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TRICARE
MANAGEMENT ACTIVITY

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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: CHANGES INCLUDED IN THE NATIONAL DEFENSE AUTHORIZATION ACT FOR FISCAL YEAR 2007; IMPROVEMENTS TO DESCRIPTIONS OF CANCER SCREENING FOR WOMEN

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REMOVE PAGE(S)

INSERT PAGE(S)

CHAPTER 4

Table of Contents, pages ix and x

Chapter pages 73 through 79

Table of Contents, pages ix and x

Chapter pages 73 through 79

(g) Exclusions and limitations. 64

(1) Not medically or psychologically necessary. 64

(2) Unnecessary diagnostic tests. 64

(3) Institutional level of care. 64

(4) Diagnostic admission. 65

(5) Unnecessary postpartum inpatient stay, mother or newborn. 65

(6) Therapeutic absences. 65

(7) Custodial care. 65

(8) Domiciliary care. 65

(9) Rest or rest cures. 65

(10) Amounts above allowable costs or charges. 65

(11) No legal obligation to pay, no charge would be made. 65

(12) Furnished without charge. 65

(13) Furnished by local, state, or Federal Government. 65

(14) Study, grant, or research programs. 65

(15) Unproven drugs, devices, and medical treatments or procedures. 66

 (iii) Care excluded. 67

 (iv) Examples of unproven drugs, devices or medical treatments or
 procedures. 67

(16) Immediate family, household. 71

(17) Double coverage. 71

(18) Nonavailability Statement required. 71

(19) Preauthorization required. 71

(20) Psychoanalysis or psychotherapy, part of education. 71

(21) Runaways. 72

(22) Services or supplies ordered by a court or other government agency. 72

(23) Work-related (occupational) disease or injury. 72

(24) Cosmetic, reconstructive, or plastic surgery. 72

(25) Surgery, psychological reasons. 72

(26) Electrolysis. 72

(27) Dental care. 72

(28) Obesity, weight reduction. 72

(29) Transsexualism or such other conditions as gender dysphoria. 72

(30) Therapy or counseling for sexual dysfunctions or sexual inadequacies. 72

(31) Corns, calluses, and toenails. 72

(32) Dyslexia. 72

(33) Surgical sterilization, reversal. 72

(34) Noncoital reproductive procedures including artificial insemination, in-vitro
fertilization, gamete intrafallopian transfer and all other such reproductive
technologies. 73

(35) Nonprescription contraceptives. 73

(36) Tests to determine paternity or sex of a child. 73

(37) Preventive care. 73

(38) Chiropractors and naturopaths. 74

(39) Counseling. 74

(40) Acupuncture. 74

TMA Version - April 2005

TMA Version - April 2005

(41) Hair transplants, wigs/hair pieces/cranial prosthesis.	74
(i) Benefits provided.	74
(ii) Exclusions.	74
(D) Any diagnostic or therapeutic method or supply intended to encourage hair regrowth.	74
(42) Education or training.	74
(43) Exercise/relaxation/comfort devices.	75
(44) Exercise.	75
(45) [Reserved].	75
(46) Vision care.	75
(47) Eye and hearing examinations.	75
(48) Prosthetic devices.	75
(49) Orthopedic shoes.	75
(50) Eyeglasses.	75
(51) Hearing aids.	75
(52) Telephone services.	75
(53) Air conditioners, humidifiers, dehumidifiers, and purifiers.	76
(54) Elevators or chair lifts.	76
(55) Alterations.	76
(56) Clothing.	76
(57) Food, food substitutes.	76
(58) Enuretic.	76
(59) Duplicate equipment.	76
(60) Autopsy and postmortem.	76
(61) Camping.	76
(62) Housekeeper, companion.	76
(63) Noncovered condition, unauthorized provider.	76
(64) Comfort or convenience.	76
(65) "Stop smoking" programs.	76
(66) Megavitamin psychiatric therapy, orthomolecular psychiatric therapy.	76
(67) Transportation.	76
(68) Travel.	76
(69) Institutions.	77
(70) [Reserved]	77
(71) [Reserved]	77
(72) Inpatient mental health services.	77
(73) Economic interest in connection with mental health admissions.	77
(74) Not specifically listed.	77

