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TRICARE
MANAGEMENT ACTIVITY

MB&RB

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(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; HOSPITAL-BASED PSYCHIATRIC PARTIAL HOSPITALIZATION PROGRAMS

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WHEN PRESCRIBED ACTION HAS BEEN TAKEN, FILE THIS TRANSMITTAL WITH BASIC DOCUMENT.

REMOVE PAGE(S)

INSERT PAGE(S)

CHAPTER 6

Table of Contents, pages iii through vi

Chapter pages 23 through 48, 53, and 54

Table of Contents, pages iii through vi

Chapter pages 23 through 48, 53, and 54

	(2) [Reserved]	20
(xi)	Birthing centers	20
	(A) Certification requirements	20
	(B) CHAMPUS birthing center standards	21
	(1) Environment	21
	(2) Policies and procedures	21
	(3) Informed consent	21
	(4) Beneficiary care	21
	(5) Medical direction	21
	(6) Admission and emergency care criteria and procedures	22
	(7) Emergency treatment	22
	(8) Emergency medical transportation	22
	(9) Professional staff	22
	(10) Medical records	22
	(11) Quality assurance	22
	(12) Governance and administration	22
(xii)	Psychiatric partial hospitalization programs	23
	(A) Organization and administration	23
	(1) Definition	23
	(2) Eligibility	23
	(3) Governing body	23
	(4) Chief executive officer	24
	(5) Clinical Director	24
	(6) Medical director	24
	(7) Medical or professional staff organization	24
	(8) Personnel policies and records	24
	(9) Staff development	24
	(10) Fiscal accountability	24
	(11) Designated teaching facilities	24
	(12) Emergency reports and records	24
	(B) Treatment services	24
	(1) Staff composition	24
	(2) Staff qualifications	25
	(3) Patient rights	25
	(4) Behavioral management	25
	(5) Admission process	25
	(6) Assessments	25
	(7) Clinical formulation	26
	(8) Treatment planning	26
	(9) Discharge and transition planning	26
	(10) Clinical documentation	26
	(11) Progress notes	26
	(12) Therapeutic services	26
	(13) Ancillary services	27
(C)	Standards for physical plant and environment	27
	(1) Physical environment	27
	(2) Physical plant safety	27
	(3) Disaster planning	27
(D)	Standards for evaluation system	27
	(1) Quality assessment and improvement	27

TMA Version - April 2005

TMA Version - April 2005

	(2) Utilization review.....	27
	(3) Patient records.	27
	(4) Drug utilization review.....	27
	(5) Risk management.....	27
	(6) Infection control.	28
	(7) Safety.	28
	(8) Facility evaluation.	28
	(E) Participation agreement requirements.	28
	(F) Other requirements applicable to PHPs.....	30
(xiii)	Hospice programs.	30
(xiv)	Substance use disorder rehabilitation facilities.....	31
	(A) Organization and administration.	31
	(1) Definition of inpatient rehabilitation center.....	31
	(2) Definition of partial hospitalization center for the treatment of substance use disorders.	32
	(3) Eligibility.	32
	(4) Governing body.	33
	(5) Chief executive officer.....	33
	(6) Clinical Director.	33
	(7) Medical director.	33
	(8) Medical or professional staff organization.....	33
	(9) Personnel policies and records.....	34
	(10) Staff development.	34
	(11) Fiscal accountability.....	34
	(12) Designated teaching facilities.....	34
	(13) Emergency reports and records.....	34
	(B) Treatment services.	34
	(1) Staff composition.	34
	(2) Staff qualifications.	34
	(3) Patient rights.	34
	(4) Behavioral management.....	35
	(5) Admission process.....	35
	(6) Assessment.	35
	(7) Clinical formulation.....	35
	(8) Treatment planning.	35
	(9) Discharge and transition planning.	35
	(10) Clinical documentation.....	35
	(11) Progress notes.....	36
	(12) Therapeutic services.....	36
	(13) Ancillary services.....	36
	(C) Standards for physical plant and environment.....	36
	(1) Physical environment.	36
	(2) Physical plant safety.	36
	(3) Disaster planning.....	36
	(D) Standards for evaluation system.	36
	(1) Quality assessment and improvement.	36
	(2) Utilization review.....	36
	(3) Patient records review.....	37
	(4) Drug utilization review.....	37
	(5) Risk management.....	37

(6) Infection control.....	37
(7) Safety.....	37
(8) Facility evaluation.....	37
(E) Participation agreement requirements.....	37
(F) Other requirements applicable to substance use disorder rehabilitation facilities.....	39
(xv) Home health agencies (HHAs).....	39
(xvi) CAHs.....	41
(c) Individual professional providers of care—	41
(1) General—.....	41
(i) Purpose.....	41
(ii) Professional corporation affiliation or association membership permitted..	41
(iii) Scope of practice limitation.....	41
(iv) Employee status exclusion.....	41
(v) Training status exclusion.....	41
(2) Conditions of authorization—.....	41
(i) Professional license requirement.....	41
(ii) Professional certification requirement.....	42
(iii) Education, training and experience requirement.....	42
(iv) Physician referral and supervision.....	42
(3) Types of providers.....	42
(i) Physicians.....	42
(B) Doctors of Osteopathy (D.O.).....	42
(ii) Dentists.....	42
(A) Doctors of Dental Medicine (D.M.D.).....	42
(B) Doctors of Dental Surgery (D.D.S.).....	43
(iii) Other allied health professionals.....	43
(A) Clinical psychologist.....	43
(B) Doctors of Optometry.....	43
(C) Doctors of Podiatry or Surgical Chiropody.....	43
(D) Certified nurse midwives.....	43
(E) Certified nurse practitioner.....	43
(F) Certified Clinical Social Worker.....	44
(G) Certified psychiatric nurse specialist.....	44
(H) Certified physician assistant.....	44
(I) Anesthesiologist Assistant.....	45
(J) Certified Registered Nurse Anesthetist (CRNA).....	46
(K) Other individual paramedical providers.....	46
(iv) Extramedical individual providers.....	46
(A) Certified marriage and family therapists.....	46
(B) Pastoral counselors.....	47
(C) Mental health counselor.....	49
(E) Christian Science practitioners and Christian Science nurses.....	50
(d) Other providers.....	50
(1) Independent laboratory.....	50
(2) Suppliers of portable x-ray services.....	50
(3) Pharmacies.....	50
(4) Ambulance companies.....	50

TMA Version - April 2005

- (5) Medical equipment firms, medical supply firms, and Durable Medical Equipment, Prosthetic, Orthotic, Supplies providers/suppliers. 50
- (6) Mammography suppliers. 50
- (e) Extended Care Health Option Providers.—** 50
 - (1) General. 50
 - (2) ECHO provider categories-- 51
 - (i) ECHO inpatient care provider. 51
 - (ii) ECHO outpatient care provider. 51
 - (iii) ECHO vendor. 51
 - (3) ECHO provider exclusion or suspension. 51
- (f) Corporate services providers—** 51
 - (1) General. 51
 - (2) Conditions of authorization. 52
 - (3) Transfer of participation agreement. 53
 - (4) Pricing and payment methodology:. 53
 - (5) Termination of participation agreement. 53

(xii) Psychiatric partial hospitalization programs. Paragraph (b)(4)(xii) of this section establishes standards and requirements for psychiatric partial hospitalization programs.

(A) Organization and administration. (1) Definition. Partial hospitalization is defined as a time-limited, ambulatory, active treatment program that offers therapeutically intensive, coordinated, and structured clinical services within a stable therapeutic milieu. Partial hospitalization programs serve patients who exhibit psychiatric symptoms, disturbances of conduct, and decompensating conditions affecting mental health.

(2) Eligibility. (i) Every free-standing psychiatric partial hospitalization program must be certified pursuant to TRICARE certification standards. Such standards shall incorporate the basic standards set forth in paragraphs (b)(4)(xii)(A) through (D) of this section, and shall include such additional elaborative criteria and standards as the Director, TRICARE Management Activity, determines are necessary to implement the basic standards. Each psychiatric partial hospitalization program must be either a distinct part of an otherwise-authorized institutional provider or a free-standing program. Approval of a hospital by TRICARE is sufficient for its partial hospitalization program to be an authorized TRICARE provider. Such hospital-based partial hospitalization programs are not required to be separately certified pursuant to TRICARE certification standards.

(ii) To be eligible for CHAMPUS certification, the facility is required to be licensed and fully operational for a period of at least six months (with a minimum patient census of at least 30 percent of bed capacity) and operate in substantial compliance with state and federal regulations.

(iii) The facility is currently accredited by the Joint Commission on Accreditation of Healthcare Organizations under the current edition of the Accreditation Manual for Mental Health, Chemical Dependency, and Mental Retardation/Developmental Disabilities Services.

