



TRICARE  
MANAGEMENT ACTIVITY

**MB&RB**

**OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE  
HEALTH AFFAIRS**

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

**FINAL RULE**

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

**CHANGE TITLE: TRICARE: NON-PHYSICIAN REFERRALS FOR PHYSICAL THERAPY,  
OCCUPATIONAL THERAPY, AND SPEECH THERAPY**

**FEDERAL REGISTER: Vol 75, No 159 (Pages 50880 - 50882)**

**PAGE CHANGE(S): See page 2.**

**ATTACHMENT(S): 15 PAGES  
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**WHEN PRESCRIBED ACTION HAS BEEN TAKEN, FILE THIS TRANSMITTAL WITH BASIC DOCUMENT.**

**REMOVE PAGE(S)**

**INSERT PAGE(S)**

**CHAPTER 4**

Chapter pages 27, 28, and 79

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**CHAPTER 6**

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(8) Collateral visits. Covered collateral visits are those that are medically or psychologically necessary for the treatment of the patient and, as such, are considered as a psychotherapy session for purposes of paragraph (c)(3)(ix)(B) of this section.

(B) Limitations and review requirements--(1) Outpatient psychotherapy. Outpatient psychotherapy generally is limited to a maximum of two psychotherapy sessions per week, in any combination of individual, family, conjoint, collateral, or group sessions. Before benefits can be extended for more than two outpatient psychotherapy sessions per week, professional review of the medical or psychological necessity for and appropriateness of the more intensive therapy is required.

(2) Inpatient psychotherapy. Coverage of inpatient psychotherapy is based on medical or psychological necessity for the services identified in the patient's treatment plan. As a general rule, up to five psychotherapy sessions per week are considered appropriate when specified in the treatment as necessary to meet certain measurable/observable goals and objectives. Additional sessions per week or more than one type of psychotherapy sessions performed on the same day (for example, an individual psychotherapy session and a family psychotherapy session on the same day) could be considered for coverage, depending on the medical or psychological necessity for the services. Benefits for inpatient psychotherapy will end automatically when authorization has been granted for the maximum number of inpatient mental health days in accordance with the limits as described in this section, unless additional coverage is granted by the Director, OCHAMPUS or a designee.

(C) Covered ancillary therapies. Includes art, music, dance, occupational, and other ancillary therapies, when included by the attending provider in an approved inpatient, residential treatment plan and under the clinical supervision of a licensed doctoral level mental health professional. These ancillary therapies are not separately reimbursed professional services but are included within the institutional reimbursement.

(D) Review of claims for treatment of mental disorder. The Director, OCHAMPUS, shall establish and maintain procedures for review, including professional review, of the services provided for the treatment of mental disorders.

(x) Physical and occupational therapy. Assessment and treatment services of a CHAMPUS-authorized physical or occupational therapist may be cost-shared when:

(A) The services are prescribed and monitored by a physician, certified physician assistant or certified nurse practitioner.

(B) The purpose of the prescription is to reduce the disabling effects of an illness, injury, or neuromuscular disorder; and

(C) The prescribed treatment increases, stabilizes, or slows the deterioration of the beneficiary's ability to perform specified purposeful activity in the manner, or within the range considered normal, for a human being.

(xi) Well-child care. Benefits routinely are covered for well-child care from birth to under six years of age. These periodic health examinations are designed for prevention, early detection and treatment of disease and consist of screening procedures, immunizations and risk counseling.

(A) The following services are covered when required as a part of the specific well-child care program and when rendered by the attending pediatrician, family physician, certified nurse practitioner, or certified physician assistant.

(1) Newborn examination, heredity and metabolic screening, and newborn circumcision.

(2) Periodic health supervision visits, in accordance with American Academy of Pediatrics (AAP) guidelines, intended to promote the optimal health for infants and children to include the following services:

(i) History and physical examination and mental health assessment.

(ii) Vision, hearing, and dental screening.

