7	1 17
298 NUTRITIONAL & MISC. METABOLIC DISORDERS AGE 0-17	0.6039	4.8	3.4	1 16
299 INBORN ERRORS OF METABOLISM	1.0303	5.6	3.9	1 19
300 ENDOCRINE DISORDERS AGE >=70 AND/OR C.C.	1.0597	6.2	4.8	1 20
301 ENDOCRINE DISORDERS AGE <70 W/O C.C.	0.6648	4.6	3.1	1 15
302 KIDNEY TRANSPLANT	3.7135	17.5	15.2	5 32
303 KIDNEY, URETER & MAJOR BLADDER PROCEDURE FOR NEOPLASM	2.3414	10.3	9.5	4 21
304 KIDNEY, URETER & MAJ BLDR PROC FOR NON-NEOPL AGE >=70 &/OR C.C.	2.1561	9.0	7.2	1 24
305 KIDNEY, URETER & MAJ BLDR PROC FOR NON-NEOPL AGE <70 W/O C.C.	1.3649	5.8	4.4	1 20
306 PROSTATECTOMY AGE >=70 AND/OR C.C.	2.0958	12.4	7.5	1 24
307 PROSTATECTOMY AGE <70 W/O C.C.	1.0308	6.0	4.8	1 16
308 MINOR BLADDER PROCEDURES AGE >=70 AND/OR C.C.	1.4545	7.1	4.8	1 21
309 MINOR BLADDER PROCEDURES AGE <70 W/O C.C.	1.1876	5.9	4.2	1 21
310 TRANSURETHRAL PROCEDURES AGE >=70 AND/OR C.C.	1.0370	4.4	3.3	1 14
311 TRANSURETHRAL PROCEDURES AGE <70 W/O C.C.	0.7452	3.3	2.7	1 9
312 URETHRAL PROCEDURES, AGE >=70 AND/OR C.C.	0.7844	4.4	3.6	1 14
313 URETHRAL PROCEDURES, AGE 18-69 W/O C.C.	0.6461	3.5	2.4	1 11
314 URETHRAL PROCEDURES, AGE 0-17	0.5325	2.8	2.2	1 8
315 OTHER KIDNEY & URINARY TRACT O.R. PROCEDURES	2.6432	10.7	7.3	1 24
316 RENAL FAILURE	1.9126	8.4	5.9	1 22
317 ADMIT FOR RENAL DIALYSIS	0.4907*	3.4	2.3	1 10
318 KIDNEY & URINARY TRACT NEOPLASMS AGE >=70 AND/OR C.C.	1.3748	8.1	5.2	1 22
319 KIDNEY & URINARY TRACT NEOPLASMS AGE <70 W/O C.C.	0.6935	4.3	3.1	1 15