(iv) The facility has a written participation agreement with OCHAMPUS. On October 1, 1995, the PHP is not a CHAMPUS-authorized provider and CHAMPUS benefits are not paid for services provided until the date upon which a participation agreement is signed by the Director, OCHAMPUS. Partial hospitalization is capable of providing an interdisciplinary program of medical and therapeutic services a minimum of three hours per day, five days per week, and may include full- or half-day, evening, and weekend treatment programs.

(3) Governing body. (i) The PHP shall have a governing body which is responsible for the policies, bylaws, and activities of the facilities. If the PHP is owned by a partnership or single owner, the partners or single owner are regarded as the governing body. The facility will provide an up-to-date list of names, addresses, telephone numbers, and titles of the members of the governing body.

(ii) The governing body ensures appropriate and adequate services for all patients and oversees continuing development and improvement of care. Where business relationships exist between the governing body and facility, appropriate conflict-of-interest policies are in place.

(iii) Board members are fully informed about facility services and the governing body conducts annual review of its performance in meeting purposes, responsibilities, goals and objectives.

TMA Version - April 2005

(4) Chief executive officer. The Chief Executive Officer, appointed by and subject to the direction of the governing body, shall assume overall administrative responsibility for the operation of the facility according to governing body policies. The chief executive officer shall have five years' administrative experience in the field of mental health. On October 1, 1997, the CEO shall possess a degree in business administration, public health, hospital administration, nursing, social work, or psychology, or meet similar educational requirements as prescribed by the Director, OCHAMPUS.

(5) Clinical Director. The clinical director, appointed by the governing body, shall be a psychiatrist or doctoral level psychologist who meets applicable CHAMPUS requirements for individual professional providers and is licensed to practice in the state where the PHP is located. The clinical director shall possess requisite education and experience, credentials applicable under state practice and licensing laws appropriate to the professional discipline, and a minimum of five years' clinical experience in the treatment of mental disorders specific to the ages and disabilities of the patients served. The clinical director shall be responsible for planning, development, implementation, and monitoring of all clinical activities.

(6) Medical director. The medical director, appointed by the governing body, shall be licensed to practice medicine in the state where the residential treatment center is located and shall possess requisite education and experience, including graduation from an accredited school of medicine or osteopathy, an approved residency in psychiatry and a minimum of five years clinical experience in the treatment of mental disorders specific to the ages and disabilities of the patients served. The Medical Director shall be responsible for the planning, development, implementation, and monitoring of all activities relating to medical treatment of patients. If qualified, the Medical Director may also serve as Clinical Director.

(7) Medical or professional staff organization. The governing body shall establish a medical or professional staff organization to assure effective implementation of clinical privileging, professional conduct rules, and other activities directly affecting patient care.

(8) Personnel policies and records. The PHP shall maintain written personnel policies, updated job descriptions, personnel records to assure the selection of qualified personnel and successful job performance of those personnel.

(9) Staff development. The facility shall provide appropriate training and development programs for administrative, professional support, and direct care staff.

(10) Fiscal accountability. The PHP shall assure fiscal accountability to applicable government authorities and patients.

(11) Designated teaching facilities. Students, residents, interns, or fellows providing direct clinical care are under the supervision of a qualified staff member approved by an accredited university. The teaching program is approved by the Director, OCHAMPUS.

(12) Emergency reports and records. The facility notifies OCHAMPUS of any serious occurrence involving CHAMPUS beneficiaries.

(B) Treatment services. (1) Staff composition. (i) The PHP shall ensure that patient care needs will be appropriately addressed during all hours of operation by a sufficient number of fully qualified (including license, registration or certification requirements, educational

attainment, and professional experience) health care professionals. Clinicians providing individual, group, and family therapy meet CHAMPUS requirements as qualified mental health providers, and operate within the scope of their licenses. The ultimate authority for managing care is vested in a psychiatrist or licensed doctor level psychologist. The management of medical care is vested in a physician.

(ii) The PHP shall establish and follow written plans to assure adequate staff coverage during all hours of operation, including physician availability, other professional staff coverage, and support staff in the respective disciplines.

(2) Staff qualifications. The PHP will have a sufficient number of qualified mental health providers, administrative, and support staff to address patients' clinical needs and to coordinate the services provided. PHPs which employ individuals with master's or doctoral level degrees in a mental health discipline who do not meet the licensure, certification and experience requirements for a qualified mental health provider but are actively working toward licensure or certification, may provide services within the all-inclusive per diem rate, provided the individual works under the clinical supervision of a fully qualified mental health provider employed by the PHP. All other program services shall be provided by trained, licensed staff.

(3) Patient rights. (i) The PHP shall provide adequate protection for all patient rights, including rights provided by law, privacy, personal rights, safety, confidentiality, informed consent, grievances, and personal dignity.

(ii) The facility has a written policy regarding patient abuse and neglect.

(iii) Facility marketing and advertising meets professional standards.

(4) Behavioral management. The PHP shall adhere to a comprehensive, written plan of behavior management, developed by the clinical director and the medical or professional staff and approved by the governing body, including strictly limited procedures to assure that restraint or seclusion are used only in extraordinary circumstances, are carefully monitored, and are fully documented. Only trained and clinically privileged RNs or qualified mental health professionals may be responsible for implementation of seclusion and restraint procedures in an emergency situation.

(5) Admission process. The PHP shall maintain written policies and procedures to ensure that prior to an admission, a determination is made, and approved pursuant to CHAMPUS preauthorization requirements, that the admission is medically and/or psychologically necessary and the program is appropriate to meet the patient's needs. Medical and/or psychological necessity determinations shall be rendered by qualified mental health professionals who meet CHAMPUS requirements for individual professional providers and who are permitted by law and by the facility to refer patients for admission.

(6) Assessments. The professional staff of the PHP shall complete a multidisciplinary assessment which includes, but is not limited to physical health, psychological health, physiological, developmental, family, educational, spiritual, and skills assessment of each patient admitted. Unless otherwise specified, all required clinical assessment are completed prior to development of the interdisciplinary treatment plan.

TMA Version - April 2005

(7) Clinical formulation. A qualified mental health provider of the PHP will complete a clinical formulation on all patients. The clinical formulation will be reviewed and approved by the responsible individual professional provider and will incorporate significant findings from each of the multidisciplinary assessments. It will provide the basis for development of an interdisciplinary treatment plan.

(8) Treatment planning. A qualified mental health professional with admitting privileges shall be responsible for the development, supervision, implementation, and assessment of a written, individualized, interdisciplinary plan of treatment, which shall be completed by the fifth day following admission to a full-day PHP, or by the seventh day following admission to a half-day PHP, and shall include measurable and observable goals for incremental progress and discharge. The treatment plan shall undergo review at least every two weeks, or when major changes occur in treatment.

(9) Discharge and transition planning. The PHP shall develop an individualized transition plan which addresses anticipated needs of the patient at discharge. The transition plan involves determining necessary modifications in the treatment plan, facilitating the termination of treatment, and identifying resources for maintaining therapeutic stability following discharge.

(10) Clinical documentation. Clinical records shall be maintained on each patient to plan care and treatment and provide ongoing evaluation of the patient's progress. All care is documented and each clinical record contains at least the following: demographic data, consent forms, pertinent legal documents, all treatment plans and patient assessments, consultation and laboratory reports, physician orders, progress notes, and a discharge summary. All documentation will adhere to applicable provisions of the JCAHO and requirements set forth in Sec. 199.7(b)(3). An appropriately qualified records administrator or technician will supervise and maintain the quality of the records. These requirements are in addition to other records requirements of this part, and documentation requirements of the Joint Commission on Accreditation of Health Care Organization.

(11) Progress notes. PHPs shall document the course of treatment for patients and families using progress notes which provide information to review, analyze, and modify the treatment plans. Progress notes are legible, contemporaneous, sequential, signed and dated and adhere to applicable provisions of the Manual for Mental Health, Chemical Dependency, and Mental Retardation/Developmental Disabilities Services and requirements set forth in section 199.7(b)(3).

(12) Therapeutic services. (i) Individual, group, and family therapy are provided to all patients, consistent with each patient's treatment plan by qualified mental health providers.

(ii) A range of therapeutic activities, directed and staffed by qualified personnel, are offered to help patients meet the goals of the treatment plan.

(iii) Educational services are provided or arranged that are appropriate to the patient's needs.

(13) Ancillary services. A full range of ancillary services are provided. Emergency services include policies and procedures for handling emergencies with qualified personnel and written agreements with each facility providing these services. Other ancillary services include physical health, pharmacy and dietary services.

(C) Standards for physical plant and environment. (1) Physical environment. The buildings and grounds of the PHP shall be maintained so as to avoid health and safety hazards, be supportive of the services provided to patients, and promote patient comfort, dignity, privacy, personal hygiene, and personal safety.