(iii) Developmental appraisal to include body measurement.

(iv) Immunizations as recommended by the Centers for Disease Control (CDC).

(v) Pediatric risk assessment for lead exposure and blood lead level test.

(vi) Tuberculosis screening.

(vii) Blood pressure screening.

(viii) Measurement of hemoglobin and hematocrit for anemia.

(ix) Urinalysis.

(x) Health guidance and counseling, including breastfeeding and nutrition counseling.

(B) Additional services or visits required because of specific findings or because the particular circumstances of the individual case are covered if medically necessary and otherwise authorized for benefits under CHAMPUS.

(C) The Deputy Assistant Secretary of Defense, Health Services Financing, will determine when such services are separately reimbursable apart from the health supervision visit.

(xii) (Reserved)

(xiii) Physicians in a teaching setting.

(A) Teaching physicians.

(1) General. The services of teaching physicians may be reimbursed on an allowable charge basis only when the teaching physician has established an attending physician relationship between the teaching physician and the patient or when the teaching physician provides distinct, identifiable, personal services (e.g., services rendered as a consultant, assistant surgeon, etc.). Attending physician services may include both direct patient care

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; **75 FR 50882, Aug. 18, 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.

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(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. *(1) 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.*

*(i) Licensed registered nurses.*

*(ii) Audiologists.*

*(2) 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, a certified physician assistant or certified nurse practitioner and a physician, a certified physician assistant, or certified nurse practitioner must also provide continuing and ongoing oversight and supervision of the program or episode of treatment provided by these individual paramedical providers.*

*(i) Licensed registered physical therapist and occupational therapist.*

*(ii) Licensed registered speech therapists (speech pathologists).*

(L) Nutritionist. A nutritionist may provide DSMT via an accredited DSMT program. The nutritionist must be licensed by the State in which the care is provided, and must be under the supervision of a physician who is overseeing the DSMT program.

(M) Registered Dietitian. A dietitian may provide DSMT via an accredited DSMT program. The dietitian must be licensed by the State in which the care is provided, and must be under the supervision of a physician who is overseeing the DSMT program.

(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.

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(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 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.

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(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

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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.

(C) Mental health counselor. For the purposes of CHAMPUS, a mental health counselor is an individual who meets the following requirements:

- (1) Minimum of a master's degree in mental health counseling or allied mental health field from a regionally accredited institution; and
- (2) Two years of post-masters experience which includes 3000 hours of clinical work and 100 hours of face-to-face supervision; and
- (3) Is licensed or certified to practice as a mental health counselor by the jurisdiction where practicing (see paragraph (c)(3)(iv)(D) of this section for more specific information); and
- (4) May only be reimbursed when:
  - (i) The CHAMPUS beneficiary is referred for therapy by a physician; and
  - (ii) A physician is providing ongoing oversight and supervision of the therapy being provided; and
  - (iii) The mental health counselor certifies 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).

(D) The following additional information applies to each of the above categories of extramedical individual providers:

- (1) These providers must also be licensed or certified to practice as a certified marriage and family therapist, pastoral counselor or mental health counselor by the jurisdiction where practicing. In jurisdictions that do not provide for licensure or certification, the provider must be certified by or eligible for full clinical membership in the appropriate national professional association that sets standards for the specific profession.
- (2) Grace period for therapists or counselors in states where licensure/certification is optional. CHAMPUS is providing a grace period for those therapists or counselors who did not obtain optional licensure/certification in their jurisdiction, not realizing it was a

