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TRICARE
MANAGEMENT ACTIVITY

MB&RS

**CHANGE 19
32 CFR 199
AUGUST 12, 2008**

**PUBLICATIONS SYSTEM CHANGE TRANSMITTAL
FOR
TITLE 32 - CODE OF FEDERAL REGULATIONS - PART 199
(TMA VERSION)**

FINAL RULE

The Department of Defense, Office of the Secretary, has authorized the following addition(s)/revision(s) to 32 CFR Part 199, reissued April 2005.

**CHANGE TITLE: TRICARE; RESERVE AND GUARD FAMILY MEMBER
BENEFITS**

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PAGE CHANGE(S): See page 2.

**ATTACHMENT(S): 18 PAGES
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WHEN PRESCRIBED ACTION HAS BEEN TAKEN, FILE THIS TRANSMITTAL WITH BASIC DOCUMENT

CHANGE 19
32 CFR 199
AUGUST 12, 2008

REMOVE PAGE(S)

INSERT PAGE(S)

CHAPTER 4

Chapter pages 59, 60, and 79

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CHAPTER 14

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(1) Individual Deductible: Each beneficiary is liable for the first one hundred and fifty dollars (\$150.00) of the CHAMPUS-determined allowable amount on claims for care provided in the same fiscal year.

(2) Family Deductible: The total deductible amount for all members of a family with the same sponsor during one fiscal year shall not exceed three hundred dollars (\$300.00).

(C) CHAMPUS-approved Ambulatory Surgical Centers or Birthing Centers. No deductible shall be applied to allowable amounts for services or items rendered to active duty for authorized NATO dependents.

(D) Allowable Amount does not exceed Deductible Amount. If fiscal year allowable amounts for two or more beneficiary members of a family total less than \$100.00 (\$300.00 if paragraph (f) (2)(i)(B)(2) of this section applies), but more of the beneficiary members submit a claim for over \$50.00 (\$150.00 if paragraph (f)(2)(i)(B)(1) of this section applies), neither the family nor the individual deductible will have been met and no CHAMPUS benefits are payable.

(E) For any family the outpatient deductible amounts will be applied sequentially as the CHAMPUS claims are processed.

(F) If the fiscal year outpatient deductible under either paragraphs (f)(2)(i)(A) or (f)(2)(i)(B) of this section has been met by a beneficiary or a family through the submission of a claim or claims to a CHAMPUS fiscal intermediary in another geographic location from the location where a current claim is being submitted, the beneficiary or sponsor must obtain a deductible certificate from the CHAMPUS fiscal intermediary where the applicable beneficiary or family fiscal year deductible was met. Such deductible certificate must be attached to the current claim being submitted for benefits. Failure to obtain a deductible certificate under such circumstances will result in a second beneficiary or family fiscal year deductible being applied. However, this second deductible may be reimbursed once appropriate documentation, as described in paragraph (f)(2)(i)(F) of this section, is supplied to the CHAMPUS fiscal intermediary applying the second deductible.

(G) Notwithstanding the dates specified in paragraphs (f)(2)(i)(A) and (f)(2)(i)(B) of this section in the case of dependents of active duty members of rank E-5 or above with Persian Gulf Conflict service, dependents of service members who were killed in the Gulf, or who died subsequent to Gulf service, and of members who retired prior to October 1, 1991, after having served in the Gulf War, the deductible shall be the amount specified in paragraph (f)(2)(i)(A) of this section for care rendered prior to October 1, 1991, and the amount specified in paragraph (f)(2)(i)(B) of this section for care rendered on or after October 1, 1991.

(H) The Director, TRICARE Management Activity, may waive the annual individual or family fiscal year deductible for dependents of a Reserve Component member who is called or ordered to active duty for a period of more than 30 days or a National Guard member who is called or ordered to fulltime federal National Guard duty for a period of more than 30 days in support of a contingency operation (as defined in 10 U.S.C. 101(a)(13)). For purposes of this paragraph, a dependent is a lawful husband or wife of the member and a child is defined in paragraphs (b)(2)(ii)(A) through (F) and (b)(2)(ii)(H)(1), (2), and (4) of Sec 199.3.

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(ii) Inpatient cost-sharing. Dependents of members of the Uniformed Services are responsible for the payment of the first \$25 of the allowable institutional costs incurred with each covered inpatient admission to a hospital or other authorized institutional provider (refer to Sec. 199.6 of the part), or the amount the beneficiary or sponsor would have been charged had the inpatient care been provided in a Uniformed Service hospital, whichever is greater.

NOTE: The Secretary of Defense (after consulting with the Secretary of Health and Human Services and the Secretary of Transportation) prescribes the fair charges for inpatient hospital care provided through Uniformed Services medical facilities. This determination is made each fiscal year.