(2) Physical plant safety. The PHP shall be of permanent construction and maintained in a manner that protects the lives and ensures the physical safety of patients, staff, and visitors, including conformity with all applicable building, fire, health, and safety codes.

(3) Disaster planning. The PHP shall maintain and rehearse written plans for taking care of casualties and handling other consequences arising from internal and external disasters.

(D) Standards for evaluation system. (1) Quality assessment and improvement. The PHP shall develop and implement a comprehensive quality assurance and quality improvement program that monitors the quality, efficiency, appropriateness, and effectiveness of care, treatments, and services the PHP provides for patients and their families. Explicit clinical indicators shall be used to be used to evaluate all functions of the PHP and contribute to an ongoing process of program improvement. The clinical director is responsible for developing and implementing quality assessment and improvement activities throughout the facility.

(2) Utilization review. The PHP shall implement a utilization review process, pursuant to a written plan approved by the professional staff, the administration and the governing body, that assesses distribution of services, clinical necessity of treatment, appropriateness of admission, continued stay, and timeliness of discharge, as part of an overall effort to provide quality patient care in a cost-effective manner. Findings of the utilization review process are used as a basis for revising the plan of operation, including a review of staff qualifications and staff composition.

(3) Patient records. The PHP shall implement a process, including regular monthly reviews of a representative sample of patient records, to determine completeness, accuracy, timeliness of entries, appropriate signatures, and pertinence of clinical entries. Conclusions, recommendations, actions taken, and the results of actions are monitored and reported.

(4) Drug utilization review. The PHP shall implement a comprehensive process for the monitoring and evaluating of the prophylactic, therapeutic, and empiric use of drugs to assure that medications are provided appropriately, safely, and effectively.

(5) Risk management. The PHP shall implement a comprehensive risk management program, fully coordinated with other aspects of the quality assurance and quality improvement program, to prevent and control risks to patients and staff, and to minimize costs associated with clinical aspects of patient care and safety.

TMA Version - April 2005

(6) Infection control. The PHP shall implement a comprehensive system for the surveillance, prevention, control, and reporting of infections acquired or brought into the facility.

(7) Safety. The PHP shall implement an effective program to assure a safe environment for patients, staff, and visitors, including an incident reporting system, disaster training and safety education, a continuous safety surveillance system, and an active multidisciplinary safety committee.

(8) Facility evaluation. The PHP annually evaluates accomplishment of the goals and objectives of each clinical program component or facility service of the PHP and reports findings and recommendations to the governing body.

(E) Participation agreement requirements. In addition to other requirements set forth in paragraph (b)(4)(xii) of this section, in order for the services of a PHP to be authorized, the PHP shall have entered into a Participation Agreement with OCHAMPUS. The period of a Participation Agreement shall be specified in the agreement, and will generally be for not more than five years. On October 1, 1995, the PHP shall not be considered to be a CHAMPUS authorized provider and CHAMPUS payments shall not be made for services provided by the PHP until the date the participation agreement is signed by the Director, OCHAMPUS. In addition to review of a facility's application and supporting documentation, an on-site inspection by OCHAMPUS authorized personnel may be required prior to signing a participation agreement. The Participation Agreement shall include at least the following requirements:

(1) Render partial hospitalization program services to eligible CHAMPUS beneficiaries in need of such services, in accordance with the participation agreement and CHAMPUS regulation.

(2) Accept payment for its services based upon the methodology provided in Sec. 199.14, or such other method as determined by the Director, OCHAMPUS;

(3) Accept the CHAMPUS all-inclusive per diem rate as payment in full and collect from the CHAMPUS beneficiary or the family of the CHAMPUS beneficiary only those amounts that represent the beneficiary's liability, as defined in Sec. 199.4, and charges for services and supplies that are not a benefit of CHAMPUS;

(4) Make all reasonable efforts acceptable to the Director, OCHAMPUS, to collect those amounts, which represent the beneficiary's liability, as defined in Sec. 199.4;

(5) Comply with the provisions of Sec. 199.8, and submit claims first to all health insurance coverage to which the beneficiary is entitled that is primary to CHAMPUS;

(6) Submit claims for services provided to CHAMPUS beneficiaries at least every 30 days (except to the extent a delay is necessitated by efforts to first collect from other health insurance). If claims are not submitted at least every 30 days, the PHP agrees not to bill the beneficiary or the beneficiary's family for any amounts disallowed by CHAMPUS;

(7) Free-standing partial hospitalization programs shall certify that:

(i) It is and will remain in compliance with the provisions of paragraph (b)(4)(xii) of this section establishing standards for psychiatric partial hospitalization programs;

(ii) It has conducted a self assessment of the facility's compliance with the CHAMPUS Standards for Psychiatric Partial Hospitalization Programs, as issued by the Director, OCHAMPUS, and notified the Director, OCHAMPUS of any matter regarding which the facility is not in compliance with such standards; and

(iii) It will maintain compliance with the CHAMPUS Standards for Psychiatric Partial Hospitalization Programs, as issued by the Director, OCHAMPUS, except for any such standards regarding which the facility notifies the Director, OCHAMPUS that it is not in compliance.

(8) Designate an individual who will act as liaison for CHAMPUS inquiries. The PHP shall inform OCHAMPUS in writing of the designated individual;

(9) Furnish OCHAMPUS with cost data, as requested by OCHAMPUS, certified by an independent accounting firm or other agency as authorized by the Director, OCHAMPUS;

(10) Comply with all requirements of this section applicable to institutional providers generally concerning preauthorization, concurrent care review, claims processing, beneficiary liability, double coverage, utilization and quality review and other matters;

(11) Grant the Director, OCHAMPUS, or designee, the right to conduct quality assurance audits or accounting audits with full access to patients and records (including records relating to patients who are not CHAMPUS beneficiaries) to determine the quality and cost-effectiveness of care rendered. The audits may be conducted on a scheduled or unscheduled (unannounced) basis. This right to audit/review includes, but is not limited to:

(i) Examination of fiscal and all other records of the PHP which would confirm compliance with the participation agreement and designation as an authorized CHAMPUS PHP provider;

(ii) Conducting such audits of PHP records including clinical, financial, and census records, as may be necessary to determine the nature of the services being provided, and the basis for charges and claims against the United States for services provided CHAMPUS beneficiaries;

(iii) Examining reports of evaluations and inspections conducted by federal, state and local government, and private agencies and organizations;

(iv) Conducting on-site inspections of the facilities of the PHP and interviewing employees, members of the staff, contractors, board members, volunteers, and patients, as required;

(v) Audits conducted by the United States General Account Office.

TMA Version - April 2005

(F) Other requirements applicable to PHPs. (1) Even though a PHP may qualify as a CHAMPUS-authorized provider and may have entered into a participation agreement with CHAMPUS, payment by CHAMPUS for particular services provided is contingent upon the PHP also meeting all conditions set forth in section 199.4 of this part.

(2) The PHP shall provide patient services to CHAMPUS beneficiaries in the same manner it provides inpatient services to all other patients. The PHP may not discriminate against CHAMPUS beneficiaries in any manner, including admission practices, placement in special or separate wings or rooms, or provisions of special or limited treatment.

(3) The PHP shall assure that all certifications and information provided to the Director, OCHAMPUS incident to the process of obtaining and retaining authorized provider status is accurate and that it has no material errors or omissions. In the case of any misrepresentations, whether by inaccurate information being provided or material facts withheld, authorized provider status will be denied or terminated, and the PHP will be ineligible for consideration for authorized provider status for a two year period.

(xiii) Hospice programs. Hospice programs must be Medicare approved and meet all Medicare conditions of participation (42 CFR part 418) in relation to CHAMPUS patients in order to receive payment under the CHAMPUS program. A hospice program may be found to be out of compliance with a particular Medicare condition of participation and still participate in the CHAMPUS as long as the hospice is allowed continued participation in Medicare while the condition of noncompliance is being corrected. The hospice program can be either a public agency or private organization (or a subdivision thereof) which:

(A) Is primarily engaged in providing the care and services described under Sec. 199.4(e)(19) and makes such services available on a 24-hour basis.

(B) Provides bereavement counseling for the immediate family or terminally ill individuals.

(C) Provides for such care and services in individuals' homes, on an outpatient basis, and on a short-term inpatient basis, directly or under arrangements made by the hospice program, except that the agency or organization must:

(1) Ensure that substantially all the core services are routinely provided directly by hospice employees.

(2) Maintain professional management responsibility for all services which are not directly furnished to the patient, regardless of the location or facility in which the services are rendered.

(3) Provide assurances that the aggregate number of days of inpatient care provided in any 12-month period does not exceed 20 percent of the aggregate number of days of hospice care during the same period.