CHAMPUS WEIGHT AND THRESHOLD SUMMARY

DRG NUMBER DESCRIPTION	CHAMPUS ARITHMETIC GEOMETRIC SHORT STAY LONG STAY				
	WEIGHT	MEAN LOS	MEAN LOS	THRESHOLD	THRESHOLD
320 KIDNEY & URINARY TRACT INFECTIONS AGE >=70 AND/OR C.C.	0.9528	5.9	5.0	1	15
321 KIDNEY & URINARY TRACT INFECTIONS AGE 18-69 W/O C.C.	0.6524	4.4	3.7	1	11
322 KIDNEY & URINARY TRACT INFECTIONS AGE 0-17	0.5497	4.3	3.6	1	11
323 URINARY STONES AGE >=70 AND/OR CC,&/OR ESW LITHOTRIPSY	0.9396	3.6	2.6	1	11
324 URINARY STONES AGE <70 W/O C.C.	0.5417	2.4	1.9	1	6
325 KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >=70 AND/OR C.C.	0.8738	5.4	4.0	1	19
326 KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE 18-69 W/O C.C.	0.6338	3.6	2.7	1	11
327 KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE 0-17	0.5118	3.8	2.9	1	11
328 URETHRAL STRICTURE AGE >=70 AND/OR C.C.	0.6042	3.7	3.0	1	11
329 URETHRAL STRICTURE AGE 18-69 W/O C.C.	0.5086	3.3	2.4	1	10
330 URETHRAL STRICTURE AGE 0-17	0.2788*	0.0	1.6	1	5
331 OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >=70 AND/OR C.C.	1.0961	6.8	4.6	1	21
332 OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE 18-69 W/O C.C.	0.6032	3.7	2.8	1	11
333 OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE 0-17	0.5760	3.8	2.6	1	12
334 MAJOR MALE PELVIC PROCEDURES WITH C.C.	2.0361	11.1	10.1	4	24
335 MAJOR MALE PELVIC PROCEDURES W/O C.C.	1.7552	8.5	8.0	4	15
336 TRANSURETHRAL PROSTATECTOMY AGE >=70 AND/OR C.C.	0.9604	5.1	4.6	2	10
337 TRANSURETHRAL PROSTATECTOMY AGE <70 W/O C.C.	0.7762	4.3	4.1	2	7
338 TESTES PROCEDURES, FOR MALIGNANCY	0.7460	3.8	2.7	1	13
339 TESTES PROCEDURES, NON-MALIGNANT AGE >=18	0.5773	2.5	1.9	1	7
340 TESTES PROCEDURES, NON-MALIGNANT AGE 0-17	0.4925	1.9	1.6	1	4
341 PENIS PROCEDURES	0.9421	4.1	3.2	1	13
342 CIRCUMCISION AGE >=18	0.4662	1.7	1.4	1	4
343 CIRCUMCISION AGE 0-17	0.6514	4.9	2.2	1	19
344 OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES FOR MALIGNANCY	1.0783	4.8	3.9	1	15
345 OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXCEPT FOR MALIG	0.8772	5.0	3.5	1	19
346 MALIGNANCY, MALE REPRODUCTIVE SYSTEM, AGE >=70 AND/OR C.C.	1.3703	9.3	5.0	1	22
347 MALIGNANCY, MALE REPRODUCTIVE SYSTEM, AGE <70 W/O C.C.	0.6337	4.1	3.0	1	13
348 BENIGN PROSTATIC HYPERTROPHY AGE >=70 AND/OR C.C.	0.6458	3.8	2.8	1	13

CHAMPUS WEIGHT AND THRESHOLD SUMMARY

DRG	CHAMPUS ARITHMETIC WEIGHT	CHAMPUS GEOMETRIC MEAN LOS	CHAMPUS SHORT STAY THRESHOLD	CHAMPUS LONG STAY THRESHOLD
NUMBER DESCRIPTION	MEAN LOS	MEAN LOS		
349 BENIGN PROSTATIC HYPERTROPHY AGE <70 W/O C.C.	0.5316	2.4	2.0	1
350 INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM	0.6710	4.5	3.8	1
351 STERILIZATION, MALE	0.3333*	1.9	1.6	1
352 OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES	0.5645	3.6	2.5	1
353 PELVIC EVISCERATION, RADICAL HYSTERECTOMY & VULVECTOMY	1.9489	9.1	8.4	3
354 UTERINE, ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG AGE >69 OR CC	1.5556	7.7	6.9	2
355 UTERINE, ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG AGE <70 W/O CC	1.0703	5.7	5.3	2
356 FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES	0.9374	5.6	5.0	1
357 UTERUS & ADNEXA PROCEDURES, FOR OVARIAN OR ADNEXAL MALIGNANCY	2.0570	9.0	8.0	3
358 UTERUS & ADNEXA PROC FOR NON-MALIGNANCY AGE > 69 OR CC	1.3064	6.4	5.9	2
359 UTERINE AND ADNEXA PROC FOR NON-MALIGNANCY < 70 W/O CC	0.9826	5.1	4.8	2
360 VAGINA, CERVIX & VULVA PROCEDURES	0.6131	2.9	2.3	1
361 LAPAROSCOPY & INCISIONAL TUBAL INTERRUPTION	0.6894	3.0	2.3	1
362 ENDOSCOPIC TUBAL INTERRUPTION	0.3483	1.4	1.2	1
363 D&C, CONIZATION & RADIO-IMPLANT, FOR MALIGNANCY	0.6366	3.2	2.6	1
364 D&C, CONIZATION EXCEPT FOR MALIGNANCY	0.4863	2.1	1.7	1
365 OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES	1.2070	6.0	5.1	1
366 MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM AGE >=70 AND/OR C.C.	1.1986	7.5	5.0	1
367 MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM AGE <70 W/O C.C.	0.6089	3.3	2.2	1
368 INFECTIONS, FEMALE REPRODUCTIVE SYSTEM	0.6357	4.0	3.5	1
369 MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS	0.4241	2.8	2.2	1
370 CESAREAN SECTION WITH C.C.	1.0878	6.0	5.4	2
371 CESAREAN SECTION W/O C.C.	0.9012	4.8	4.6	2
372 VAGINAL DELIVERY WITH COMPLICATING DIAGNOSES	0.8102	4.4	3.6	1
373 VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	0.4666	2.7	2.4	1
374 VAGINAL DELIVERY WITH STERILIZATION AND/OR D&C	0.6730	3.0	2.8	1
375 VAGINAL DELIVERY WITH O.R. PROC EXCEPT STERIL AND/OR D&C	0.6817*	0.0	4.4	1
376 POSTPARTUM AND POSTABORTION DIAGNOSES W/O O.R. PROCEDURE	0.4692	3.1	2.5	1
377 POSTPARTUM AND POSTABORTION DIAGNOSES WITH O.R. PROCEDURE	0.6218	2.5	1.9	1