CHAMPUS requirement for authorization. The exemption by state law for pastoral counselors may have misled this group into thinking licensure was not required. The same situation may have occurred with the other therapist or counselor categories where licensure was either not mandated by the state or was provided under a more general category such as "professional counselors." This grace period pertains only to the licensure/certification requirement, applies only to therapists or counselors who are already approved as of October 29, 1990, and only in those areas where the licensure/certification is optional. Any therapist or counselor who is not licensed/certified in the state in which he/she is practicing by August 1, 1991, will be terminated under the provisions of Sec. 199.9. This grace period does not change any of the other existing requirements which remain in effect. During this grace period, membership or proof of eligibility for full clinical membership in a recognized professional association is required for those therapists or counselors who are not licensed or certified by the state. The following organizations are recognized for therapists or counselors at the level indicated: Full clinical member of the American Association of Marriage and Family Therapy; membership at the fellow or diplomate level of the American Association of Pastoral Counselors; and membership in the National Academy of Certified Clinical Mental Health Counselors. Acceptable proof of eligibility for membership is a letter from the appropriate certifying organization. This opportunity for delayed certification/licensure is limited to the counselor or therapist category only as the language in all of the other provider categories has been consistent and unmodified from the time each of the other provider categories were added. The grace period does not apply in those states where licensure is mandatory.

(E) Christian Science practitioners and Christian Science nurses. CHAMPUS cost-shares the services of Christian Science practitioners and nurses. In order to bill as such, practitioners or nurses must be listed or be eligible for listing in the Christian Science Journal<sup>2</sup> at the time the service is provided.

**(d) Other providers.** Certain medical supplies and services of an ancillary or supplemental nature are coverable by CHAMPUS, subject to certain controls. This category of provider includes the following:

(1) Independent laboratory. Laboratory services of independent laboratories may be cost-shared if the laboratory is approved for participation under Medicare and certified by the Medicare Bureau, Health Care Financing Administration.

(2) Suppliers of portable x-ray services. Such suppliers must meet the conditions of coverage of the Medicare program, set forth in the Medicare regulations, or the Medicaid program in that state in which the covered service is provided.

(3) Pharmacies. Pharmacies must meet the applicable requirements of state law in the state in which the pharmacy is located. In addition to being subject to the policies and procedures for authorized providers established by this section, additional policies and procedures may be established for authorized pharmacies under Sec. 199.21 of this Part implementing the Pharmacy Benefits Program.

<sup>2</sup> Copies of this journal can be obtained through the Christian Science Publishing Company, 1 Norway Street, Boston, MA 02115-3122 or the Christian Science Publishing Society, P.O. Box 11369, Des Moines, IA 50340.

(4) Ambulance companies. Such companies must meet the requirements of state and local laws in the jurisdiction in which the ambulance firm is licensed.

(5) Medical equipment firms, medical supply firms, and Durable Medical Equipment, Prosthetic, Orthotic, Supplies providers/suppliers. Any firm, supplier, or provider that is an authorized provider under Medicare or is otherwise designated an authorized provider by the Director, TRICARE Management Activity.

(6) Mammography suppliers. Mammography services may be cost-shared only if the supplier is certified by Medicare for participation as a mammography supplier, or is certified by the American College of Radiology as having met its mammography supplier standards.

**(e) Extended Care Health Option Providers.**—(1) General. (i) Services and items cost-shared through Sec. 199.5 must be rendered by a CHAMPUS-authorized provider.

(ii) A Program for Persons with Disabilities (PPPWD) provider with TRICARE-authorized status on the effective date for the Extended Care Health Option (ECHO) Program shall be deemed to be a TRICARE-authorized provider until the expiration of all outstanding PFPWD benefit authorizations for services or items being rendered by the provider.

(2) ECHO provider categories--(i) ECHO inpatient care provider. A provider of residential institutional care, which is otherwise an ECHO benefit, shall be:

(A) A not-for-profit entity or a public facility; and

(B) Located within a state; and

(C) Be certified as eligible for Medicaid payment in accordance with a state plan for medical assistance under Title XIX of the Social Security Act (Medicaid) as a Medicaid Nursing Facility, or Intermediate Care Facility for the Mentally Retarded, or be a TRICARE-authorized institutional provider as defined in paragraph (b) of this section, or be approved by a state educational agency as a training institution.