(A) Inpatient cost-sharing payable with each separate inpatient admission. A separate cost-sharing amount (as described in paragraph (f)(2) of this section) is payable for each inpatient admission to a hospital or other authorized institution, regardless of the purpose of the admission (such as medical or surgical), regardless of the number of times the beneficiary is admitted, and regardless of whether or not the inpatient admissions are for the same or related conditions; except that successive inpatient admissions shall be deemed one inpatient confinement for the purpose of computing the inpatient cost-share payable, provided not more than 60 days have elapsed between the successive admissions. However, notwithstanding this provision, all admissions related to a single maternity episode shall be considered one confinement, regardless of the number of days between admissions (refer to paragraph (b) of this section).

(B) Multiple family inpatient admissions. A separate cost-sharing amount is payable for each inpatient admission, regardless of whether or not two or more beneficiary members of a family are admitted at the same time or from the same cause (such as an accident). A separate beneficiary inpatient cost-sharing amount must be applied for each separate admission on each beneficiary member of the family.

(C) Newborn patient in his or her own right. When a newborn infant remains as an inpatient in his or her own right (usually after the mother is discharged), the newborn child becomes the beneficiary and patient and the extended inpatient stay becomes a separate inpatient admission. In such a situation, a new, separate inpatient cost-sharing amount is applied. If a multiple birth is involved (such as twins or triplets) and two or more newborn infants become patients in their own right, a separate inpatient cost-sharing amount must be applied to the inpatient stay for each newborn child who has remained as an inpatient in his or her own right.

(D) Inpatient cost-sharing for mental health services. For care provided on or after October 1, 1995, the inpatient cost-sharing for mental health services is \$20 per day for each day of the inpatient admission. This \$20 per day cost sharing amount applies to admissions to any hospital for mental health services, any residential treatment facility, any substance abuse rehabilitation facility, and any partial hospitalization program providing mental health or substance use disorder rehabilitation services.

(iii) Outpatient cost-sharing. Dependents of members of the Uniformed Services are responsible for payment of 20 percent of the CHAMPUS-determined allowable cost or charge beyond the annual fiscal year deductible amount (as described in paragraph (f)(2)(i) of this

[51 FR 24008, Jul. 1, 1986; 67 FR 15725, Apr. 3, 2002; 67 FR 18826, Apr. 17, 2002; 67 FR 40602, Jun. 13, 2002; 67 FR 42720, Jun. 25, 2002; 67 FR 45311, Jul. 9, 2002; 68 FR 44880, Jul. 31, 2003; 68 FR 44883, Jul. 31, 2003; 68 FR 65173, Nov. 19, 2003; 69 FR 29229, May 21, 2004; 69 FR 44947, Jul. 28, 2004; 69 FR 51564, Aug. 20, 2004; 69 FR 55359, Sep. 14, 2004; 69 FR 60554, Oct. 12, 2004; 70 FR 12802, Mar. 16, 2005; 70 FR 61377, Oct. 24, 2005; 71 FR 31944, Jun. 2, 2006; 71 FR 35390, Jun. 20, 2006; 72 FR 54353, Sep. 25, 2007; **73 FR 46809, Aug. 12, 2008**]

EDITORIAL NOTE: For Federal Register citations affecting Sec. 199.4, see the List of CFR Sections Affected, which appears in the Finding Aids section of the printed volume and on GPO Access.

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(iii) Recovery of payment. Recovery of the accelerated payment is made by recoupment as HHA bills are processed or by direct payment by the HHA.

(8) Assessment data. Beneficiary assessment data, incorporating the use of the current version of the OASIS items, must be submitted to the contractor for payment under the HHA prospective payment system.

(9) Administrative review. An HHA is not entitled to judicial or administrative review with regard to:

(i) Establishment of the payment unit, including the national 60-day prospective episode payment rate, adjustments and outlier payment.

(ii) Establishment of transition period, definition and application of the unit of payment.

(iii) Computation of the initial standard prospective payment amounts.

(iv) Establishment of case-mix and area wage adjustment factors.

(i) Changes in Federal Law affecting Medicare. With regard to paragraph (b) and (h) of this section, the Department of Defense must, within the time frame specified in law and to the extent it is practicable, bring the TRICARE program into compliance with any changes in Federal Law affecting the Medicare program that occur after the effective date of the DoD rule to implement the prospective payment systems for skilled nursing facilities and home health agencies.

(j) Reimbursement of individual health care professionals and other non-institutional, non-professional providers. The CHAMPUS-determined reasonable charge (the amount allowed by CHAMPUS) for the service of an individual health care professional or other non-institutional, non-professional 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--(i) Introduction--(A) In general. The allowable charge method is the preferred and primary method for reimbursement of individual health care professionals and other non-institutional health care providers (covered by 10 U.S.C. 1079(h)(1)). The allowable charge for authorized care shall be the lower of the billed charge or the local CHAMPUS Maximum Allowable Charge (CMAC).

(B) CHAMPUS Maximum Allowable Charge. Beginning in calendar year 1992, prevailing charge levels and appropriate charge levels will be calculated on a national level. There will then be calculated a national CHAMPUS Maximum Allowable Charge (CMAC) level for each procedure, which shall be the lesser of the national prevailing charge level or the national appropriate charge level. The national CMAC will then be adjusted for localities in accordance with paragraph (j)(1)(iv) of this section.