(h) Payment and liability for certain potentially excludable services under the Peer Review Organization program--	78
(1) Applicability.	78
(2) Payment for certain potentially excludable expenses.	78
(3) Liability for certain excludable services.	78
(4) Criteria for determining that beneficiary knew or could reasonably have been expected to have known that services were excludable.	78
(5) Criteria for determining that provider knew or could reasonably have been expected to have known that services were excludable.	78

(34) Noncoital reproductive procedures including artificial insemination, in-vitro fertilization, gamete intrafallopian transfer and all other such reproductive technologies. Services and supplies related to artificial insemination (including semen donors and semen banks), in-vitro fertilization, gamete intrafallopian transfer and all other noncoital reproductive technologies.

(35) Nonprescription contraceptives.

(36) Tests to determine paternity or sex of a child. Diagnostic tests to establish paternity of a child; or tests to determine sex of an unborn child.

(37) Preventive care. Preventive care, such as routine, annual, or employment-requested physical examinations; routine screening procedures; except that the following are not excluded:

- (i) Well-child care.
- (ii) Immunizations for individuals age six and older, as recommended by the CDC.
- (iii) Rabies shots.
- (iv) Tetanus shot following an accidental injury.
- (v) Rh immune globulin.
- (vi) Genetic tests as specified in paragraph (e)(3)(ii) of this section.
- (vii) Immunizations and physical examinations provided when required in the case of dependents of active duty military personnel who are traveling outside the United States as a result of an active duty member's assignment and such travel is being performed under orders issued by a Uniformed Service.
- (viii) Cervical and breast cancer screenings in accordance with standards issued by the Director, TRICARE Management Activity, based on guidelines from the U.S. Department of Health and Human Services. Such standards may establish a specific schedule, including frequency, age specifications, and gender of the beneficiary, as appropriate.
- (ix) Health promotion and disease prevention visits may include all of the services provided pursuant to Sec. 199.18(b)(2) and may be provided in connection with immunizations and cancer screening examinations authorized by paragraphs (g)(37)(ii) or (g)(37)(viii) of this section.
- (x) Physical examinations for beneficiaries ages 5-11 that are required in connection with school enrollment, and that are provided on or after October 30, 2000.
- (xi) Other cancer screenings authorized by 10 U.S.C. 1079.
- (xii) Health promotion and disease prevention visits (which may include all of the services provided pursuant to Sec. 199.18(b)(2)) may be provided in connection with immunizations and cancer screening examinations authorized by paragraphs (g)(37)(ii) of this section or

(g)(37)(viii) through (x) of this section.

(xiii) Physical examinations for beneficiaries ages 5 through 11 that are required in connection with school enrollment, and that are provided on or after October 30, 2000.

(38) Chiropractors and naturopaths. Services of chiropractors and naturopaths whether or not such services would be eligible for benefits if rendered by an authorized provider.

(39) Counseling. Counseling services that are not medically necessary in the treatment of a diagnosed medical condition: For example, educational counseling, vocational counseling, nutritional counseling, and counseling for socioeconomic purposes, stress management, lifestyle modification. Services provided by a certified marriage and family therapist, pastoral, or mental health counselor in the treatment of a mental disorder are covered only as specifically provided in Section 199.6. Services provided by alcoholism rehabilitation counselors are covered only when rendered in a CHAMPUS-authorized treatment setting and only when the cost of those services is included in the facility's CHAMPUS-determined allowable cost rate.

(40) Acupuncture. Acupuncture, whether used as a therapeutic agent or as an anesthetic.

(41) Hair transplants, wigs/hair pieces/cranial prosthesis.