CHAMPUS WEIGHT AND THRESHOLD SUMMARY

DRG NUMBER DESCRIPTION	CHAMPUS ARITHMETIC GEOMETRIC SHORT STAY LONG STAY			
	WEIGHT	MEAN LOS	MEAN LOS	THRESHOLD THRESHOLD
378 ECTOPIC PREGNANCY	0.8096	3.9	3.7	1 7
379 THREATENED ABORTION	0.3214	2.6	2.0	1 7
380 ABORTION W/O D&C	0.3211	1.8	1.5	1 4
381 ABORTION WITH D&C, ASPIRATION CURETTAGE, OR HYSTEROTOMY	0.3652	1.4	1.2	1 2
382 FALSE LABOR	0.1479	1.3	1.2	1 2
383 OTHER ANTEPARTUM DIAGNOSES WITH MEDICAL COMPLICATIONS	0.3560	3.2	2.6	1 9
384 OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS	0.3615	2.9	2.0	1 8
385 NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	0.8322	5.1	2.9	1 18
386 EXTREME IMMATURE OR RESPIRATORY DISTRESS SYNDROME, NEONATE	3.3194	16.8	10.6	1 27
387 PREMATURITY WITH MAJOR PROBLEMS	1.6986	11.9	8.5	1 25
388 PREMATURITY W/O MAJOR PROBLEMS	0.7994	7.6	5.3	1 22
389 FULL TERM NEONATE WITH MAJOR PROBLEMS	0.5024	4.6	3.7	1 12
390 NEONATES WITH OTHER SIGNIFICANT PROBLEMS	0.2257	3.3	2.9	1 8
391 NORMAL NEWBORNS	0.1390	2.7	2.4	1 6
392 SPLENECTOMY AGE >=18	3.0019	10.3	8.5	2 25
393 SPLENECTOMY AGE 0-17	1.8160	8.4	7.6	3 16
394 OTHER O.R. PROCEDURES OF THE BLOOD & BLOOD FORMING ORGANS	1.1131	5.3	3.2	1 20
395 RED BLOOD CELL DISORDERS AGE >=18	0.9470	5.5	4.0	1 19
396 RED BLOOD CELL DISORDERS AGE 0-17	0.6575	4.3	3.2	1 14
397 COAGULATION DISORDERS	0.7945	4.5	3.3	1 15
398 RETICULOENDOTHELIAL & IMMUNITY DISORDERS AGE >=70 AND/OR C.C.	1.3348	6.7	5.3	1 20
399 RETICULOENDOTHELIAL & IMMUNITY DISORDERS AGE <70 W/O C.C.	0.7116	4.8	3.6	1 16
400 LYMPHOMA OR LEUKEMIA WITH MAJOR O.R. PROCEDURE	3.6784	11.3	8.6	2 25
401 LYMPHOMA AND NON-ACUTE LEUKEMIA WITH O.R. PROC WITH C.C.	2.0607	9.7	6.0	1 23
402 LYMPHOMA AND NON-ACUTE LEUKEMIA WITH O.R. PROCEDURE W/O C.C.	1.2718	5.7	4.1	1 20
403 LYMPHOMA AND NON-ACUTE LEUKEMIA WITH C.C.	1.7645	8.8	5.8	1 22
404 LYMPHOMA AND NON-ACUTE LEUKEMIA W/O C.C.	1.0364	5.7	3.8	1 20
405 ACUTE LEUKEMIA WITHOUT MAJOR O.R. PROCEDURE, AGE 0-17	1.6238	8.0	5.0	1 21
406 MYELOPROLIF DISORD OR POORLY DIFF NEOPLASM W MAJ O.R. PROC & C.C.	2.7904	12.4	9.5	2 26

