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TRICARE
MANAGEMENT ACTIVITY

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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 REIMBURSEMENT REVISIONS

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

**CHANGE 51
32 CFR 199
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REMOVE PAGE(S)

INSERT PAGE(S)

CHAPTER 4

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CHAPTER 14

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(i) Benefit coverage. CHAMPUS beneficiaries who are terminally ill (that is, a life expectancy of six months or less if the disease runs its normal course) will be eligible for the following services and supplies in lieu of most other CHAMPUS benefits:

(A) Physician services.

(B) Nursing care provided by or under the supervision of a registered professional nurse.

(C) Medical social services provided by a social worker who has at least a bachelor's degree from a school accredited or approved by the Council on Social Work Education, and who is working under the direction of a physician. Medical social services include, but are not limited to the following:

(1) Assessment of social and emotional factors related to the beneficiary's illness, need for care, response to treatment, and adjustment to care.

(2) Assessment of the relationship of the beneficiary's medical and nursing requirements to the individual's home situation, financial resources, and availability of community resources.

(3) Appropriate action to obtain available community resources to assist in resolving the beneficiary's problem.

(4) Counseling services that are required by the beneficiary.

(D) Counseling services provided to the terminally ill individual and the family member or other persons caring for the individual at home. Counseling, including dietary counseling, may be provided both for the purpose of training the individual's family or other care-giver to provide care, and for the purpose of helping the individual and those caring for him or her to adjust to the individual's approaching death. Bereavement counseling, which consists of counseling services provided to the individual's family after the individual's death, is a required hospice service but it is not reimbursable.

(E) Home health aide services furnished by qualified aides and homemaker services. Home health aides may provide personal care services. Aides also may perform household services to maintain a safe and sanitary environment in areas of the home used by the patient. Examples of such services are changing the bed or light cleaning and laundering essential to the comfort and cleanliness of the patient. Aide services must be provided under the general supervision of a registered nurse. Homemaker services may include assistance in personal care, maintenance of a safe and healthy environment, and services to enable the individual to carry out the plan of care. Qualifications for home health aides can be found in 42 CFR 484.36.

(F) Medical appliances and supplies, including drugs and biologicals. Only drugs that are used primarily for the relief of pain and symptom control related to the individual's terminal illness are covered. Appliances may include covered durable medical equipment, as well as other self-help and personal comfort items related to the palliation or management of the patient's condition while he or she is under hospice care. Equipment is provided by the hospice for use in the beneficiary's home while he or she is under hospice care. Medical supplies include those that are part of the written plan of care. Medical appliances and supplies are included within the hospice all-inclusive rates.

(G) Physical therapy, occupational therapy and speech-language pathology services provided for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills.

(H) Short-term inpatient care provided in a Medicare participating hospice inpatient unit, or a Medicare participating hospital, skilled nursing facility (SNF) or, in the case of respite care, a Medicaid-certified nursing facility that additionally meets the special hospice standards regarding staffing and patient areas. Services provided in an inpatient setting must conform to the written plan of care. Inpatient care may be required for procedures necessary for pain control or acute or chronic symptom management. Inpatient care may also be furnished to provide respite for the individual's family or other persons caring for the individual at home. Respite care is the only type of inpatient care that may be provided in a Medicaid-certified nursing facility. The limitations on custodial care and personal comfort items applicable to other CHAMPUS services are not applicable to hospice care.

(ii) Core services. The hospice must ensure that substantially all core services are routinely provided directly by hospice employees; i.e., physician services, nursing care, medical social services, and counseling for individuals and care givers. Refer to paragraphs (e)(19)(i)(A), (e)(19)(i)(B), (e)(19)(i)(C), and (e)(19)(i)(D) of this section.

(iii) Non-core services. While non-core services (i.e., home health aide services, medical appliances and supplies, drugs and biologicals, physical therapy, occupational therapy, speech-language pathology and short-term inpatient care) may be provided under arrangements with other agencies or organizations, the hospice must maintain professional management of the patient at all times and in all settings. Refer to paragraphs (e)(19)(i)(E), (e)(19)(i)(F), (e)(19)(i)(G), and (e)(19)(i)(H) of this section.

(iv) Availability of services. The hospice must make nursing services, physician services, and drugs and biologicals routinely available on a 24-hour basis. All other covered services must be made available on a 24-hour basis to the extent necessary to meet the needs of individuals for care that is reasonable and necessary for the palliation and management of the terminal illness and related condition. These services must be provided in a manner consistent with accepted standards of practice.

(v) **Periods of care. Hospice care is divided into distinct periods of care. The periods of care that may be elected by the terminally ill CHAMPUS beneficiary shall be as the Director, TRICARE determines to be appropriate, but shall not be less than those offered under Medicare's Hospice Program.**

(vi) Conditions for coverage. The CHAMPUS beneficiary must meet the following conditions/criteria in order to be eligible for the hospice benefits and services referenced in paragraph (e)(19)(i) of this section.