(ii) ECHO outpatient care provider. A provider of ECHO outpatient, ambulatory, or in-home services shall be:

(A) A TRICARE-authorized provider of services as defined in this section; or

(B) An individual, corporation, foundation, or public entity that predominantly renders services of a type uniquely allowable as an ECHO benefit and not otherwise allowable as a benefit of Sec. 199.4, that meets all applicable licensing or other regulatory requirements of the state, county, municipality, or other political jurisdiction in which the ECHO service is rendered, or in the absence of such licensing or regulatory requirements, as determined by the Director, TRICARE Management Activity or designee.

(iii) ECHO vendor. A provider of an allowable ECHO item, such as supplies or equipment, shall be deemed to be a TRICARE-authorized vendor for the provision of the specific item, supply or equipment when the vendor supplies such information as the Director, TRICARE Management Activity or designee determines necessary to adjudicate a specific claim.

(3) ECHO provider exclusion or suspension. A provider of ECHO services or items may be excluded or suspended for a pattern of discrimination on the basis of disability. Such exclusion or suspension shall be accomplished according to the provisions of Sec. 199.9.

**(f) Corporate services providers—**(1) General. (i) This corporate services provider class is established to accommodate individuals who would meet the criteria for status as a CHAMPUS authorized individual professional provider as established by paragraph (c) of this section but for the fact that they are employed directly or contractually by a corporation or foundation that provides principally professional services which are within the scope of the CHAMPUS benefit.

(ii) Payment for otherwise allowable services may be made to a CHAMPUS-authorized corporate services provider subject to the applicable requirements, exclusions and limitations of this part.

(iii) The Director, OCHAMPUS, or designee, may create discrete types within any allowable category of provider established by this paragraph (f) to improve the efficiency of CHAMPUS management.

(iv) The Director, OCHAMPUS, or designee, may require, as a condition of authorization, that a specific category or type of provider established by this paragraph (f):

(A) Maintain certain accreditation in addition to or in lieu of the requirement of paragraph (f)(2)(v) of this section;

(B) Cooperate fully with a designated utilization and clinical quality management organization which has a contract with the Department of Defense for the geographic area in which the provider does business;

(C) Render services for which direct or indirect payment is expected to be made by CHAMPUS only after obtaining CHAMPUS written authorization; and

(D) Maintain Medicare approval for payment when the Director, OCHAMPUS, or designee, determines that a category, or type, of provider established by this paragraph (f) is substantially comparable to a provider or supplier for which Medicare has regulatory conditions of participation or conditions of coverage.

(v) Otherwise allowable services may be rendered at the authorized corporate services provider's place of business, or in the beneficiary's home under such circumstances as the Director, OCHAMPUS, or designee, determines to be necessary for the efficient delivery of such in-home services.

(vi) The Director, OCHAMPUS, or designee, may limit the term of a participation agreement for any category or type of provider established by this paragraph (f).

(vii) Corporate services providers shall be assigned to only one of the following allowable categories based upon the predominate type of procedure rendered by the organization;

(A) Medical treatment procedures;

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- (B) Surgical treatment procedures;
- (C) Maternity management procedures;
- (D) Rehabilitation and/or habilitation procedures; or
- (E) Diagnostic technical procedures.

(viii) The Director, OCHAMPUS, or designee, shall determine the appropriate procedural category of a qualified organization and may change the category based upon the provider's CHAMPUS claim characteristics. The category determination of the Director, OCHAMPUS, designee, is conclusive and may not be appealed.

(2) Conditions of authorization. An applicant must meet the following conditions to be eligible for authorization as a CHAMPUS corporate services provider:

- (i) Be a corporation or a foundation, but not a professional corporation or professional association; and
- (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.

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(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; 74 FR 65438, Dec 10, 2009; 75 FR 47460, Aug. 6, 2010; 75 FR 50882, Aug. 18, 2010]

**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.