CHAMPUS WEIGHT AND THRESHOLD SUMMARY

DRG NUMBER DESCRIPTION	CHAMPUS WEIGHT	ARITHMETIC MEAN LOS	GEOMETRIC MEAN LOS	SHORT STAY THRESHOLD	LONG STAY THRESHOLD
407 MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W/O C.C.	1.3771	6.9	5.7	1	22
408 MYELOPROLIF DISORD OR POORLY DIFF NEOPL WITH OTHER O.R.PROC	1.0734	5.1	3.6	1	15
409 RADIO THERAPY	0.8893	6.2	4.3	1	21
410 CHEMOTHERAPY	0.6178	2.9	2.3	1	8
411 HISTORY OF MALIGNANCY W/O ENDOSCOPY	1.0036	7.0	3.0	1	20
412 HISTORY OF MALIGNANCY WITH ENDOSCOPY	0.3388*	2.4	1.9	1	6
413 OTHR MYELOPROLIF DISORD OR POORLY DIFF NEOPL DX AGE<70 &/OR C.C	1.2413	8.2	5.1	1	22
414 OTHR MYELOPROLIF DISORD OR POORLY DIFF NEOPL DX AGE<70 W/O C.C.	0.9064	6.6	3.7	1	20
415 O.R. PROCEDURE FOR INFECTIOUS & PARASITIC DISEASES	3.2853	13.4	9.3	1	26
416 SEPTICEMIA AGE >=18	1.9711	9.0	6.8	1	23
417 SEPTICEMIA AGE 0-17	0.7178	5.4	4.2	1	15
418 POSTOPERATIVE & POST-TRAUMATIC INFECTIONS	1.1579	7.4	5.4	1	22
419 FEVER OF UNKNOWN ORIGIN AGE >=70 AND/OR C.C.	1.1611	6.5	5.5	1	17
420 FEVER OF UNKNOWN ORIGIN AGE 18-69 W/O C.C.	0.9760	6.0	4.7	1	18
421 VIRAL ILLNESS AGE >=18	0.5359	3.6	3.0	1	9
422 VIRAL ILLNESS & FEVER OF UNKNOWN ORIGIN AGE 0-17	0.4118	3.3	2.8	1	8
423 OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES	1.0385	6.4	4.2	1	21
424 O.R. PROCEDURES WITH PRINCIPAL DIAGNOSIS OF MENTAL ILLNESS	.	.	.	.	.
425 ACUTE ADJUST REACT & DISTURBANCES OF PSYCHOSOCIAL DYSFUNCTION	.	.	.	.	.
426 DEPRESSIVE NEUROSES	.	.	.	.	.
427 NEUROSES EXCEPT DEPRESSIVE	.	.	.	.	.
428 DISORDERS OF PERSONALITY & IMPULSE CONTROL	.	.	.	.	.
429 ORGANIC DISTURBANCES & MENTAL RETARDATION	.	.	.	.	.
430 PSYCHOSES	.	.	.	.	.
431 CHILDHOOD MENTAL DISORDERS	.	.	.	.	.
432 OTHER DIAGNOSES OF MENTAL DISORDERS	.	.	.	.	.
433 ALCOHOL/DRUG USE AND INDUCED ORGANIC MENTAL DISORDERS, LEFT ANA	.	.	.	.	.
434 ALC/DRUG ABUSE, INTOX INDUCED MNTL SYN EXC DEPEND &/OR OTH SYMPT T	.	.	.	.	.
435 ALCOHOL/DRUG DEPEND, DETOX AND/OR OTH SYMPTOMATIC TREATMENT	.	.	.	.	.