NOTE: In accordance with section 744 of the DoD Appropriation Act for 1981 (Pub. L. 96-527), CHAMPUS coverage for wigs or hairpieces is permitted effective December 15, 1980, under the conditions listed below. Continued availability of benefits will depend on the language of the annual DoD Appropriation Acts.

(i) Benefits provided. Benefits may be extended, in accordance with the CHAMPUS-determined allowable charge, for one wig or hairpiece per beneficiary (lifetime maximum) when the attending physician certifies that alopecia has resulted from treatment of a malignant disease and the beneficiary certifies that a wig or hairpiece has not been obtained previously through the U.S. Government (including the Veterans Administration).

(ii) Exclusions. The wig or hairpiece benefit does not include coverage for the following:

(A) Alopecia resulting from conditions other than treatment of malignant disease.

(B) Maintenance, wig or hairpiece supplies, or replacement of the wig or hairpiece.

(C) Hair transplants or any other surgical procedure involving the attachment of hair or a wig or hairpiece to the scalp.

(D) Any diagnostic or therapeutic method or supply intended to encourage hair regrowth.

(42) Education or training. Self-help, academic education or vocational training services and supplies, unless the provisions of Sec. 199.4, paragraph (b)(1)(v) relating to general or special education, apply.

TMA Version - April 2005

(43) Exercise/relaxation/comfort devices. Exercise equipment, spas, whirlpools, hot tubs, swimming pools, health club membership or other such charges or items.

(44) Exercise. General exercise programs, even if recommended by a physician and regardless of whether or not rendered by an authorized provider. In addition, passive exercises and range of motion exercises also are excluded, except when prescribed by a physician and rendered by a physical therapist concurrent to, and as an integral part of, a comprehensive program of physical therapy.

(45) (Reserved).

(46) Vision care. Eye exercises or visual training (orthoptics).

(47) Eye and hearing examinations. Eye and hearing examinations except as specifically provided in paragraphs (c)(2)(xvi), (c)(3)(xi), and (e)(24) of this section, or except when rendered in connection with medical or surgical treatment of a covered illness or injury.

(48) Prosthetic devices. Prostheses other than those determined by the Director, OCHAMPUS to be necessary because of significant conditions resulting from trauma, congenital anomalies, or disease. All dental prostheses are excluded, except for those specifically required in connection with otherwise covered orthodontia directly related to the surgical correction of a cleft palate anomaly.

(49) Orthopedic shoes. Orthopedic shoes, arch supports, shoe inserts, and other supportive devices for the feet, including special-ordered, custom-made built-up shoes, or regular shoes later built up.

(50) Eyeglasses. Eyeglasses, spectacles, contact lenses, or other optical devices, except as specifically provided under paragraph (e)(6) of this section.

(51) Hearing aids. Hearing aids or other auditory sensory enhancing devices, except those allowed in paragraph (e)(24) of this section.

(52) Telephone services. Services or advice rendered by telephone are excluded, except that a diagnostic or monitoring procedure which incorporates electronic transmission of data or remote detection and measurement of a condition, activity, or function (biotelemetry) is not excluded when:

(i) The procedure without electronic transmission of data or biotelemetry is otherwise an explicit or derived benefit of this section; and

(ii) The addition of electronic transmission of data or biotelemetry to the procedure is found by the Director, CHAMPUS, or designee, to be medically necessary and appropriate medical care which usually improves the efficiency of the management of a clinical condition in defined circumstances; and

(iii) That each data transmission or biotelemetry device incorporated into a procedure that is otherwise an explicit or derived benefit of this section, has been classified by the U.S. Food and Drug Administration, either separately or as a part of a system, for use consistent with the defined circumstances in paragraph (g)(52)(ii) of this section.