(A) There must be written certification in the medical record that the CHAMPUS beneficiary is terminally ill with a life expectancy of six months or less if the terminal illness runs its normal course.

(1) Timing of certification. The hospice must obtain written certification of terminal illness for each of the election periods described in paragraph (e)(19)(vi)(B) of this section, even if a single election continues in effect for two, three or four periods.

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.

(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; 75 FR 50882, Aug 18, 2010; 75 FR 2253, Jan 13, 2011; 76 FR 8297, Feb 14, 2011; 76 FR 57642, Sep 16, 2011; 76 FR 80743, Dec 27, 2011; 76 FR 81370, Dec 28, 2011; **77 FR 38175, Jun 27, 2012**]

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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(iv) Payment to a hospital transferring an inpatient to another hospital. If a hospital subject to the CHAMPUS DRG-based payment system transfers an inpatient to another such hospital, the transferring hospital shall be paid a per diem rate (except that in neonatal cases, other than normal newborns, the hospital will be paid at 125 percent of that per diem rate), as determined under instructions issued by TSO, for each day of the patient's stay in that hospital, not to exceed the DRG-based payment that would have been paid if the patient had been discharged to another setting. For admissions occurring on or after October 1, 1995, the transferring hospital shall be paid twice the per diem rate for the first day of any transfer stay, and the per diem amount for each subsequent day, up to the limit described in this paragraph.

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

(D) DRG system updates. The CHAMPUS DRG-based payment system is modeled on the Medicare Prospective Payment System (PPS) and uses annually updated items and numbers from the Medicare PPS as provided for in this part and in instructions issued by the Director, OCHAMPUS. The effective date of these items and numbers shall correspond to that under the Medicare PPS except where distinctions are made in this part.

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

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

(C) Services exempt from the DRG-based payment system. The following hospital services, even when provided in a hospital subject to the CHAMPUS DRG-based payment system, are exempt from the CHAMPUS DRG-based payment system. The services in paragraphs (a)(1)(ii)(C)(1) through (a)(1)(ii)(C)(4) and (a)(1)(ii)(C)(7) through (a)(1)(ii)(C)(9) of this section shall be reimbursed under the procedures in paragraph (a)(3) of this section, and the services in paragraphs (a)(1)(ii)(C)(5) and (a)(1)(ii)(C)(6) of this section shall be reimbursed under the procedures in paragraph (g) of this section.

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

(2) All services related to solid organ acquisition for CHAMPUS covered transplants by CHAMPUS-authorized transplantation centers.

(3) All services related to heart and liver transplantation for admissions prior to October 1, 1998, which would otherwise be paid under the respective DRG.

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- (4) All services related to CHAMPUS covered solid organ transplantations for which there is no DRG assignment.
 - (5) All professional services provided by hospital-based physicians.
 - (6) All services provided by nurse anesthetists.
 - (7) All services related to discharges involving pediatric bone marrow transplants (patient under 18 at admission).
 - (8) All services related to discharges involving children who have been determined to be HIV seropositive (patient under 18 at admission).
 - (9) All services related to discharges involving pediatric cystic fibrosis (patient under 18 at admission).
 - (10) For admissions occurring on or after October 1, 1990, and before October 1, 1994, and for discharges occurring on or after October 1, 1997, the costs of blood clotting factor for hemophilia inpatients. An additional payment shall be made to a hospital for each unit of blood clotting factor furnished to a CHAMPUS inpatient who is hemophiliac in accordance with the amounts established under the Medicare Prospective Payment System (42 CFR 412.115).
- (D) Hospitals subject to the CHAMPUS DRG-based payment system. All hospitals within the fifty states, the District of Columbia, and Puerto Rico which are certified to provide services to CHAMPUS beneficiaries are subject to the DRG-based payment system except for the following hospitals or hospital units which are exempt.
- (1) Psychiatric hospitals. A psychiatric hospital which is exempt from the Medicare Prospective Payment System is also exempt from the CHAMPUS DRG-based payment system. In order for a psychiatric hospital which does not participate in Medicare to be exempt from the CHAMPUS DRG-based payment system, it must meet the same criteria (as determined by the Director, OCHAMPUS, or a designee) as required for exemption from the Medicare Prospective Payment System as contained in 42 CFR 412.23.
 - (2) Rehabilitation hospitals. A rehabilitation hospital which is exempt from the Medicare Prospective Payment System is also exempt from the CHAMPUS DRG-based payment system. In order for a rehabilitation hospital which does not participate in Medicare to be exempt from the CHAMPUS DRG-based payment system, it must meet the same criteria (as determined by the Director, OCHAMPUS, or a designee) as required for exemption from the Medicare Prospective Payment System as contained in 42 CFR 412.23.
 - (3) Psychiatric and rehabilitation units (distinct parts). A psychiatric or rehabilitation unit which is exempt from the Medicare prospective payment system is also exempt from the CHAMPUS DRG-based payment system. In order for a distinct unit which does not participate in Medicare to be exempt from the CHAMPUS DRG-based payment system, it must meet the same criteria (as determined by the Director, OCHAMPUS, or a designee) as required for exemption from the Medicare Prospective Payment System as contained in 42 CFR 412.23.