(4) Have an interdisciplinary group composed of the following personnel who provide the care and services described under Sec. 199.4(e)(19) and who establish the policies governing

the provision of such care/services:

- (i) A physician;
 - (ii) A registered professional nurse;
 - (iii) A social worker; and
 - (iv) A pastoral or other counselor.
- (5) Maintain central clinical records on all patients.
- (6) Utilize volunteers.
- (7) The hospice and all hospice employees must be licensed in accordance with applicable Federal, State and local laws and regulations.
- (8) The hospice must enter into an agreement with CHAMPUS in order to be qualified to participate and to be eligible for payment under the program. In this agreement the hospice and CHAMPUS agree that the hospice will:
- (i) Not charge the beneficiary or any other person for items or services for which the beneficiary is entitled to have payment made under the CHAMPUS hospice benefit.
 - (ii) Be allowed to charge the beneficiary for items or services requested by the beneficiary in addition to those that are covered under the CHAMPUS hospice benefit.
- (9) Meet such other requirements as the Secretary of Defense may find necessary in the interest of the health and safety of the individuals who are provided care and services by such agency or organization.
- (xiv) Substance use disorder rehabilitation facilities. Paragraph (b)(4)(xiv) of this section establishes standards and requirements for substance use order rehabilitation facilities (SUDRF). This includes both inpatient rehabilitation centers for the treatment of substance use disorders and partial hospitalization centers for the treatment of substance use disorders.
- (A) Organization and administration. (1) Definition of inpatient rehabilitation center. An inpatient rehabilitation center is a facility, or distinct part of a facility, that provides medically monitored, interdisciplinary addiction-focused treatment to beneficiaries who have psychoactive substance use disorders. Qualified health care professionals provide 24-hour, seven-day-per-week, medically monitored assessment, treatment, and evaluation. An inpatient rehabilitation center is appropriate for patients whose addiction-related symptoms, or concomitant physical and emotional/behavioral problems reflect persistent dysfunction in several major life areas. Inpatient rehabilitation is differentiated from:
- (i) Acute psychoactive substance use treatment and from treatment of acute biomedical/emotional/behavioral problems; which problems are either life-threatening and/or severely incapacitating and often occur within the context of a discrete episode of addiction-related biomedical or psychiatric dysfunction;

TMA Version - April 2005

- (ii) A partial hospitalization center, which serves patients who exhibit emotional/behavioral dysfunction but who can function in the community for defined periods of time with support in one or more of the major life areas;
 - (iii) A group home, sober-living environment, halfway house, or three-quarter way house;
 - (iv) Therapeutic schools, which are educational programs supplemented by addiction-focused services;
 - (v) Facilities that treat patients with primary psychiatric diagnoses other than psychoactive substance use or dependence; and
 - (vi) Facilities that care for patients with the primary diagnosis of mental retardation or developmental disability.
- (2) Definition of partial hospitalization center for the treatment of substance use disorders. A partial hospitalization center for the treatment of substance use disorders is an addiction-focused service that provides active treatment to adolescents between the ages of 13 and 18 or adults aged 18 and over. Partial hospitalization is a generic term for day, evening, or weekend programs that treat patients with psychoactive substance use disorders according to a comprehensive, individualized, integrated schedule of care. A partial hospitalization center is organized, interdisciplinary, and medically monitored. Partial hospitalization is appropriate for those whose addiction-related symptoms or concomitant physical and emotional/behavioral problems can be managed outside the hospital environment for defined periods of time with support in one or more of the major life areas.
- (3) Eligibility. (i) Every inpatient rehabilitation center and partial hospitalization center for the treatment of substance use disorders must be certified pursuant to CHAMPUS certification standards. Such standards shall incorporate the basic standards set forth in paragraphs (b)(4)(xiv) (A) through (D) of this section, and shall include such additional elaborative criteria and standards as the Director, OCHAMPUS determines are necessary to implement the basic standards.
- (ii) To be eligible for CHAMPUS certification, the SUDRF is required to be licensed and fully operational (with a minimum patient census of the lesser of: six patients or 30 percent of bed capacity) for a period of at least six months and operate in substantial compliance with state and federal regulations.
 - (iii) The SUDRF is currently accredited by the Joint Commission on Accreditation of Healthcare Organizations under the Accreditation Manual for Mental Health, Chemical Dependency, and Mental Retardation/Developmental Disabilities Services, or by the Commission on Accreditation of Rehabilitation Facilities as an alcoholism and other drug dependency rehabilitation program under the Standards Manual for Organizations Serving People with Disabilities, or other designated standards approved by the Director, OCHAMPUS.
 - (iv) The SUDRF has a written participation agreement with OCHAMPUS. On October 1, 1995, the SUDRF is not considered a CHAMPUS-authorized provider, and CHAMPUS benefits are not paid for services provided until the date upon which a participation agreement is signed by the Director, OCHAMPUS.

(4) Governing body. (i) The SUDRF shall have a governing body which is responsible for the policies, bylaws, and activities of the facility. If the SUDRF is owned by a partnership or single owner, the partners or single owner are regarded as the governing body. The facility will provide an up-to-date list of names, addresses, telephone numbers and titles of the members of the governing body.

(ii) The governing body ensures appropriate and adequate services for all patients and oversees continuing development and improvement of care. Where business relationships exist between the governing body and facility, appropriate conflict-of-interest policies are in place.

(iii) Board members are fully informed about facility services and the governing body conducts annual reviews of its performance in meeting purposes, responsibilities, goals and objectives.

(5) Chief executive officer. The chief executive officer, appointed by and subject to the direction of the governing body, shall assume overall administrative responsibility for the operation of the facility according to governing body policies. The chief executive officer shall have five years' administrative experience in the field of mental health or addictions. On October 1, 1997 the CEO shall possess a degree in business administration, public health, hospital administration, nursing, social work, or psychology, or meet similar educational requirements as prescribed by the Director, OCHAMPUS.

(6) Clinical Director. The clinical director, appointed by the governing body, shall be a qualified psychiatrist or doctoral level psychologist who meets applicable CHAMPUS requirements for individual professional providers and is licensed to practice in the state where the SUDRF is located. The clinical director shall possess requisite education and experience, including credentials applicable under state practice and licensing laws appropriate to the professional discipline. The clinical director shall satisfy at least one of the following requirements: certification by the American Society of Addiction Medicine; one year or 1,000 hours of experience in the treatment of psychoactive substance use disorders; or is a psychiatrist or doctoral level psychologist with experience in the treatment of substance use disorders. The clinical director shall be responsible for planning, development, implementation, and monitoring of all clinical activities.

(7) Medical director. The medical director, appointed by the governing body, shall be licensed to practice medicine in the state where the center is located and shall possess requisite education including graduation from an accredited school of medicine or osteopathy. The medical director shall satisfy at least one of the following requirements: certification by the American Society of Addiction Medicine; one year or 1,000 hours of experience in the treatment of psychoactive substance use disorders; or is a psychiatrist with experience in the treatment of substance use disorders. The medical director shall be responsible for the planning, development, implementation, and monitoring of all activities relating to medical treatment of patients. If qualified, the Medical Director may also serve as Clinical Director.

(8) Medical or professional staff organization. The governing body shall establish a medical or professional staff organization to assure effective implementation of clinical privileging, professional conduct rules, and other activities directly affecting patient care.

TMA Version - April 2005

TMA Version - April 2005

(9) Personnel policies and records. The SUDRF shall maintain written personnel policies, updated job descriptions, personnel records to assure the selection of qualified personnel and successful job performance of those personnel.

(10) Staff development. The SUDRF shall provide appropriate training and development programs for administrative, support, and direct care staff.

(11) Fiscal accountability. The SUDRF shall assure fiscal accountability to applicable government authorities and patients.

(12) Designated teaching facilities. Students, residents, interns, or fellows providing direct clinical care are under the supervision of a qualified staff member approved by an accredited university or approved training program. The teaching program is approved by the Director, OCHAMPUS.

(13) Emergency reports and records. The facility notifies OCHAMPUS of any serious occurrence involving CHAMPUS beneficiaries.

(B) Treatment services. (1) Staff composition. (i) The SUDRF shall follow written plans which assure that medical and clinical patient needs will be appropriately addressed during all hours of operation by a sufficient number of fully qualified (including license, registration or certification requirements, educational attainment, and professional experience) health care professionals and support staff in the respective disciplines. Clinicians providing individual, group and family therapy meet CHAMPUS requirements as qualified mental health providers and operate within the scope of their licenses. The ultimate authority for planning, development, implementation, and monitoring of all clinical activities is vested in a psychiatrist or doctoral level clinical psychologist. The management of medical care is vested in a physician.

(ii) The SUDRF shall establish and follow written plans to assure adequate staff coverage during all hours of operation of the center, including physician availability and other professional staff coverage 24 hours per day, seven days per week for an inpatient rehabilitation center and during all hours of operation for a partial hospitalization center.