- (53) Air conditioners, humidifiers, dehumidifiers, and purifiers.
- (54) Elevators or chair lifts.
- (55) Alterations. Alterations to living spaces or permanent features attached thereto, even when necessary to accommodate installation of covered durable medical equipment or to facilitate entrance or exit.
- (56) Clothing. Items of clothing or shoes, even if required by virtue of an allergy (such as cotton fabric as against synthetic fabric and vegetable-dyed shoes).
- (57) Food, food substitutes. Food, food substitutes, vitamins, or other nutritional supplements, including those related to prenatal care.
- (58) Enuretic. Enuretic conditioning programs, but enuretic alarms may be cost-shared when determined to be medically necessary in the treatment of enuresis.
- (59) Duplicate equipment. As defined in Sec. 199.2, duplicate equipment is excluded.
- (60) Autopsy and postmortem.
- (61) Camping. All camping even though organized for a specific therapeutic purpose (such as diabetic camp or a camp for emotionally disturbed children), and even though offered as a part of an otherwise covered treatment plan or offered through a CHAMPUS-approved facility.
- (62) Housekeeper, companion. Housekeeping, homemaker, or attendant services; sitter or companion.
- (63) Noncovered condition, unauthorized provider. All services and supplies (including inpatient institutional costs) related to a noncovered condition or treatment, or provided by an unauthorized provider.
- (64) Comfort or convenience. Personal, comfort, or convenience items such as beauty and barber services, radio, television, and telephone.
- (65) "Stop smoking" programs. Services and supplies related to "stop smoking" regimens.
- (66) Megavitamin psychiatric therapy, orthomolecular psychiatric therapy.
- (67) Transportation. All transportation except by ambulance, as specifically provided under paragraph (d), and except as authorized in paragraph (e)(5) of this section.
- (68) Travel. All travel even though prescribed by a physician and even if its purpose is to obtain medical care, except as specified in paragraph (a)(6) of this section in connection with a CHAMPUS-required physical examination and as specified in Sec. 199.17(n)(2)(vi).

(69) Institutions. Services and supplies provided by other than a hospital, unless the institution has been approved specifically by OCHAMPUS. Nursing homes, intermediate care facilities, halfway houses, homes for the aged, or institutions of similar purpose are excluded from consideration as approved facilities under the Basic Program.

NOTE: In order to be approved under CHAMPUS, an institution must, in addition to meeting CHAMPUS standards, provide a level of care for which CHAMPUS benefits are payable.

(70)–(71) [Reserved]

(72) Inpatient mental health services. Effective for care received on or after October 1, 1991, services in excess of 30 days in any fiscal year (or in an admission), in the case of a patient nineteen years of age or older, 45 days in any fiscal year (or in an admission) in the case of a patient under 19 years of age, or 150 days in any fiscal year (or in an admission) in the case of inpatient mental health services provided as residential treatment care, unless coverage for such services is granted by a waiver by the Director, OCHAMPUS, or a designee. In cases involving the day limitations, waivers shall be handled in accordance with paragraphs (b)(8) or (b)(9) of this section. For services prior to October 1, 1991, services in excess of 60 days in any calendar year unless additional coverage is granted by the Director, OCHAMPUS, or a designee.

(73) Economic interest in connection with mental health admissions. Inpatient mental health services (including both acute care and RTC services) are excluded for care received when a patient is referred to a provider of such services by a physician (or other health care professional with authority to admit) who has an economic interest in the facility to which the patient is referred, unless a waiver is granted. Requests for waiver shall be considered under the same procedure and based on the same criteria as used for obtaining preadmission authorization (or continued stay authorization for emergency admissions), with the only additional requirement being that the economic interest be disclosed as part of the request. The same reconsideration and appeals procedures that apply to day limit waivers shall also apply to decisions regarding requested waivers of the economic interest exclusion. However, a provider may appeal a reconsidered determination that an economic relationship constitutes an economic interest within the scope of the exclusion to the same extent that a provider may appeal determination under Sec. 199.15(i)(3). This exclusion does not apply to services under the Extended Care Health Option (ECHO) in Sec. 199.5 or provided as partial hospital care. If a situation arises where a decision is made to exclude CHAMPUS payment solely on the basis of the provider's economic interest, the normal CHAMPUS appeals process will be available.

