



OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
HEALTH AFFAIRS

16401 EAST CENTRETECH PARKWAY
AURORA, COLORADO 80011-9066

TRICARE
MANAGEMENT ACTIVITY

MB&RB

**CHANGE 54
32 CFR 199
FEBRUARY 26, 2013**

**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; ELIMINATION OF NON-AVAILABILITY STATEMENT (NAS) REQUIREMENT FOR NON-EMERGENCY INPATIENT MENTAL HEALTH CARE

FEDERAL REGISTER: Vol 78, No 38 (Pages 12951 - 12953)

PAGE CHANGE(S): See page 2.

ATTACHMENT(S): 36 PAGES
DISTRIBUTION: 32 CFR 199

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

CHANGE 54
32 CFR 199
FEBRUARY 26, 2013

REMOVE PAGE(S)

INSERT PAGE(S)

CHAPTER 4

Table of Contents, pages i through viii

Chapter pages 3 through 28, 75, and 76

Table of Contents, pages i through viii

Chapter pages 3 through 28, 75, and 76

BASIC PROGRAM BENEFITS

(a) General.....	1
(1)	1
(i) Scope of benefits.....	1
(ii) Impact of TRICARE program.....	1
(2) Persons eligible for Basic Program benefits.....	1
(3) Authority to act for CHAMPUS.....	1
(4) Status of patient controlling for purposes of cost-sharing.....	1
(5) Right to information.....	1
(6) Physical examinations.....	2
(7) Claims filing deadline.....	2
(8) Double coverage and third party recoveries.....	2
(9) Nonavailability Statements within a 40-mile catchment area.....	3
(10) [Reserved].....	4
(11) Quality and Utilization Review Peer Review Organization program.....	4
(12) Utilization review, quality assurance and reauthorization for inpatient mental health services and partial hospitalization.....	4
(i) In general.....	4
(ii) Preadmission authorization.....	4
(13) Implementing instructions.....	5
 (b) Institutional benefits.....	 5
(1) General.....	5
(i) Billing practices.....	5
(ii) Successive inpatient admissions.....	6
(iii) Related services and supplies.....	6
(iv) Inpatient, appropriate level required.....	6
(v) General or special education not covered.....	6
(2) Covered hospital services and supplies--	6
(i) Room and board.....	6
(ii) General staff nursing services.....	6
(iii) ICU.....	6
(iv) Operating room, recovery room.....	6
(v) Drugs and medicines.....	7
(vi) Durable medical equipment, medical supplies, and dressings.....	7
(vii) Diagnostic services.....	7
(viii) Anesthesia.....	7
(ix) Blood.....	7
(x) Radiation therapy.....	7
(xi) Physical therapy.....	7
(xii) Oxygen.....	7
(xiii) Intravenous injections.....	7
(xiv) Shock therapy.....	7
(xv) Chemotherapy.....	7
(xvi) Renal and peritoneal dialysis.....	7
(xvii) Psychological evaluation tests.....	7

TMA Version - April 2005

TMA Version - April 2005

	(xviii) Other medical services.	7
(3)	Covered services and supplies provided by special medical treatment institutions or facilities, other than hospitals or RTCs--	8
	(i) Room and board.	8
	(ii) General staff nursing services.	8
	(iii) Drugs and medicines.	8
	(iv) Durable medical equipment, medical supplies, and dressings.	8
	(v) Diagnostic services.	8
	(vi) Blood.	8
	(vii) Physical therapy.	8
	(viii) Oxygen.	8
	(ix) Intravenous injections.	8
	(x) Shock therapy.	8
	(xi) Chemotherapy.	8
	(xii) Psychological evaluation tests.	8
	(xiii) Renal and peritoneal dialysis.	8
	(xiv) Skilled nursing facility (SNF) services.	8
	(xv) Other medical services.	9
(4)	Services and supplies provided by RTCs--	9
	(i) Room and board.	9
	(ii) Patient assessment.	9
	(iii) Diagnostic services.	9
	(iv) Psychological evaluation tests.	10
	(v) Treatment of mental disorders.	10
	(vi) Other necessary medical care.	10
	(vii) Criteria for determining medical or psychological necessity.	10
	(viii) Preauthorization requirement.	11
	(ix) Concurrent review.	11
(5)	Extent of institutional benefits--	12
	(i) Inpatient room accommodations--	12
	(A) Semiprivate.	12
	(B) Private.	12
	(C) Duration of private room stay.	12
	(D) Hospital (except an acute care hospital, general or special) or other authorized institutional provider without semiprivate accommodations.	12
	(ii) General staff nursing services.	12
	(iii) ICU.	13
	(iv) Treatment rooms.	13
	(v) Drugs and medicines.	13
	(vi) Durable medical equipment, medical supplies, and dressings.	13
	(vii) Transitional use items.	14
	(viii) Anesthetics and oxygen.	14
(6)	Inpatient mental health services.	14
	(i) Criteria for determining medical or psychological necessity.	14
	(ii) Emergency admissions.	14
	(iii) Preauthorization requirements.	15
	(iv) Concurrent review.	16