(C) Limits on balance billing by nonparticipating providers. Nonparticipating providers may not balance bill a beneficiary an amount which exceeds the applicable balance billing limit. The balance billing limit shall be the same percentage as the Medicare limiting

charge percentage for nonparticipating physicians. The balance billing limit may be waived by the Director, OCHAMPUS on a case-by-case basis if requested by the CHAMPUS beneficiary (or sponsor) involved. A decision by the Director to waive or not waive the limit in any particular case is not subject to the appeal and hearing procedures of Sec. 199.10.

(D) Special rule for TRICARE Prime Enrollees. In the case of a TRICARE Prime enrollee (see section 199.17) who receives authorized care from a non-participating provider, the CHAMPUS determined reasonable charge will be the CMAC level as established in paragraph (j)(1)(i)(B) of this section plus any balance billing amount up to the balance billing limit as referred to in paragraph (j)(1)(i)(C) of this section. The authorization for such care shall be pursuant to the procedures established by the Director, OCHAMPUS (also referred to as the TRICARE Support Office).

(E) Special rule for certain TRICARE Standard Beneficiaries. In the case of dependent spouse or child, as defined in paragraphs (b)(2)(ii)(A) through (F) and (b)(2)(ii)(H)(1), (2), and (4) of Sec. 199.3, of a Reserve Component member serving on active duty pursuant to a call or order to active duty for a period of more than 30 days in support of a contingency operation under a provision of law referred to in section 101(a)(13)(B) of title 10, United States Code, the Director, TRICARE Management Activity, may authorize non-participating providers the allowable charge to be the CMAC level as established in paragraph (j)(1)(i)(B) of this section plus any balance billing amount up to the balance billing limit as referred to in paragraph (j)(1)(i)(C) of this section.

(ii) Prevailing charge level. (A) Beginning in calendar year 1992, the prevailing charge level shall be calculated on a national basis.

(B) The national prevailing charge level referred to in paragraph (j)(1)(ii)(A) of this section is the level that does not exceed the amount equivalent to the 80th percentile of billed charges made for similar services during the base period. The 80th percentile of charges shall be determined on the basis of statistical data and methodology acceptable to the Director, OCHAMPUS (or a designee).

(C) For purposes of paragraph (j)(1)(ii)(B) of this section, the base period shall be a period of 12 calendar months and shall be adjusted once a year, unless the Director, OCHAMPUS, determines that a different period for adjustment is appropriate and publishes a notice to that effect in the Federal Register.

(iii) Appropriate charge level. Beginning in calendar year 1992, the appropriate charge level shall be calculated on a national basis. The appropriate charge level for each procedure is the product of the two-step process set forth in paragraphs (j)(1)(iii)(A) and (B) of this section. This process involves comparing the prior year's CMAC with the fully phased in Medicare fee. For years after the Medicare fee has been fully phased in, the comparison shall be to the current year Medicare fee. For any particular procedure for which comparable Medicare fee and CHAMPUS data are unavailable, but for which alternative data are available that the Director, OCHAMPUS (or designee) determines provide a reasonable approximation of relative value or price, the comparison may be based on such alternative data.

(A) Step 1: Procedures classified. All procedures are classified into one of three categories, as follows:

(1) Overpriced procedures. These are the procedures for which the prior year's national CMAC exceeds the Medicare fee.

(2) Other procedures. These are procedures subject to the allowable charge method that are not included in either the overpriced procedures group or the underpriced procedures group.

(3) Underpriced procedures. These are the procedures for which the prior year's national CMAC is less than the Medicare fee.

(B) Step 2: Calculating appropriate charge levels. For each year, appropriate charge levels will be calculated by adjusting the prior year's CMAC as follows:

(1) For overpriced procedures, the appropriate charge level for each procedure shall be the prior year's CMAC, reduced by the lesser of: the percentage by which it exceeds the Medicare fee or fifteen percent.

(2) For other procedures, the appropriate charge level for each procedure shall be the same as the prior year's CMAC.

(3) For underpriced procedures, the appropriate charge level for each procedure shall be the prior year's CMAC, increased by the lesser of: the percentage by which it is exceeded by the Medicare fee or the Medicare Economic Index.

(C) Special rule for cases in which the CHAMPUS appropriate charge was prematurely reduced. In any case in which a recalculation of the Medicare fee results in a Medicare rate higher than the CHAMPUS appropriate charge for a procedure that had been considered an overpriced procedure, the reduction in the CHAMPUS appropriate charge shall be restored up to the level of the recalculated Medicare rate.

(D) Special rule for cases in which the national CMAC is less than the Medicare rate.

NOTE: This paragraph will be implemented when CMAC rates are published.