(2) Staff qualifications. Within the scope of its programs and services, the SUDRF has a sufficient number of professional, administrative, and support staff to address the medical and clinical needs of patients and to coordinate the services provided. SUDRFs that employ individuals with master's or doctoral level degrees in a mental health discipline who do not meet the licensure, certification and experience requirements for a qualified mental health provider but are actively working toward licensure or certification, may provide services within the DRG, provided the individual works under the clinical supervision of a fully qualified mental health provider employed by the SUDRF.

(3) Patient rights. (i) The SUDRF shall provide adequate protection for all patient rights, safety, confidentiality, informed consent, grievances, and personal dignity.

(ii) The SUDRF has a written policy regarding patient abuse and neglect.

(iii) SUDRF marketing and advertising meets professional standards.

(4) Behavioral management. When a SUDRF uses a behavioral management program, the center shall adhere to a comprehensive, written plan of behavioral management, developed by the clinical director and the medical or professional staff and approved by the governing body. It shall be based on positive reinforcement methods and, except for infrequent use of temporary physical holds or time outs, does not include the use of restraint or seclusion. Only trained and clinically privileged RNs or qualified mental health professionals may be responsible for the implementation of seclusion and restraint in an emergency situation.

(5) Admission process. The SUDRF shall maintain written policies and procedures to ensure that, prior to an admission, a determination is made, and approved pursuant to CHAMPUS preauthorization requirements, that the admission is medically and/or psychologically necessary and the program is appropriate to meet the patient's needs. Medical and/or psychological necessity determinations shall be rendered by qualified mental health professionals who meet CHAMPUS requirements for individual professional providers and who are permitted by law and by the facility to refer patients for admission.

(6) Assessment. The professional staff of the SUDRF shall provide a complete, multidisciplinary assessment of each patient which includes, but is not limited to, medical history, physical health, nursing needs, alcohol and drug history, emotional and behavioral factors, age-appropriate social circumstances, psychological condition, education status, and skills. Unless otherwise specified, all required clinical assessments are completed prior to development of the multidisciplinary treatment plan.

(7) Clinical formulation. A qualified mental health care professional of the SUDRF will complete a clinical formulation on all patients. The clinical formulation will be reviewed and approved by the responsible individual professional provider and will incorporate significant findings from each of the multidisciplinary assessments. It will provide the basis for development of an interdisciplinary treatment plan.

(8) Treatment planning. A qualified health care professional with admitting privileges shall be responsible for the development, supervision, implementation, and assessment of a written, individualized, and interdisciplinary plan of treatment, which shall be completed within 10 days of admission to an inpatient rehabilitation center or by the fifth day following admission to full day partial hospitalization center, and by the seventh day of treatment for half day partial hospitalization. The treatment plan shall include individual, measurable, and observable goals for incremental progress towards the treatment plan objectives and goals and discharge. A preliminary treatment plan is completed within 24 hours of admission and includes at least a physician's admission note and orders. The master treatment plan is regularly reviewed for effectiveness and revised when major changes occur in treatment.

(9) Discharge and transition planning. The SUDRF shall maintain a transition planning process to address adequately the anticipated needs of the patient prior to the time of discharge.

(10) Clinical documentation. Clinical records shall be maintained on each patient to plan care and treatment and provide ongoing evaluation of the patient's progress. All care is documented and each clinical record contains at least the following: demographic data, consent forms, pertinent legal documents, all treatment plans and patient assessments, consultation and laboratory reports, physician orders, progress notes, and a discharge

summary. All documentation will adhere to applicable provisions of the JCAHO and requirements set forth in Sec. 199.7(b)(3). An appropriately qualified records administrator or technician will supervise and maintain the quality of the records. These requirements are in addition to other records requirements of this part, and provisions of the JCAHO Manual for Mental Health, Chemical Dependency, and Mental Retardation/Developmental Disabilities Services.

(11) Progress notes. Timely and complete progress notes shall be maintained to document the course of treatment for the patient and family.

(12) Therapeutic services. (i) Individual, group, and family psychotherapy and addiction counseling services are provided to all patients, consistent with each patient's treatment plan by qualified mental health providers.

(ii) A range of therapeutic activities, directed and staffed by qualified personnel, are offered to help patients meet the goals of the treatment plan.

(iii) Therapeutic educational services are provided or arranged that are appropriate to the patient's educational and therapeutic needs.

(13) Ancillary services. A full range of ancillary services is provided. Emergency services include policies and procedures for handling emergencies with qualified personnel and written agreements with each facility providing the service. Other ancillary services include physical health, pharmacy and dietary services.

(C) Standards for physical plant and environment. (1) Physical environment. The buildings and grounds of the SUDRF shall be maintained so as to avoid health and safety hazards, be supportive of the services provided to patients, and promote patient comfort, dignity, privacy, personal hygiene, and personal safety.

(2) Physical plant safety. The SUDRF shall be maintained in a manner that protects the lives and ensures the physical safety of patients, staff, and visitors, including conformity with all applicable building, fire, health, and safety codes.

(3) Disaster planning. The SUDRF shall maintain and rehearse written plans for taking care of casualties and handling other consequences arising from internal or external disasters.

(D) Standards for evaluation system. (1) Quality assessment and improvement. The SUDRF develop and implement a comprehensive quality assurance and quality improvement program that monitors the quality, efficiency, appropriateness, and effectiveness of the care, treatments, and services it provides for patients and their families, utilizing clinical indicators of effectiveness to contribute to an ongoing process of program improvement. The clinical director is responsible for developing and implementing quality assessment and improvement activities throughout the facility.

(2) Utilization review. The SUDRF shall implement a utilization review process, pursuant to a written plan approved by the professional staff, the administration, and the governing body, that assesses the appropriateness of admissions, continued stay, and timeliness of discharge as part of an effort to provide quality patient care in a cost-effective manner.

TMA Version - April 2005

Findings of the utilization review process are used as a basis for revising the plan of operation, including a review of staff qualifications and staff composition.

(3) Patient records review. The center shall implement a process, including monthly reviews of a representative sample of patient records, to determine the completeness and accuracy of the patient records and the timeliness and pertinence of record entries, particularly with regard to regular recording of progress/non-progress in treatment plan.

(4) Drug utilization review. An inpatient rehabilitation center and, when applicable, a partial hospitalization center, shall implement a comprehensive process for the monitoring and evaluating of the prophylactic, therapeutic, and empiric use of drugs to assure that medications are provided appropriately, safely, and effectively.

(5) Risk management. The SUDRF shall implement a comprehensive risk management program, fully coordinated with other aspects of the quality assurance and quality improvement program, to prevent and control risks to patients and staff and costs associated with clinical aspects of patient care and safety.

(6) Infection control. The SUDRF shall implement a comprehensive system for the surveillance, prevention, control, and reporting of infections acquired or brought into the facility.

(7) Safety. The SUDRF shall implement an effective program to assure a safe environment for patients, staff, and visitors.

(8) Facility evaluation. The SUDRF annually evaluates accomplishment of the goals and objectives of each clinical program and service of the SUDRF and reports findings and recommendations to the governing body.

(E) Participation agreement requirements. In addition to other requirements set forth in paragraph (b)(4)(xiv) of this section, in order for the services of an inpatient rehabilitation center or partial hospitalization center for the treatment of substance abuse disorders to be authorized, the center shall have entered into a Participation Agreement with OCHAMPUS. The period of a Participation Agreement shall be specified in the agreement, and will generally be for not more than five years. On October 1, 1995, the SUDRF shall not be considered to be a CHAMPUS authorized provider and CHAMPUS payments shall not be made for services provided by the SUDRF until the date the participation agreement is signed by the Director, OCHAMPUS. In addition to review of the SUDRF's application and supporting documentation, an on-site visit by OCHAMPUS representatives may be part of the authorization process. In addition, such a Participation Agreement may not be signed until an SUDRF has been licensed and operational for at least six months. The Participation Agreement shall include at least the following requirements:

(1) Render applicable services to eligible CHAMPUS beneficiaries in need of such services, in accordance with the participation agreement and CHAMPUS regulation;

(2) Accept payment for its services based upon the methodology provided in Sec. 199.14, or such other method as determined by the Director, OCHAMPUS;