TMA Version - April 2005

(7) Emergency inpatient hospital services. 16

 (i) Existence of medical emergency. 16

 (ii) Immediate admission required. 16

 (iii) Closest hospital utilized. 16

(8) RTC day limit. 16

 (ii) Waiver of the RTC day limit. 17

(9) Acute care day limits. 17

 (iii) Waiver of the acute care day limits. 18

(10) Psychiatric partial hospitalization services. 18

 (i) In general. 18

 (ii) Criteria for determining medical or psychological necessity of
 psychiatric partial hospitalization services. 18

 (iii) Preauthorization and concurrent review requirements. 19

 (iv) Institutional benefits limited to 60 days. 19

 (v) Waiver of the 60-day partial hospitalization program limit. 19

 (vi) Services and supplies. 20

 (A) Board. 20

 (B) Patient assessment. 20

 (C) Psychological testing. 20

 (D) Treatment services. 20

 (vii) Social services required. 20

 (viii) Educational services required. 20

 (ix) Family therapy required. 20

 (x) Professional mental health benefits limited. 21

 (xi) Non-mental health related medical services. 21

(c) Professional services benefit-- 21

 (1) General. 21

 (i) Billing practices. 21

 (ii) Services must be related. 21

 (2) Covered services of physicians and other authorized profession providers. 21

 (i) Surgery. 21

 (ii) Surgical assistance. 23

 (iii) Inpatient medical services. 23

 (iv) Outpatient medical services. 23

 (v) Psychiatric services. 23

 (vi) Consultation services. 23

 (vii) Anesthesia services. 23

 (viii) Radiation therapy services. 23

 (ix) X-ray services. 23

 (x) Laboratory and pathological services. 23

 (xi) Physical medicine services or physiatry services. 23

 (xii) Maternity care. 23

 (xiii) Well-child care. 23

 (xiv) Other medical care. 23

 (xv) [Reserved] 23

 (xvi) Routine eye examinations. 23

TMA Version - April 2005

- (3) Extent of professional benefits-- 23
 - (i) Multiple Surgery. 23
 - (ii) Different types of inpatient care, concurrent. 24
 - (iii) Need for surgical assistance. 24
 - (iv) Aftercare following surgery. 24
 - (v) Cast and sutures, removal. 25
 - (vi) Inpatient care, concurrent. 25
 - (vii) Consultants who become the attending surgeon. 25
 - (viii) Anesthesia administered by the attending physician. 25
 - (ix) Treatment of mental disorders. 25
 - (A) Covered diagnostic and therapeutic services. 26
 - (1) Individual psychotherapy, adult or child. 26
 - (2) Group psychotherapy. 26
 - (3) Family or conjoint psychotherapy. 26
 - (4) Psychoanalysis. 26
 - (5) Psychological testing and assessment. 26
 - (6) Administration of psychotropic drugs. 26
 - (7) Electroconvulsive treatment. 26
 - (8) Collateral visits. 26
 - (B) Limitations and review requirements-- 27
 - (1) Outpatient psychotherapy. 27
 - (2) Inpatient psychotherapy. 27
 - (C) Covered ancillary therapies. 27
 - (D) Review of claims for treatment of mental disorder. 27
 - (x) Physical and occupational therapy. 27
 - (xi) Well-child care. 27
 - (i) History and physical examination and mental health assessment. 28
 - (ii) Vision, hearing, and dental screening. 28
 - (iii) Developmental appraisal to include body measurement. 28
 - (iv) Immunizations as recommended by the Centers for Disease Control (CDC). 28
 - (v) Pediatric risk assessment for lead exposure and blood lead level test. 28
 - (vi) Tuberculosis screening. 28
 - (vii) Blood pressure screening. 28
 - (viii) Measurement of hemoglobin and hematocrit for anemia. 28
 - (ix) Urinalysis. 28
 - (x) Health guidance and counseling, including breastfeeding and nutrition counseling. 28
 - (xii) [Reserved] 28
 - (xiii) Physicians in a teaching setting. 28
 - (A) Teaching physicians. 28
 - (1) General. 28
 - (2) Direct supervision by an attending physician of care provided by physicians in training. 29
 - (3) Individual, personal services. 29
 - (4) Who may bill. 29