In any case in which the national CMAC calculated in accordance with paragraphs (j)(1)(i) through (iii) of this section is less than the Medicare rate, the Director, TSO, may determine that the use of the Medicare Economic Index under paragraph (j)(1)(iii)(B) of this section will result in a CMAC rate below the level necessary to assure that beneficiaries will retain adequate access to health care services. Upon making such a determination, the Director, TSO, may increase the national CMAC to a level not greater than the Medicare rate.

(iv) Calculating CHAMPUS Maximum Allowable Charge levels for localities. (A) In general. The national CHAMPUS Maximum Allowable Charge level for each procedure will be adjusted for localities using the same (or similar) geographical areas and the same geographic adjustment factors as are used for determining allowable charges under Medicare.

(B) Special locality-based phase-in provision. (1) In general. Beginning with the recalculation of CMACS for calendar year 1993, the CMAC in a locality will not be less than 72.25 percent of the maximum charge level in effect for that locality on December 31, 1991. For recalculations of CMACs for calendar years after 1993, the CMAC in a locality will not be less than 85 percent of the CMAC in effect for that locality at the end of the prior calendar year.

(2) Exception. The special locality-based phase-in provision established by paragraph (j)(1)(iv)(B)(1) of this section shall not be applicable in the case of any procedure code for which there were not CHAMPUS claims in the locality accounting for at least 50 services.

(C) Special locality-based waivers of reductions to assure adequate access to care. Beginning with the recalculation of CMACs for calendar year 1993, in the case of any procedure classified as an overpriced procedure pursuant to paragraph (j)(1)(iii)(A)(1) of this section, a reduction in the CMAC in a locality below the level in effect at the end of the previous calendar year that would otherwise occur pursuant to paragraphs (j)(1)(iii) and (j)(1)(iv) of this section may be waived pursuant to paragraph (j)(1)(iii)(C) of this section.

(1) Waiver based on balanced billing rates. Except as provided in paragraph (j)(1)(iv)(C)(2) of this section such a reduction will be waived if there has been excessive balance billing in the locality for the procedure involved. For this purpose, the extent of balance billing will be determined based on a review of all services under the procedure code involved in the prior year (or most recent period for which data are available). If the number of services for which balance billing was not required was less than 60 percent of all services provided, the Director will determine that there was excessive balance billing with respect to that procedure in that locality and will waive the reduction in the CMAC that would otherwise occur. A decision by the Director to waive or not waive the reduction is not subject to the appeal and hearing procedures of Sec. 199.10.

(2) Exception. As an exception to the paragraph (j)(1)(iv)(C)(1) of this section, the waiver required by that paragraph shall not be applicable in the case of any procedure code for which there were not CHAMPUS claims in the locality accounting for at least 50 services. A waiver may, however, be granted in such cases pursuant to paragraph (j)(1)(iv)(C)(3) of this section.

(3) Waiver based on other evidence that adequate access to care would be impaired. The Director, OCHAMPUS may waive a reduction that would otherwise occur (or restore a reduction that was already taken) if the Director determines that available evidence shows that the reduction would impair adequate access. For this purpose, such evidence may include consideration of the number of providers in the locality who provide the affected services, the number of such providers who are CHAMPUS Participating Providers, the number of CHAMPUS beneficiaries in the area, and other relevant factors. Providers or beneficiaries in a locality may submit to the Director, OCHAMPUS a petition, together with appropriate documentation regarding relevant factors, for a determination that adequate access would be impaired. The Director, OCHAMPUS will consider and respond to all such petitions. Petitions may be filed at any time. Any petition received by the date which is 120 days prior to the implementation of a recalculation of CMACs will be assured of consideration prior to that implementation. The Director, OCHAMPUS may establish procedures for handling petitions. A decision by the Director to waive or not waive a reduction is not subject to the appeal and hearing procedures of Sec. 199.10.

(D) Special locality-based exception to applicable CMACs to assure adequate beneficiary access to care. In addition to the authority to waive reductions under paragraph (j)(1)(iv)(C) of this section, the Director may authorize establishment of higher payment rates for specific services than would otherwise be allowable, under paragraph (j)(1) of this section, if the Director determines that available evidence shows that access to health care services is severely impaired. For this purpose, such evidence may include consideration of the number of providers in the locality who provide the affected services, the number of providers who are CHAMPUS participating providers, the number of CHAMPUS beneficiaries in the locality, the availability of military providers in the location or nearby, and any other factors the Director determines relevant.

(1) Procedure. Providers or beneficiaries in a locality may submit to the Director, a petition, together with appropriate documentation regarding relevant factors, for a determination that adequate access to health care services is severely impaired. The Director, will consider and respond to all petitions. A decision to authorize a higher payment amount is subject to review and determination or modification by the Director at any time if circumstances change so that adequate access to health care services would no longer be severely impaired. A decision by the Director, to authorize, not authorize, terminate, or modify authorization of higher payment amounts is not subject to the appeal and hearing procedures of Sec. 199.10 of the part.