TMA Version - April 2005

- (3) Accept the CHAMPUS-determined rate as payment in full and collect from the CHAMPUS beneficiary or the family of the CHAMPUS beneficiary only those amounts that represent the beneficiary's liability, as defined in Sec. 199.4, and charges for services and supplies that are not a benefit of CHAMPUS;
- (4) Make all reasonable efforts acceptable to the Director, OCHAMPUS, to collect those amounts which represent the beneficiary's liability, as defined in Sec. 199.4;
- (5) Comply with the provisions of Sec. 199.8, and submit claims first to all health insurance coverage to which the beneficiary is entitled that is primary to CHAMPUS;
- (6) Furnish OCHAMPUS with cost data, as requested by OCHAMPUS, certified to by an independent accounting firm or other agency as authorized by the Director, OCHAMPUS;
- (7) Certify that:
 - (i) It is and will remain in compliance with the provisions of paragraph (b)(4)(xiv) of the section establishing standards for substance use disorder rehabilitation facilities;
 - (ii) It has conducted a self assessment of the SUDRF'S compliance with the CHAMPUS Standards for Substance Use Disorder Rehabilitation Facilities, as issued by the Director, OCHAMPUS, and notified the Director, OCHAMPUS of any matter regarding which the facility is not in compliance with such standards; and
 - (iii) It will maintain compliance with the CHAMPUS Standards for Substance Use Disorder Rehabilitation Facilities, as issued by the Director, OCHAMPUS, except for any such standards regarding which the facility notifies the Director, OCHAMPUS that it is not in compliance.
- (8) Grant the Director, OCHAMPUS, or designee, the right to conduct quality assurance audits or accounting audits with full access to patients and records (including records relating to patients who are not CHAMPUS beneficiaries) to determine the quality and cost effectiveness of care rendered. The audits may be conducted on a scheduled or unscheduled (unannounced) basis. This right to audit/review included, but is not limited to:
 - (i) Examination of fiscal and all other records of the center which would confirm compliance with the participation agreement and designation as an authorized CHAMPUS provider;
 - (ii) Conducting such audits of center records including clinical, financial, and census records, as may be necessary to determine the nature of the services being provided, and the basis for charges and claims against the United States for services provided CHAMPUS beneficiaries;
 - (iii) Examining reports of evaluations and inspection conducted by federal, state and local government, and private agencies and organizations;
 - (iv) Conducting on-site inspections of the facilities of the SUDRF and interviewing employees, members of the staff, contractors, board members, volunteers, and patients, as required.

- (v) Audits conducted by the United States General Accounting Office.
- (F) Other requirements applicable to substance use disorder rehabilitation facilities.
 - (1) Even though a SUDRF may qualify as a CHAMPUS-authorized provider and may have entered into a participation agreement with CHAMPUS, payment by CHAMPUS for particular services provided is contingent upon the SUDRF also meeting all conditions set forth in Sec. 199.4.
 - (2) The center shall provide inpatient services to CHAMPUS beneficiaries in the same manner it provides services to all other patients. The center may not discriminate against CHAMPUS beneficiaries in any manner, including admission practices, placement in special or separate wings or rooms, or provisions of special or limited treatment.
 - (3) The substance use disorder facility shall assure that all certifications and information provided to the Director, OCHAMPUS incident to the process of obtaining and retaining authorized provider status is accurate and that it has no material errors or omissions. In the case of any misrepresentations, whether by inaccurate information being provided or material facts withheld, authorized provider status will be denied or terminated, and the facility will be ineligible for consideration for authorized provider status for a two year period.
- (xv) Home health agencies (HHAs). HHAs must be Medicare approved and meet all Medicare conditions of participation under sections 1861(o) and 1891 of the Social Security Act (42 U.S.C. 1395x(o) and 1395bbb) and 42 CFR part 484 in relation to TRICARE beneficiaries in order to receive payment under the TRICARE program. An HHA may be found to be out of compliance with a particular Medicare condition of participation and still participate in the TRICARE program as long as the HHA is allowed continued participation in Medicare while the condition of noncompliance is being corrected. An HHA is a public or private organization, or a subdivision of such an agency or organization, that meets the following requirements:
 - (A) Engaged in providing skilled nursing services and other therapeutic services, such as physical therapy, speech-language pathology services, or occupational therapy, medical services, and home health aide services.
 - (1) Makes available part-time or intermittent skilled nursing services and at least one other therapeutic service on a visiting basis in place of residence used as a patient's home.
 - (2) Furnishes at least one of the qualifying services directly through agency employees, but may furnish the second qualifying service and additional services under arrangement with another HHA or organization.
 - (B) Policies established by a professional group associated with the agency or organization (including at least one physician and one registered nurse) to govern the services and provides for supervision of such services by a physician or a registered nurse.
 - (C) Maintains clinical records for all patients.
 - (D) Licensed in accordance with State and local law or is approved by the State or local licensing agency as meeting the licensing standards, where applicable.

TMA Version - April 2005

(E) Enters into an agreement with TRICARE in order to participate and to be eligible for payment under the program. In this agreement the HHA and TRICARE agree that the HHA will:

(1) Not charge the beneficiary or any other person for items or services for which the beneficiary is entitled to have payment under the TRICARE HHA prospective payment system.

(2) Be allowed to charge the beneficiary for items or services requested by the beneficiary in addition to those that are covered under the TRICARE HHA prospective payment system.

(F) Abide by the following consolidated billing requirements:

(1) The HHA must submit all TRICARE claims for all home health services, excluding durable medical equipment (DME), while the beneficiary is under the home health plan without regard to whether or not the item or service was furnished by the HHA, by others under arrangement with the HHA, or under any other contracting or consulting arrangement.

(2) Separate payment will be made for DME items and services provided under the home health benefit which are under the DME fee schedule. DME is excluded from the consolidated billing requirements.

(3) Home health services included in consolidated billing are:

(i) Part-time or intermittent skilled nursing;

(ii) Part-time or intermittent home health aide services;

(iii) Physical therapy, occupational therapy and speech-language pathology;

(iv) Medical social services;

(v) Routine and non-routine medical supplies;

(vi) A covered osteoporosis drug (not paid under PPS rate) but excluding other drugs and biologicals;

(vii) Medical services provided by an intern or resident-in-training of a hospital, under an approved teaching program of the hospital in the case of an HHA that is affiliated or under common control of a hospital;

(viii) Services at hospitals, SNFs or rehabilitation centers when they involve equipment too cumbersome to bring home.

(G) Meet such other requirements as the Secretary of Health and Human Services and/or Secretary of Defense may find necessary in the interest of the health and safety of the individuals who are provided care and services by such agency or organization.

(xvi) CAHs. CAHs must meet all conditions of participation under 42 CFR 485.601 through 485.645 in relation to TRICARE beneficiaries in order to receive payment under the TRICARE program. If a CAH provides inpatient psychiatric services or inpatient rehabilitation services in a distinct part unit, these distinct part units must meet the conditions of participation in 42 CFR 485.647, with the exception of being paid under the inpatient prospective payment system for psychiatric facilities as specified in 42 CFR 412.1(a)(2) or the inpatient prospective payment system for rehabilitation hospitals or rehabilitation units as specified in 42 CFR 412(a)(3).

(c) Individual professional providers of care—(1) General—(i) Purpose. This individual professional provider class is established to accommodate individuals who are recognized by 10 U.S.C. 1079(a) as authorized to assess or diagnose illness, injury, or bodily malfunction as a prerequisite for CHAMPUS cost-share of otherwise allowable related preventive or treatment services or supplies, and to accommodate such other qualified individuals who the Director, OCHAMPUS, or designee, may authorize to render otherwise allowable services essential to the efficient implementation of a plan-of-care established and managed by a 10 U.S.C. 1079(a) authorized professional.

(ii) Professional corporation affiliation or association membership permitted. Paragraph (c) of this section applies to those individual health care professionals who have formed a professional corporation or association pursuant to applicable state laws. Such a professional corporation or association may file claims on behalf of a CHAMPUS-authorized individual professional provider and be the payee for any payment resulting from such claims when the CHAMPUS-authorized individual certifies to the Director, OCHAMPUS, or designee, in writing that the professional corporation or association is acting on the authorized individual's behalf.

(iii) Scope of practice limitation. For CHAMPUS cost-sharing to be authorized, otherwise allowable services provided by a CHAMPUS-authorized individual professional provider shall be within the scope of the individual's license as regulated by the applicable state practice act of the state where the individual rendered the service to the CHAMPUS beneficiary or shall be within the scope of the test which was the basis for the individual's qualifying certification.

(iv) Employee status exclusion. An individual employed directly, or indirectly by contract, by an individual or entity to render professional services otherwise allowable by this part is excluded from provider status as established by this paragraph (c) for the duration of each employment.

(v) Training status exclusion. Individual health care professionals who are allowed to render health care services only under direct and ongoing supervision as training to be credited towards earning a clinical academic degree or other clinical credential required for the individual to practice independently are excluded from provider status as established by this paragraph (c) for the duration of such training.

(2) Conditions of authorization—(i) Professional license requirement. The individual must be currently licensed to render professional health care services in each state in which the individual renders services to CHAMPUS beneficiaries. Such license is required when a specific state provides, but does not require, license for a specific category of individual

professional provider. The license must be at full clinical practice level to meet this requirement. A temporary license at the full clinical practice level is acceptable.

(ii) Professional certification requirement. When a state does not license a specific category of individual professional, certification by a Qualified Accreditation Organization, as defined in Sec. 199.2, is required. Certification must be at full clinical practice level. A temporary certification at the full clinical practice level is acceptable.