(74) Not specifically listed. Services and supplies not specifically listed as a benefit in this part. This exclusion is not intended to preclude extending benefits for those services or supplies specifically determined to be covered within the intent of this part by the Director, OCHAMPUS, or a designee, even though not otherwise listed.

NOTE: The fact that a physician may prescribe, order, recommend, or approve a service or supply does not, of itself, make it medically necessary or make the charge an allowable expense, even though it is not listed specifically as an exclusion.

TMA Version - April 2005

(h) Payment and liability for certain potentially excludable services under the Peer Review Organization program--(1) Applicability. This subsection provides special rules that apply only to services retrospectively determined under the Peer Review organization (PRO) program (operated pursuant to Sec. 199.15) to be potentially excludable (in whole or in part) from the basic program under paragraph (g) of this section. Services may be excluded by reason of being not medically necessary (paragraph (g)(1) of this section), at an inappropriate level (paragraph (g)(3) of this section), custodial care (paragraph (g)(7) of this section) or other reason relative to reasonableness, necessity or appropriateness (which services shall throughout the remainder of this subsection, be referred to as “not medically necessary”). (Also throughout the remainder of the subsection, “services” includes items and “provider” includes supplier). This paragraph does not apply to coverage determinations made by OCHAMPUS or the fiscal intermediaries which are not based on medical necessity determinations made under the PRO program.

(2) Payment for certain potentially excludable expenses. Services determined under the PRO program to be potentially excludable by reason of the exclusions in paragraph (g) of this section for not medically necessary services will not be determined to be excludable if neither the beneficiary to whom the services were provided nor the provider (institutional or individual) who furnished the services knew, or could reasonably have been expected to know, that the services were subject to those exclusions. Payment may be made for such services as if the exclusions did not apply.

(3) Liability for certain excludable services. In any case in which items or services are determined excludable by the PRO program by reason of being not medically necessary and payment may not be made under paragraph (h)(2) of this section because the requirements of paragraph (h)(2) of this section are not met, the beneficiary may not be held liable (and shall be entitled to a full refund from the provider of the amount excluded and any cost share amount already paid) if:

- (i) The beneficiary did not know and could not reasonably have been expected to know that the services were excludable by reason of being not medically necessary; and
- (ii) The provider knew or could reasonably have been expected to know that the items or services were excludable by reason of being not medically necessary.

(4) Criteria for determining that beneficiary knew or could reasonably have been expected to have known that services were excludable. A beneficiary who receives services excludable by reason of being not medically necessary will be found to have known that the services were excludable if the beneficiary has been given written notice that the services were excludable or that similar or comparable services provided on a previous occasion were excludable and that notice was given by the OCHAMPUS, CHAMPUS PRO or fiscal intermediary, a group or committee responsible for utilization review for the provider, or the provider who provided the services.

(5) Criteria for determining that provider knew or could reasonably have been expected to have known that services were excludable. An institutional or individual provider will be found to have known or been reasonably expected to have known that

services were excludable under this subsection under any one of the following circumstances:

- (i) The PRO or fiscal intermediary had informed the provider that the services provided were excludable or that similar or reasonably comparable services were excludable.
- (ii) The utilization review group or committee for an institutional provider or the beneficiary's attending physician had informed the provider that the services provided were excludable.
- (iii) The provider had informed the beneficiary that the services were excludable.
- (iv) The provider had received written materials, including notices, manual issuances, bulletins, guides, directives or other materials, providing notification of PRO screening criteria specific to the condition of the beneficiary. Attending physicians who are members of the medical staff of an institutional provider will be found to have also received written materials provided to the institutional provider.
- (v) The services that are at issue are the subject of what are generally considered acceptable standards of practice by the local medical community.
- (vi) Preadmission authorization was available but not requested, or concurrent review requirements were not followed.

[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; 73 FR 74965, Dec. 10, 2008; 74 FR 34696, Jul. 17, 2009; 75 FR 47459, Aug. 6, 2010; **75 FR 47461, Aug. 6, 2010**]

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.

TMA Version - April 2005