(2) Establishing the higher payment rate(s). When the Director, determines that beneficiary access to health care services in a locality is severely impaired, the Director may establish the higher payment rate(s) as he or she deems appropriate and cost-effective through one of the following methodologies to assure adequate access:

(i) A percent factor may be added to the otherwise applicable payment amount allowable under paragraph (j)(1) of this section;

(ii) A prevailing charge may be calculated, by applying the prevailing charge methodology of paragraph (j)(1)(ii) of this section to a specific locality (which need not be the same as the localities used for purposes of paragraph (j)(1)(iv)(A) of this section; or another government payment rate may be adopted, for example, an applicable state Medicaid rate).

(3) Application of higher payment rates. Higher payment rates defined under paragraph (j)(1)(iv)(D) of this section may be applied to all similar services performed in a locality, or, if circumstances warrant, a new locality may be defined for application of the higher payments. Establishment of a new locality may be undertaken where access impairment is localized and not pervasive across the existing locality. Generally, establishment of a new, more specific locality will occur when the area is remote so that geographical characteristics and other factors significantly impair transportation through normal means to health care services routinely available within the existing locality.

(E) Special locality-based exception to applicable CMACs to ensure an adequate TRICARE Prime preferred network. The Director, may authorize reimbursements to health care providers participating in a TRICARE preferred provider network under Sec. 199.17(p) of this part at rates higher than would otherwise be allowable under paragraph (j)(1) of this section, if the Director, determines that application of the higher rates is necessary to ensure the availability of an adequate number and mix of qualified health care providers in a network in a specific locality. This authority may only be used to ensure adequate networks

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in those localities designated by the Director, as requiring TRICARE preferred provider networks, not in localities in which preferred provider networks have been suggested or established but are not determined by the Director to be necessary. Appropriate evidence for determining that higher rates are necessary may include consideration of the number of available primary care and specialist providers in the network locality, availability (including reassignment) of military providers in the location or nearby, the appropriate mix of primary care and specialists needed to satisfy demand and meet appropriate patient access standards (appointment/waiting time, travel distance, etc.), the efforts that have been made to create an adequate network, other cost-effective alternatives, and other relevant factors. The Director, may establish procedures by which exceptions to applicable CMACs are requested and approved or denied under paragraph (j)(1)(iv)(E) of this section. A decision by the Director, to authorize or deny an exception is not subject to the appeal and hearing procedures of Sec. 199.10. When the Director, determines that it is necessary and cost-effective to approve a higher rate or rates in order to ensure the availability of an adequate number of qualified health care providers in a network in a specific locality, the higher rate may not exceed the lesser of the following:

(1) The amount equal to the local fee for service charge for the service in the service area in which the service is provided as determined by the Director, based on one or more of the following payment rates:

- (i) Usual, customary, and reasonable;
- (ii) The Health Care Financing Administration's Resource Based Relative Value Scale;
- (iii) Negotiated fee schedules;
- (iv) Global fees; or
- (v) Sliding scale individual fee allowances.

(2) The amount equal to 115 percent of the otherwise allowable charge under paragraph (j)(1) of the section for the service.

(v) Special rules for 1991. (A) Appropriate charge levels for care provided on or after January 1, 1991, and before the 1992 appropriate levels take effect shall be the same as those in effect on December 31, 1990, except that appropriate charge levels for care provided on or after October 7, 1991, shall be those established pursuant to this paragraph (j)(1)(v) of this section.

(B) Appropriate charge levels will be established for each locality for which a appropriate charge level was in effect immediately prior to October 7, 1991. For each procedure, the appropriate charge level shall be the prevailing charge level in effect immediately prior to October 7, 1991, adjusted as provided in (j)(1)(v)(B)(1) through (3) of this section.

(1) For each overpriced procedure, the level shall be reduced by fifteen percent. For this purpose, overpriced procedures are the procedures determined by the Physician Payment Review Commission to be overvalued pursuant to the process established under the Medicare program, other procedures considered overvalued in the Medicare program (for which Congress directed reductions in Medicare allowable levels for 1991), radiology

procedures and pathology procedures.

(2) For each other procedure, the level shall remain unchanged. For this purpose, other procedures are procedures which are not overpriced procedures or primary care procedures.

(3) For each primary care procedure, the level shall be adjusted by the MEI, as the MEI is applied to Medicare prevailing charge levels. For this purpose, primary care procedures include maternity care and delivery services and well baby care services.

(C) For purposes of this paragraph (j)(i)(v), "appropriate charge levels" in effect at any time prior to October 7, 1991 shall mean the lesser of:

(1) The prevailing charge levels then in effect, or

(2) The fiscal year 1988 prevailing charge levels adjusted by the Medicare Economic Index (MEI), as the MEI was applied beginning in the fiscal year 1989.

(vi) Special transition rule for 1992. (A) For purposes of calculating the national appropriate charge levels for 1992, the prior year's appropriate charge level for each service will be considered to be the level that does not exceed the amount equivalent to the 80th percentile of billed charges made for similar services during the base period of July 1, 1986 to June 30, 1987 (determined as under paragraph (j)(1)(ii)(B) of this section), adjusted to calendar year 1991 based on the adjustments made for maximum CHAMPUS allowable charge levels through 1990 and the application of paragraph (j)(1)(v) of this section for 1991.