CHAMPUS WEIGHT AND THRESHOLD SUMMARY

DRG NUMBER DESCRIPTION	CHAMPUS ARITHMETIC GEOMETRIC SHORT STAY LONG STAY			
	WEIGHT	MEAN LOS	MEAN LOS	THRESHOLD THRESHOLD
436 ALCOHOL/DRUG DEPENDENCE WITH REHABILITATION THERAPY	-	-	-	-
437 ALCOHOL/DRUG DEPENDENCE, COMBINED REHAB AND DETOX THERAPY	-	-	-	-
438 NO LONGER VALID	-	-	-	-
439 SKIN GRAFTS FOR INJURIES	1.4983	7.9	4.7	1 21
440 WOUND DEBRIDEMENTS FOR INJURIES	1.5195	8.2	5.2	1 22
441 HAND PROCEDURES FOR INJURIES	0.9523	3.4	2.3	1 10
442 OTHER O.R. PROCEDURES FOR INJURIES AGE >=70 AND/OR C.C.	2.5787	9.5	6.3	1 23
443 OTHER O.R. PROCEDURES FOR INJURIES AGE <70 W/O C.C.	1.3343	5.8	3.5	1 20
444 MULTIPLE TRAUMA AGE >=70 AND/OR C.C.	0.9972	5.4	4.2	1 17
445 MULTIPLE TRAUMA AGE 18-69 W/O C.C.	0.8053	4.5	2.9	1 15
446 MULTIPLE TRAUMA AGE 0-17	0.6391	4.6	2.6	1 16
447 ALLERGIC REACTIONS AGE >=18	0.4913	2.9	2.2	1 8
448 ALLERGIC REACTIONS AGE 0-17	0.2952	2.3	1.8	1 6
449 POISONING AND TOXIC EFFECTS OF DRUGS AGE >=70 AND/OR C.C.	0.9045	5.4	3.3	1 20
450 POISONING AND TOXIC EFFECTS OF DRUGS AGE 18-69 W/O C.C.	0.4673	2.9	2.0	1 8
451 POISONING AND TOXIC EFFECTS OF DRUGS AGE 0-17	0.3600	2.3	1.7	1 6
452 COMPLICATIONS OF TREATMENT AGE >=70 AND/OR C.C.	1.0734	6.5	4.2	1 21
453 COMPLICATIONS OF TREATMENT AGE <70 W/O C.C.	0.4458	3.2	2.2	1 10
454 OTHER INJURIES, POISONINGS & TOXIC EFF DIAG AGE >=70 AND/OR C.C.	1.3881	4.1	2.6	1 14
455 OTHER INJURIES, POISONINGS & TOXIC EFF DIAG AGE <70 W/O C.C.	0.4340	2.0	1.6	1 5
456 BURNS, TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	0.9577	8.2	5.3	1 22
457 EXTENSIVE BURNS W/O O.R. PROCEDURE	3.2280*	9.5	4.0	1 21
458 NON-EXTENSIVE BURNS WITH SKIN GRAFTS	3.0929	15.0	10.6	1 27
459 NON-EXTENSIVE BURNS WITH WOUND DEBRIDEMENT & OTHER O.R. PROC	1.7401	8.7	6.2	1 23
460 NON-EXTENSIVE BURNS W/O O.R. PROCEDURE	0.8706	5.9	3.7	1 20
461 O.R. PROC WITH DIAGNOSES OF OTHER CONTACT WITH HEALTH SERVICES	0.9335	4.6	2.8	1 16
462 REHABILITATION	3.1150	25.4	18.7	3 35
463 SIGNS & SYMPTOMS WITH C.C.	0.9359	6.4	4.7	1 21
464 SIGNS & SYMPTOMS W/O C.C.	0.6013	4.5	3.4	1 14