(iii) Education, training and experience requirement. The Director, OCHAMPUS, or designee, may establish for each category or type of provider allowed by this paragraph (c) specific education, training, and experience requirements as necessary to promote the delivery of services by fully qualified individuals.

(iv) Physician referral and supervision. When physician referral and supervision is a prerequisite for CHAMPUS cost-sharing of the services of a provider authorized under this paragraph (c), such referral and supervision means that the physicians must actually see the patient to evaluate and diagnose the condition to be treated prior to referring the beneficiary to another provider and that the referring physician provides ongoing oversight of the course of referral related treatment throughout the period during which the beneficiary is being treated in response to the referral. Written contemporaneous documentation of the referring physician's basis for referral and ongoing communication between the referring and treating provider regarding the oversight of the treatment rendered as a result of the referral must meet all requirements for medical records established by this part. Referring physician supervision does not require physical location on the premises of the treating provider or at the site of treatment.

(v) Subject to section 1079(a) of title 10, U.S.C., chapter 55, a physician or other health care practitioner who is eligible to receive reimbursement for services provided under Medicare (as defined in section 1086(d)(3)(C) of title 10 U.S.C., chapter 55) shall be considered approved to provide medical care authorized under section 1079 and section 1086 of title 10, U.S.C., chapter 55 unless the administering Secretaries have information indicating Medicare, TRICARE, or other Federal health care program integrity violations by the physician or other health care practitioner. Approval is limited to those classes of provider currently considered TRICARE authorized providers as outlined in 32 CFR 199.6. Services and supplies rendered by those providers who are not currently considered authorized providers shall be denied.

(3) Types of providers. Subject to the standards of participation provisions of this part, the following individual professional providers of medical care are authorized to provide services to CHAMPUS beneficiaries:

(i) Physicians. (A) Doctors of Medicine (M.D.).

(B) Doctors of Osteopathy (D.O.).

(ii) Dentists. Except for covered oral surgery as specified in Sec. 199.4(e) of this part, all otherwise covered services rendered by dentists require preauthorization.

(A) Doctors of Dental Medicine (D.M.D.).

TMA Version - April 2005

(B) Doctors of Dental Surgery (D.D.S.).

(iii) Other allied health professionals. The services of the following individual professional providers of care are coverable on a fee-for-service basis provided such services are otherwise authorized in this or other sections of this part.

(A) Clinical psychologist. For purposes of CHAMPUS, a clinical psychologist is an individual who is licensed or certified by the state for the independent practice of psychology and:

(1) Possesses a doctoral degree in psychology from a regionally accredited university; and

(2) Has has 2 years of supervised clinical experience in psychological health services of which at least 1 year is post-doctoral and 1 year (may be the post-doctoral year) is in an organized psychological health service training program; or

(3) As an alternative to paragraphs (c)(3)(iii)(A)(1) and (2) of this section is listed in the National Register of Health Service Providers in Psychology.

(B) Doctors of Optometry.

(C) Doctors of Podiatry or Surgical Chiropody.

(D) Certified nurse midwives. (1) A certified nurse midwife may provide covered care independent of physician referral and supervision, provided the nurse midwife is:

(i) Licensed, when required, by the local licensing agency for the jurisdiction in which the care is provided; and

(ii) Certified by the American College of Nurse Midwives. To receive certification, a candidate must be a registered nurse who has completed successfully an educational program approved by the American College of Nurse Midwives, and passed the American College of Nurse Midwives National Certification Examination.

(2) The services of a registered nurse who is not a certified nurse midwife may be authorized only when the patient has been referred for care by a licensed physician and a licensed physician provides continuing supervision of the course of care. A lay midwife who is neither a certified nurse midwife nor a registered nurse is not a CHAMPUS-authorized provider, regardless of whether the services rendered may otherwise be covered.

(E) Certified nurse practitioner. Within the scope of applicable licensure or certification requirements, a certified nurse practitioner may provide covered care independent of physician referral and supervision, provided the nurse practitioner is:

(1) A licensed, registered nurse; and

(2) Specifically licensed or certified as a nurse practitioner by the state in which the care was provided, if the state offers such specific licensure or certification; or

TMA Version - April 2005

(3) Certified as a nurse practitioner (certified nurse) by a professional organization offering certification in the speciality of practice, if the state does not offer specific licensure or certification for nurse practitioners.

(F) Certified Clinical Social Worker. A clinical social worker may provide covered services independent of physician referral and supervision, provided the clinical social worker:

(1) Is licensed or certified as a clinical social worker by the jurisdiction where practicing; or, if the jurisdiction does not provide for licensure or certification of clinical social workers, is certified by a national professional organization offering certification of clinical social workers; and

(2) Has at least a master's degree in social work from a graduate school of social work accredited by the Council on Social Work Education; and

(3) Has had a minimum of 2 years or 3,000 hours of post-master's degree supervised clinical social work practice under the supervision of a master's level social worker in an appropriate clinical setting, as determined by the Director, OCHAMPUS, or a designee.

NOTE: Patients' organic medical problems must receive appropriate concurrent management by a physician.

(G) Certified psychiatric nurse specialist. A certified psychiatric nurse specialist may provide covered care independent of physician referral and supervision. For purposes of CHAMPUS, a certified psychiatric nurse specialist is an individual who:

(1) Is a licensed, registered nurse; and

(2) Has at least a master's degree in nursing from a regionally accredited institution with a specialization in psychiatric and mental health nursing; and

(3) Has had at least 2 years of post-master's degree practice in the field of psychiatric and mental health nursing, including an average of 8 hours of direct patient contact per week; or

(4) Is listed in a CHAMPUS-recognized, professionally sanctioned listing of clinical specialists in psychiatric and mental health nursing.

(H) Certified physician assistant. A physician assistant may provide care under general supervision of a physician (see Sec. 199.14(j)(1)(ix) of this part for limitations on reimbursement). For purposes of CHAMPUS, a physician assistant must meet the applicable state requirements governing the qualifications of physician assistants and at least one of the following conditions:

(1) Is currently certified by the National Commission on Certification of Physician Assistants to assist primary care physicians, or

(2) Has satisfactorily completed a program for preparing physician assistants that:

(i) Was at least 1 academic year in length;

TMA Version - April 2005

- (ii) Consisted of supervised clinical practice and at least 4 months (in the aggregate) of classroom instruction directed toward preparing students to deliver health care; and
 - (iii) Was accredited by the American Medical Association's Committee on Allied Health Education and Accreditation; or
- (3) Has satisfactorily completed a formal educational program for preparing program physician assistants that does not meet the requirement of paragraph (c)(3)(iii)(H)(2) of this section and had been assisting primary care physicians for a minimum of 12 months during the 18-month period immediately preceding January 1, 1987.
- (l) Anesthesiologist Assistant. An anesthesiologist assistant may provide covered anesthesia services, if the anesthesiologist assistant:
- (1) Works under the direct supervision of an anesthesiologist who bills for the services and for each patient;
 - (i) The anesthesiologist performs a pre-anesthetic examination and evaluation;
 - (ii) The anesthesiologist prescribes the anesthesia plan;
 - (iii) The anesthesiologist personally participates in the most demanding aspects of the anesthesia plan including, if applicable, induction and emergence;
 - (iv) The anesthesiologist ensures that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified anesthesiologist assistant;
 - (v) The anesthesiologist monitors the course of anesthesia administration at frequent intervals;
 - (vi) The anesthesiologist remains physically present and available for immediate personal diagnosis and treatment of emergencies;
 - (vii) The anesthesiologist provides indicated post-anesthesia care; and
 - (viii) The anesthesiologist performs no other services while he or she supervises no more than four anesthesiologist assistants concurrently or a lesser number if so limited by the state in which the procedure is performed.
- (2) Is in compliance with all applicable requirements of state law, including any licensure requirements the state imposes on nonphysician anesthetists; and
- (3) Is a graduate of a Master's level anesthesiologist assistant educational program that is established under the auspices of an accredited medical school and that:
- (i) Is accredited by the Committee on Allied Health Education and Accreditation, or its successor organization; and
 - (ii) Includes approximately two years of specialized basic science and clinical education in anesthesia at a level that builds on a premedical undergraduate science background.

(4) The Director, TMA, or a designee, shall issue TRICARE policies, instructions, procedures, guidelines, standards, and criteria as may be necessary to implement the intent of this section.

(J) Certified Registered Nurse Anesthetist (CRNA). A certified registered nurse anesthetist may provide covered care independent of physician referral and supervision as specified by state licensure. For purposes of CHAMPUS, a certified registered nurse anesthetist is an individual who:

(1) Is a licensed, registered nurse; and

(2) Is certified by the Council on Certification of Nurse Anesthetists, or its successor organization.