(B) The adjustment to calendar year 1991 of the product of paragraph (j)(1)(vi)(A) of this section shall be as follows:

(1) For procedures other than those described in paragraph (j)(1)(vi)(B)(2) of this section, the adjustment to 1991 shall be on the same basis as that provided under paragraph (j)(1)(v) of this section.

(2) For any procedure that was considered an overpriced procedure for purposes of the 1991 appropriate charge levels under paragraph (j)(1)(v) of this section for which the resulting 1991 appropriate charge level was less than 150 percent of the Medicare converted relative value unit, the adjustment to 1991 for purposes of the special transition rule for 1992 shall be as if the procedure had been treated under paragraph (j)(1)(v)(B)(2) of this section for purposes of the 1991 appropriate charge level.

(vii) Adjustments and procedural rules. (A) The Director, OCHAMPUS may make adjustments to the appropriate charge levels calculated pursuant to paragraphs (j)(1)(iii) and (j)(1)(v) of this section to correct any anomalies resulting from data or statistical factors, significant differences between Medicare-relevant information and CHAMPUS-relevant considerations or other special factors that fairness requires be specially recognized. However, no such adjustment may result in reducing an appropriate charge level.

(B) The Director, OCHAMPUS will issue procedural instructions for administration of the allowable charge method.

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(viii) Clinical laboratory services. The allowable charge for clinical diagnostic laboratory test services shall be calculated in the same manner as allowable charges for other individual health care providers are calculated pursuant to paragraphs (j)(1)(i) through (j)(1)(iv) of this section, with the following exceptions and clarifications.

(A) The calculation of national prevailing charge levels, national appropriate charge levels and national CMACs for laboratory service shall begin in calendar year 1993. For purposes of the 1993 calculation, the prior year's national appropriate charge level or national prevailing charge level shall be the level that does not exceed the amount equivalent to the 80th percentile of billed charges made for similar services during the period July 1, 1991, through June 30, 1992 (referred to in this paragraph (j)(1)(viii) of this section as the "base period").

(B) For purposes of comparison to Medicare allowable payment amounts pursuant to paragraph (j)(1)(iii) of this section, the Medicare national laboratory payment limitation amounts shall be used.

(C) For purposes of establishing laboratory service local CMACs pursuant to paragraph (j)(1)(iv) of this section, the adjustment factor shall equal the ratio of the local average charge (standardized for the distribution of clinical laboratory services) to the national average charge for all clinical laboratory services during the base period.

(D) For purposes of a special locality-based phase-in provision similar to that established by paragraph (j)(1)(iv)(B) of this section, the CMAC in a locality will not be less than 85 percent of the maximum charge level in effect for that locality during the base period.

(ix) The allowable charge for physician assistant services other than assistant-at-surgery may not exceed 85 percent of the allowable charge for a comparable service rendered by a physician performing the service in a similar location. For cases in which the physician assistant and the physician perform component services of a procedure other than assistant-at-surgery (e.g., home, office or hospital visit), the combined allowable charge for the procedure may not exceed the allowable charge for the procedure rendered by a physician alone. The allowable charge for physician assistant services performed as an assistant-at-surgery may not exceed 65 percent of the allowable charge for a physician serving as an assistant surgeon when authorized as CHAMPUS benefits in accordance with the provisions of Sec. 199.4(c)(3)(iii). Physician assistant services must be billed through the employing physician who must be an authorized CHAMPUS provider.

(x) A charge that exceeds the CHAMPUS Maximum Allowable 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) Bonus payments in medically underserved areas. A bonus payment, in addition to the amount normally paid under the allowable charge methodology, may be made to physicians in medically underserved areas. For purposes of this paragraph, medically underserved areas are the same as those determined by the Secretary of Health and Human Services for the Medicare program. Such bonus payments shall be equal to the bonus payments authorized by Medicare, except as necessary to recognize any unique or distinct characteristics or requirements of the TRICARE program, and as described in instructions issued by the Executive Director, TRICARE Management Activity. If the Department of Health and Human Services acts to amend or remove the provision for bonus payments

under Medicare, TRICARE likewise may follow Medicare in amending or removing provision for such payments.

(3) All-inclusive rate. Claims from individual health-care professional providers for services rendered to CHAMPUS beneficiaries residing in an RTC that is either being reimbursed on an all-inclusive per diem rate, or is billing an all-inclusive per diem rate, shall be denied; with the exception of independent health-care professionals providing geographically distant family therapy to a family member residing a minimum of 250 miles from the RTC or covered medical services related to a nonmental health condition rendered outside the RTC. Reimbursement for individual professional services is included in the rate paid the institutional provider.

(4) 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.

(k) Reimbursement of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS). Reimbursement of DMEPOS may be based on the same amounts established under the Centers for Medicare and Medicaid Services (CMS) DMEPOS fee schedule under 42 CFR part 414, subpart D.