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

(5) Hospitals within hospitals. A hospital within a hospital which is exempt from the Medicare prospective payment system is also exempt from the CHAMPUS DRG-based payment system. In order for a hospital within a hospital which does not participate in Medicare to be exempt from the CHAMPUS DRG-based payment system, it must meet the same criteria (as determined by the Director, TSO, or a designee) as required for exemption from the Medicare Prospective Payment System as contained in 42 CFR 412.22 and the criteria for one or more of the excluded hospital classifications described in Sec. 412.23 of Title 42 CFR.

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

(7) Christian Science sanitoriums. All Christian Science sanitoriums (as defined in paragraph (b)(4)(viii) of Sec. 199.6) are exempt from the CHAMPUS DRG-based payment system.

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

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

(10) CAHs. Effective December 1, 2009, any facility which has been designated and certified as a CAH as contained in 42 CFR Part 485.606 is exempt from the CHAMPUS DRG-based payment system.

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

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(F) Substance Use Disorder Rehabilitation facilities. With admissions on or after July 1, 1995, substance use disorder rehabilitation facilities, authorized under Sec. 199.6(b)(4)(xiv), are subject to the DRG-based payment system.

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

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

(2) Remove DRGs. Those DRGs that represent discharges with invalid data or diagnoses insufficient for DRG assignment purposes are removed from the database.

(3) Indirect medical education standardization. To standardize the charges for the cost effects of indirect medical education factors, each teaching hospital's charges will be divided by 1.0 plus the following ratio on a hospital-specific basis:

$$1.43 \times \left[\left(1.0 + \frac{\text{number of interns + residents}}{\text{number of beds}} \right) 5.795 - 1.0 \right]$$

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

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

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

(7) Calculation of national average charge per discharge. A national average charge per discharge shall be calculated by summing all charges and dividing that sum by the total number of records from all DRG categories.

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

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

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

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

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

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

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

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

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

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

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

(C) For purposes of establishing laboratory service local CMACs pursuant to paragraph (j)(1)(iv) of this section, the adjustment factor shall equal the ratio of the local average charge

(standardized for the distribution of clinical laboratory services) to the national average charge for all clinical laboratory services during the base period.

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

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

(x) A charge that exceeds the CHAMPUS Maximum Allowable Charge can be determined to be allowable only when unusual circumstances or medical complications justify the higher charge. The allowable charge may not exceed the billed charge under any circumstances.

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

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

(4) Alternative method. The Director, OCHAMPUS, or a designee, may, subject to the approval of the ASD(HA), establish an alternative method of reimbursement designed to produce reasonable control over health care costs and to ensure a high level of acceptance of the CHAMPUS-determined charge by the individual health-care professionals or other noninstitutional health-care providers furnishing services and supplies to CHAMPUS

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beneficiaries. Alternative methods may not result in reimbursement greater than the allowable charge method above.

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

(l) Reimbursement Under the Military-Civilian Health Services Partnership Program.

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

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

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

(m) Accommodation of Discounts Under Provider Reimbursement Methods.

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

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

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

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

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

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

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

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

[55 FR 13266, Apr 10, 1990, as amended at 55 FR 31180, Aug 1, 1990; 55 FR 42562, Oct 22, 1990; 55 FR 43342, Oct 29, 1990; 56 FR 44006, Sep 6, 1991; 56 FR 50273, Oct 4, 1991; 58 FR 35408, Jul 1, 1993; 58 FR 51239, Oct 1, 1993; 58 FR 58961, Nov 5, 1993; 60 FR 6019, Feb 1, 1995; 60 FR 12437, Mar 7, 1995; 60 FR 52094, Oct 5, 1995; 63 FR 7287, Feb 13, 1998; 63 FR 48446, Sep 10, 1998; 63 FR 56082, Oct 21, 1998; 64 FR 60671, Nov 8, 1999; 65 FR 41003, Jul 3, 2000; 67 FR 45172, Aug 28, 2001; 67 FR 18115, Apr 15, 2002; 67 FR 40604, Jun 13, 2002; 69 FR 60555, Oct 12, 2004; 70 FR 61378, Oct 24, 2005; 72 FR 63988, Nov 14, 2007; 73 FR 46809, Aug 12, 2008; 73 FR 74965, Dec 10, 2008; 74 FR 44755, Aug 31, 2009; **77 FR 38175, Jun 27, 2012**]

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

(a) * * *

(1) * * *

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(iii) * * *

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

* * * * *

(D) * * *

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