(K) Other individual paramedical providers. The services of the following individual professional providers of care to be considered for benefits on a fee-for-service basis may be provided only if the beneficiary is referred by a physician for the treatment of a medically-diagnosed condition and a physician must also provide continuing and ongoing oversight and supervision of the program or episode of treatment provided by these individual paramedical providers.

(1) Licensed registered nurses.

(2) Licensed registered physical therapists and occupational therapists.

(3) Licensed registered physical therapists.

(4) Audiologists.

(5) Speech therapists (speech pathologists).

(iv) Extramedical individual providers. Extramedical individual providers are those who do counseling or nonmedical therapy and whose training and therapeutic concepts are outside the medical field. The services of extramedical individual professionals are coverable following the CHAMPUS determined allowable charge methodology provided such services are otherwise authorized in this or other sections of the regulation.

(A) Certified marriage and family therapists. For the purposes of CHAMPUS, a certified marriage and family therapist is an individual who meets the following requirements:

(1) Recognized graduate professional education with the minimum of an earned master's degree from a regionally accredited educational institution in an appropriate behavioral science field, mental health discipline; and

(2) The following experience:

(i) Either 200 hours of approved supervision in the practice of marriage and family counseling, ordinarily to be completed in a 2- to 3-year period, of which at least 100 hours must be in individual supervision. This supervision will occur preferably with more than one

TMA Version - April 2005

supervisor and should include a continuous process of supervision with at least three cases; and

(ii) 1,000 hours of clinical experience in the practice of marriage and family counseling under approved supervision, involving at least 50 different cases; or

(iii) 150 hours of approved supervision in the practice of psychotherapy, ordinarily to be completed in a 2- to 3-year period, of which at least 50 hours must be individual supervision; plus at least 50 hours of approved individual supervision in the practice of marriage and family counseling, ordinarily to be completed within a period of not less than 1 nor more than 2 years; and

(iv) 750 hours of clinical experience in the practice of psychotherapy under approved supervision involving at least 30 cases; plus at least 250 hours of clinical practice in marriage and family counseling under approved supervision, involving at least 20 cases; and

(3) Is licensed or certified to practice as a marriage and family therapist by the jurisdiction where practicing (see paragraph (c)(3)(iv)(D) of this section for more specific information regarding licensure); and

(4) Agrees that a patients' organic medical problems must receive appropriate concurrent management by a physician.

(5) Agrees to accept the CHAMPUS determined allowable charge as payment in full, except for applicable deductibles and cost-shares, and hold CHAMPUS beneficiaries harmless for noncovered care (i.e., may not bill a beneficiary for noncovered care, and may not balance bill a beneficiary for amounts above the allowable charge). The certified marriage and family therapist must enter into a participation agreement with the Office of CHAMPUS within which the certified marriage and family therapist agrees to all provisions specified above.

(6) As of the effective date of termination, the certified marriage and family therapist will no longer be recognized as an authorized provider under CHAMPUS. Subsequent to termination, the certified marriage and family therapist may only be reinstated as an authorized CHAMPUS extramedical provider by entering into a new participation agreement as a certified marriage and family therapist.

(B) Pastoral counselors. For the purposes of CHAMPUS, a pastoral counselor is an individual who meets the following requirements:

(1) Recognized graduate professional education with the minimum of an earned master's degree from a regionally accredited educational institution in an appropriate behavioral science field, mental health discipline; and

(2) The following experience:

(i) Either 200 hours of approved supervision in the practice of pastoral counseling, ordinarily to be completed in a 2- to 3-year period, of which at least 100 hours must be in individual supervision. This supervision will occur preferably with more than one supervisor and should include a continuous process of supervision with at least three cases;

and

(ii) 1,000 hours of clinical experience in the practice of pastoral counseling under approved supervision, involving at least 50 different cases; or

(iii) 150 hours of approved supervision in the practice of psychotherapy, ordinarily to be completed in a 2- to 3-year period, of which at least 50 hours must be individual supervision; plus at least 50 hours of approved individual supervision in the practice of pastoral counseling, ordinarily to be completed within a period of not less than 1 nor more than 2 years; and

(iv) 750 hours of clinical experience in the practice of psychotherapy under approved supervision involving at least 30 cases; plus at least 250 hours of clinical practice in pastoral counseling under approved supervision, involving at least 20 cases; and

(3) Is licensed or certified to practice as a pastoral counselor by the jurisdiction where practicing (see paragraph (c)(3)(iv)(D) of this section for more specific information regarding licensure); and

(4) The services of a pastoral counselor meeting the above requirements are coverable following the CHAMPUS determined allowable charge methodology, under the following specified conditions:

(i) The CHAMPUS beneficiary must be referred for therapy by a physician; and

(ii) A physician is providing ongoing oversight and supervision of the therapy being provided; and

(iii) The pastoral counselor must certify on each claim for reimbursement that a written communication has been made or will be made to the referring physician of the results of the treatment. Such communication will be made at the end of the treatment, or more frequently, as required by the referring physician (refer to Sec. 199.7).

(5) Because of the similarity of the requirements for licensure, certification, experience, and education, a pastoral counselor may elect to be authorized under CHAMPUS as a certified marriage and family therapist, and as such, be subject to all previously defined criteria for the certified marriage and family therapist category, to include acceptance of the CHAMPUS determined allowable charge as payment in full, except for applicable deductibles and cost-shares (i.e., balance billing of a beneficiary above the allowable charge is prohibited; may not bill beneficiary for noncovered care). The pastoral counselor must also agree to enter into the same participation agreement as a certified marriage and family therapist with the Office of CHAMPUS within which the pastoral counselor agrees to all provisions including licensure, national association membership and conditions upon termination, outlined above for certified marriage and family therapist.

NOTE: No dual status will be recognized by the Office of CHAMPUS. Pastoral counselors must elect to become one of the categories of extramedical CHAMPUS provides specified above. Once authorized as either a pastoral counselor, or a certified marriage and family therapist, claims review and reimbursement will be in accordance with the criteria established for the elected provider category.

- (ii) Be institution-affiliated or freestanding as defined in Sec. 199.2; and
- (iii) Provide:
 - (A) Services and related supplies of a type rendered by CHAMPUS individual professional providers or diagnostic technical services and related supplies of a type which requires direct patient contact and a technologist who is licensed by the state in which the procedure is rendered or who is certified by a Qualified Accreditation Organization as defined in Sec. 199.2; and
 - (B) A level of care which does not necessitate that the beneficiary be provided with on-site sleeping accommodations and food in conjunction with the delivery of services; and
 - (iv) Complies with all applicable organizational and individual licensing or certification requirements that are extant in the state, county, municipality, or other political jurisdiction in which the provider renders services; and
 - (v) Be approved for Medicare payment when determined to be substantially comparable under the provisions of paragraph (f)(1)(iv)(D) of this section or, when Medicare approved status is not required, be accredited by a qualified accreditation organization, as defined in Sec. 199.2; and
 - (vi) Has entered into a participation agreement approved by the Director, OCHAMPUS, or designee, which at least complies with the minimum participation agreement requirements of this section.
- (3) Transfer of participation agreement. In order to provide continuity of care for beneficiaries when there is a change of provider ownership, the provider agreement is automatically assigned to the new owner, subject to all the terms and conditions under which the original agreement was made.
 - (i) The merger of the provider corporation or foundation into another corporation or foundation, or the consolidation of two or more corporations or foundations resulting in the creation of a new corporation or foundation, constitutes a change of ownership.
 - (ii) Transfer of corporate stock or the merger of another corporation or foundation into the provider corporation or foundation does not constitute change of ownership.
 - (iii) The surviving corporation or foundation shall notify the Director, OCHAMPUS, or designee, in writing of the change of ownership promptly after the effective date of the transfer or change in ownership.
- (4) Pricing and payment methodology: The pricing and payment of procedures rendered by a provider authorized under this paragraph (f) shall be limited to those methods for pricing and payment allowed by this part which the Director, OCHAMPUS, or designee, determines contribute to the efficient management of CHAMPUS.
- (5) Termination of participation agreement. A provider may terminate a participation agreement upon 45 days written notice to the Director, OCHAMPUS, or designee, and to the public.

[51 FR 24008, Jul 1, 1986; 67 FR 40602, Jun 13, 2002; 67 FR 42720, Jun 25, 2002; 68 FR 65174, Nov 19, 2003; 69 FR 29229, May 21, 2004; 69 FR 44591, Jul 28, 2004; 69 FR 51568, Aug 20, 2004; 69 FR 55359, Sep 14, 2004; 70 FR 61378, Oct 24, 2005; 72 FR 63988, Nov 14, 2007; 74 FR 44755, Aug 31, 2009; 74 FR 55777, Oct 29, 2009]

EDITORIAL NOTE: For Federal Register citations affecting Sec. 199.6, see the List of Sections Affected, which appears in the Finding Aids section of the printed volume and on GPO Access.

TMA Version - April 2005