(l) Reimbursement Under the Military-Civilian Health Services Partnership Program. The Military-Civilian Health Services Partnership Program, as authorized by section 1096, chapter 55, title 10, provides for the sharing of staff, equipment, and resources between the civilian and military health care system in order to achieve more effective, efficient, or economical health care for authorized beneficiaries. Military treatment facility commanders, based upon the authority provided by their respective Surgeons General of the military departments, are responsible for entering into individual partnership agreements only when they have determined specifically that use of the Partnership Program is more economical overall to the Government than referring the need for health care services to the civilian community under the normal operation of the CHAMPUS Program. (See paragraph (p) of Sec. 199.1 for general requirements of the Partnership Program.)

(1) Reimbursement of institutional health care providers. Reimbursement of institutional health care providers under the Partnership Program shall be on the same basis as non-Partnership providers.

(2) Reimbursement of individual health-care professionals and other non-institutional health care providers. Reimbursement of individual health care professionals and other non-institutional health care providers shall be on the same basis as non-Partnership providers as detailed in paragraph (j) of this section.

(m) Accommodation of Discounts Under Provider Reimbursement Methods.

(1) General rule. The Director, OCHAMPUS (or designee) has authority to reimburse a provider at an amount below the amount usually paid pursuant to this section when, under a program approved by the Director, the provider has agreed to the lower amount.

(2) Special applications. The following are examples of applications of the general rule; they are not all inclusive.

(i) In the case and individual health care professionals and other non-institutional providers, if the discounted fee is below the provider's normal billed charge and the prevailing charge level (see paragraph (g) of this section), the discounted fee shall be the provider's actual billed charge and the CHAMPUS allowable charge.

(ii) In the case of institutional providers normally paid on the basis of a pre-set amount (such as DRG-based amount under paragraph (a)(1) of this section or per-diem amount under paragraph (a)(2) of this section), if the discount rate is lower than the pre-set rate, the discounted rate shall be the CHAMPUS-determined allowable cost. This is an exception to the usual rule that the pre-set rate is paid regardless of the institutional provider's billed charges or other factors.

(3) Procedures. (i) This paragraph applies only when both the provider and the Director have agreed to the discounted payment rate. The Director's agreement may be in the context of approval of a program that allows for such discounts.

(ii) The Director of OCHAMPUS may establish uniform terms, conditions and limitations for this payment method in order to avoid administrative complexity.

(n) 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.

(o) 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.

[55 FR 13266, Apr. 10, 1990, as amended at 55 FR 31180, Aug. 1, 1990; 55 FR 42562, Oct. 22, 1990; 55 FR 43342, Oct. 29, 1990; 56 FR 44006, Sep. 6, 1991; 56 FR 50273, Oct. 4, 1991; 58 FR 35408, Jul. 1, 1993; 58 FR 51239, Oct. 1, 1993; 58 FR 58961, Nov. 5, 1993; 60 FR 6019, Feb. 1, 1995; 60 FR 12437, Mar. 7, 1995; 60 FR 52094, Oct. 5, 1995; 63 FR 7287, Feb. 13, 1998; 63 FR 48446, Sep. 10, 1998; 63 FR 56082, Oct. 21, 1998; 64 FR 60671, Nov. 8, 1999; 65 FR 41003, Jul. 3, 2000; 67 FR 45172, Aug. 28, 2001; 67 FR 18115, Apr. 15, 2002; 67 FR 40604, Jun. 13, 2002; 69 FR 60555, Oct. 12, 2004; 70 FR 61378, Oct. 24, 2005; 72 FR 63988, Nov. 14, 2007; **73 FR 46809, Aug. 12, 2008**]

EDITORIAL NOTE: The following text, appearing at 63 FR 48445, Sept. 10, 1998, could not be incorporated into Sec. 199.14 because it was not mentioned in the amendatory instruction. For the convenience of the user, the text is set forth as follows: Sec. 199.14 Provider reimbursement methods.

(a) * * *

(1) * * *

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(iii) * * *

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

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(D) * * *

(7) Differentiate large urban and other area charges. All charges in the database shall be sorted into large urban and other area groups (using the same definitions for these categories used in the Medicare program).

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(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 large urban or other area group and dividing by the total number of discharges in the respective group.

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(E) * * *

(7) * * *

(I) * * *

(A) Short-stay outliers. Any discharge with a length-of-stay (LOS) less than 1.94 standard deviations from the DRG's arithmetic 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 arithmetic mean length-of-stay for the DRG.