CHAMPUS WEIGHT AND THRESHOLD SUMMARY

DRG NUMBER DESCRIPTION	CHAMPUS WEIGHT	ARITHMETIC MEAN LOS	GEOMETRIC MEAN LOS	SHORT STAY THRESHOLD	LONG STAY THRESHOLD
465 AFTERCARE WITH HISTORY OF MALIGNANCY AS SECONDARY DX	0.3885	1.6	1.4	1	3
466 AFTERCARE W/O HISTORY OF MALIGNANCY AS SECONDARY DX	0.4627	2.8	1.9	1	8
467 OTHER FACTORS INFLUENCING HEALTH STATUS	0.3429	2.7	2.0	1	7
468 UNRELATED OR PROC	1.6778	7.5	4.7	1	21
469 PDX INVALID AS DISCHARGE DIAGNOSIS	-	-	-	-	-
470 UNGROUPABLE	-	-	-	-	-
471 BILATERAL OR MULTIPLE MAJOR JOINT PROCEDURES OF THE LOWER EXTREM	4.3939	10.5	9.4	3	26
472 EXTENSIVE BURNS WITH O.R. PROCEDURE	12.3234*	35.4	23.1	1	40
473 ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE > 17	4.7101	17.4	10.2	1	27

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Table 2—National Urban and Rural Adjusted Standardized Amounts, Labor/Nonlabor, Cost-Share Per Diem, and Area Wage Indexes

[Editorial Note: This table will not appear in the Code of Federal Regulations]

The following standardized amounts are approximations. Revised amounts are being developed and the actual amounts will be published in the *Federal Register* in about one week.

National urban adjusted standardized amount.....	\$2,835.94
Labor portion	2,061.16
Nonlabor portion.....	774.78
National rural adjusted standardized amount.....	2,518.41
Labor portion	1,942.45
Nonlabor portion.....	575.96
Cost-share per diem for beneficiaries other than dependents of active duty members.....	175.00

Area Wage Indexes

The area wage indexes used under the CHAMPUS DRG-based payment system are those used under the Medicare PPS

as published in the *Federal Register* on June 10, 1987 (52 FR 22135).

Addendum 1—Health Program Benefit Agreement

[Editorial Note: This addendum will not appear in the Code of Federal Regulations.]

In order to receive payment under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).

dba _____
_____ as the provider of services agrees:

(a) To accept as payment for inpatient services provided to eligible beneficiaries, the CHAMPUS-determined allowable amount. This amount will be determined in accordance with the requirements of DoD 6010.8-R as published in the *Federal Register* on (insert date of publication).

(b) To refrain from billing the CHAMPUS-eligible beneficiary for amounts which exceed the CHAMPUS-determined allowable amount except for services not covered by CHAMPUS as described in DoD 6010.8-R and for amounts which constitute the CHAMPUS beneficiary's liability for cost-share and deductible.

OCHAMPUS agrees:

(a) To pay the hospital the full allowable amount less any applicable cost-share and deductible amounts.

This agreement shall be binding on the provider and OCHAMPUS upon submission

by the provider of acceptable assurance of compliance with Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973 as amended, and upon acceptance by the Director, OCHAMPUS, or his designee.

This agreement shall be effective until terminated by either party. The effective date shall be the date the agreement is signed by OCHAMPUS.

The agreement may be terminated by either party by giving the other party written notice of termination. Such notice of termination is to be received by the other party no later than 30 days prior to the date of termination. In the event of transfer of ownership, this agreement is terminated.

FOR PROVIDER OF SERVICES BY:

Name _____

Title _____

Date _____

FOR OCHAMPUS BY:

Name _____

Title _____

Date _____

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