(B) Long-stay outliers. Any discharge (except for neonatal services and services in children's hospitals) which has a length-of-stay (LOS) exceeding a threshold established in accordance with the criteria used for the Medicare Prospective Payment System as contained in 42 CFR 412.82 shall be classified as a long-stay outlier. Any discharge for neonatal services or for services in a children's hospital which has a LOS exceeding the lesser of 1.94 standard deviations or 17 days from the DRG's arithmetic mean LOS also shall be classified as a long-stay outlier. Long-stay outliers shall be reimbursed the DRG-based amount plus a percentage (as established for the Medicare Prospective Payment System) of the per diem rate for the DRG for each covered day of care beyond the long-stay outlier threshold. The per diem rate shall equal the DRG amount divided by the arithmetic mean LOS for the DRG. For admissions on or after October 1, 1997, the long stay outlier has been eliminated for all cases except children's hospitals and neonates. For admissions on or after October 1, 1998, the long stay outlier has been eliminated for children's hospitals and neonates.

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(ii) * * *

(A) Cost outliers except those in children's hospitals or for neonatal services. Any discharge which has standardized costs that exceed a threshold established in accordance with the criteria used for the Medicare Prospective Payment System as contained in 42 CFR 412.84 shall qualify as a cost outlier. The standardized costs shall be calculated by multiplying the total charges by the factor described in Sec. 199.14(a)(1)(iii)(D)(4) and adjusting this amount for indirect medical education costs. Cost outliers shall be reimbursed the DRG-based amount plus a percentage (as established for the Medicare Prospective Payment System) of all costs exceeding the threshold. Effective with admissions occurring on or after October 1, 1997, the standardized costs are no longer adjusted for indirect medical education costs.

(B) Cost outliers in children's hospitals and for neonatal services. Any discharge for services in a children's hospital or for neonatal services which has standardized costs that exceed a threshold of the greater of two times the DRG-based amount or \$13,500 shall qualify as a cost outlier. The standardized costs shall be calculated by multiplying the total charges by the factor described in Sec. 199.14(a)(1)(iii)(D)(4) (adjusted to include average capital and direct medical education costs) and adjusting this amount for indirect medical education costs. Cost outliers for services in children's hospitals and for neonatal services shall be reimbursed the DRG-based amount plus a percentage (as established for the Medicare Prospective Payment System) of all costs exceeding the threshold. Effective with admissions occurring on or after October 1, 1998, standardized costs are no longer adjusted for indirect medical education costs. In addition, CHAMPUS will calculate the outlier payments that would have occurred at each of the 59 Children's hospitals under the FY99 outlier policy for all cases that would have been outliers under the FY94 policies using the most accurate data available in September 1998. A ratio will be calculated which equals the level of outlier payments that would have been made under the FY94 outlier policies and the outlier payments that would be made if the FY99 outlier policies had applied to each of these potential outlier cases for these hospitals. The ratio will be calculated across all outlier claims for the 59 hospitals and will not be hospital specific. The ratio will be used to increase cost outlier payments in FY 1999 and FY 2000, unless the hospital has a negotiated agreement with a managed care support contractor which would affect this payment. For hospitals with managed care support agreements which affect these payments, CHAMPUS will apply these payments if the increased payments would be consistent with the agreements. In FY 2000 the ratio of outlier payments (long stay and cost) that would have occurred under the FY 94 policy and actual cost outlier payments made under the FY 99 policy will be recalculated. If the ratio has changed significantly, the ratio will be revised for use in FY 2001 and thereafter. In FY 2002, the actual cost outlier cases in FY 2000 and 2001 will be reexamined. The ratio of outlier payments that would have occurred under the FY94 policy and the actual cost outlier payments made under the FY 2000 and FY 2001 policies. If the ratio has changed significantly, the ratio will be revised for use in FY 2003.

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(G) * * *

(3) Information necessary for payment of capital and direct medical education costs. All hospitals subject to the CHAMPUS DRG-based payment system, except for children's hospitals, may be reimbursed for allowed capital and direct medical education

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costs by submitting a request to the CHAMPUS contractor. Beginning October 1, 1998, such request shall be filed with CHAMPUS on or before the last day of the twelfth month following the close of the hospitals' cost reporting period, and shall cover the one-year period corresponding to the hospital's Medicare cost-reporting period. The first such request 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 contractor must correspond to the costs reported on the hospital's Medicare cost report. An extension of the due date for filing the request may only be granted if an extension has been granted by HCFA due to a provider's operations being significantly adversely affected due to extraordinary circumstances over which the provider has no control, such as flood or fire. (If these costs change as a result of a subsequent audit by Medicare, the revised costs are to be reported to the hospital's CHAMPUS contractor within 30 days of the date the hospital is notified of the change.) The request must be signed by the hospital official responsible for verifying the amounts and shall contain the following information.

* * * * *

(d) * * *

(3) * * *

(iv) Step 4: standard payment amount per group. The standard payment amount per group will be the volume weighted median per procedure cost for the procedures in that group. For cases in which the standard payment amount per group exceeds the CHAMPUS-determined inpatient allowable amount, the Director, TSO or his designee, may make adjustments.

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(h) Reimbursement of individual health care professionals and other non-institutional, non-professional providers. The CHAMPUS-determined reasonable charge (the amount allowed by CHAMPUS) for the service of an individual health care professional or other non-institutional, non-professional 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.

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