(B) Physicians in training. 29

(d) Other benefits-- 30

(1) General. 30

(2) Billing practices. 30

(3) Other covered services and supplies-- 30

(i) Blood. 30

(ii) Durable medical equipment-- 30

(A) Scope of benefit. 30

(B) Cardiorespiratory monitor exception. 31

(C) Basic mobility equipment exception. 32

(D) Exclusions. 32

(E) Basis for reimbursement. 32

(iii) Medical supplies and dressings (consumables). 32

(iv) Oxygen. 32

(v) Ambulance. 32

(vi) Prescription drugs and medicines. 33

(vii) Prosthetics, prosthetic devices, and prosthetic supplies, 34

(viii) Orthopedic braces and appliances. 34

(ix) Diabetes Self-Management Training (DSMT). 34

(e) Special benefit information-- 34

(1) General. 34

(2) Abortion. 34

(3) Family planning. 35

(i) Birth control (such as contraception)-- 35

(A) Benefits provided. 35

(B) Exclusions. 35

(ii) Genetic testing. 35

(A) Benefits provided. 35

(B) Exclusions. 36

(4) Treatment of substance use disorders. 36

(i) Emergency and inpatient hospital services. 36

(ii) Authorized substance use disorder treatment. 36

(A) Rehabilitative care. 36

(B) Outpatient care. 37

(C) Family therapy. 37

(iii) Exclusions-- 37

(A) Aversion therapy. 37

(B) Domiciliary settings. 37

(iv) Confidentiality. 37

(v) Waiver of benefit limits. 37

(5) Transplants. 37

(i) Organ transplants. 37

(A) General. 38

(B) [Reserved] 39

(ii) Stem cell transplants. 39

(6) Eyeglasses, spectacles, contact lenses, or other optical devices. 39

(i) Exception to general exclusion. 39

(ii) Limitations. 39

TMA Version - April 2005

TMA Version - April 2005

- (7) Transsexualism or such other conditions as gender dysphoria. 39
- (8) Cosmetic, reconstructive, or plastic surgery. 40
 - (i) Limited benefits under CHAMPUS. 40
 - (ii) General exclusions. 40
 - (iii) Noncovered surgery, all related services and supplies excluded. 41
 - (iv) Example of noncovered cosmetic, reconstructive, or plastic surgery procedures. 41
 - (C) Augmentation mammoplasties. 41
 - (E) Reduction mammoplasties. 41
- (9) Complications (unfortunate sequelae) resulting from noncovered initial surgery or treatment. 42
- (10) Dental. 42
 - (i) Adjunctive dental care: Limited. 42
 - (ii) General exclusions. 43
 - (iii) Preauthorization required. 43
 - (iv) Covered oral surgery. 44
 - (v) Inpatient hospital stay in connection with non-adjunctive, noncovered dental care. 44
 - (vi) Anesthesia and institutional costs for dental care for children and certain other patients. 45
- (11) Drug abuse. 45
 - (i) Limitations on who can prescribe drugs. 45
 - (ii) Drug maintenance programs excluded. 45
 - (iii) Kinds of prescription drugs that are monitored carefully by CHAMPUS for possible abuse situations-- 45
 - (A) Narcotics. 45
 - (B) Nonnarcotic analgesics. 45
 - (C) Tranquilizers. 45
 - (D) Barbiturates. 45
 - (E) Nonbarbituate hypnotics. 45
 - (F) Stimulants. 45
 - (iv) CHAMPUS fiscal intermediary responsibilities. 45
 - (v) Unethical or illegal provider practices related to drugs. 46
 - (vi) Detoxification. 46
- (12) [Reserved] 46
- (13) Domiciliary care. 46
 - (i) Examples of domiciliary care situations. 46
 - (A) Home care is not available. 46
 - (B) Home care is not suitable. 46
 - (C) Family unwilling to care for a person in the home. 47
 - (ii) Benefits available in connection with a domiciliary care case. 47
 - (iii) General exclusion. 47
- (14) CT scanning-- 47
 - (i) Approved CT scan services. 47
 - (ii) Review guidelines and criteria. 47
- (15) Morbid obesity. 47
 - (i) Conditions for coverage. 48
 - (ii) Treatment of complications. 48
 - (iii) Exclusions. 48

CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES (CHAMPUS)

BASIC PROGRAM BENEFITS

PART 199.4

TMA Version - April 2005

(16) Maternity care. 48
 (i) Benefit. 48
 (ii) Cost-share. 48
 (17) Biofeedback Therapy. 49
 (i) Benefits Provided. 49
 (ii) Limitations. 49
 (iii) Exclusions. 49
 (iv) Provider Requirements. 49
 (v) Implementation Guidelines. 49
 (18) Cardiac rehabilitation. 49
 (i) Benefits Provided. 50
 (ii) Limitations. 50
 (iii) Exclusions. 50
 (iv) Providers. 50
 (v) Payment. 50
 (vi) Implementation Guidelines. 50
 (19) Hospice care. 50
 (i) Benefit coverage. 51
 (ii) Core services. 52
 (iii) Non-core services. 52
 (iv) Availability of services. 52
 (v) Periods of care. 52
 (vi) Conditions for coverage. 52
 (1) Timing of certification. 52
 (i) Basic requirement. 53
 (ii) Exception. 53
 (2) Sources of certification. 53
 (vii) Appeal rights under hospice benefit. 55
 (20) [Reserved] 55
 (21) Home health services. 55
 (i) Benefit coverage. 56
 (ii) Conditions for Coverage. 56
 (22) Pulmonary rehabilitation. 57
 (23) A speech generating device (SGD) 57
 (24) A hearing aid, 57
 (25) Rehabilitation therapy. 57
 (26) National Institutes of Health clinical trials. 58
 (i) Demonstration waiver. 58
 (ii) Continuous waiver. 58
 (A) General. 58
 (B) National Cancer Institute (NCI) sponsored cancer prevention,
 screening, and early detection clinical trials. 58
 (28) Preventive care. 59
 (29) Physical examinations. 60
(f) Beneficiary or sponsor liability-- 60
 (1) General. 60

TMA Version - April 2005

- (2) Dependents of members of the Uniformed Services. 60
 - (i) Annual fiscal year deductible for outpatient services and supplies.. . . . 60
 - (1) Individual Deductible: 60
 - (2) Family Deductible: 60
 - (1) Individual Deductible: 61
 - (2) Family Deductible: 61
 - (D) Allowable Amount does not exceed Deductible Amount. 61
 - (ii) Inpatient cost-sharing. 62
 - (A) Inpatient cost-sharing payable with each separate inpatient admission. 62
 - (B) Multiple family inpatient admissions. 62
 - (C) Newborn patient in his or her own right. 62
 - (D) Inpatient cost-sharing for mental health services. 62
 - (iii) Outpatient cost-sharing. 62
 - (iv) Ambulatory surgery. 63
 - (v) Psychiatric partial hospitalization services. 63
 - (vi) Transitional Assistance Management Program (TAMP). 63
- (3) Former members and dependents of former members. 63
 - (i) Annual fiscal year deductible for outpatient services or supplies. 63
 - (ii) Inpatient cost-sharing. 63
 - (A) Services subject to the CHAMPUS DRG-based payment system. 63
 - (B) Services subject to the CHAMPUS mental health per diem payment system. 63
 - (C) Other services. 64
 - (iii) Outpatient cost-sharing. 64
 - (iv) Psychiatric partial hospitalization services. 64
- (4) Former spouses. 64
 - (i) Annual fiscal year deductible for outpatient services or supplies. 64
 - (ii) Inpatient cost-sharing. 64
 - (iii) Outpatient cost-sharing. 64
- (5) Cost-Sharing under the Military-Civilian Health Services Partnership Program. . 64
 - (i) External Partnership Agreement. 64
 - (ii) Internal Partnership Agreement. 64
- (6) [Reserved] 64
- (7) [Reserved] 64
- (8) Cost-sharing for services provided under special discount arrangements-- 65
 - (i) General rule. 65
 - (ii) Specific applications. 65
- (9) Waiver of deductible amounts or cost-sharing not allowed-- 65
 - (i) General rule. 65
 - (ii) Exception for bad debts. 65
 - (iii) Remedies for noncompliance. 65
- (10) Catastrophic loss protection for basic program benefits. 65
 - (i) Dependents of active duty members. 65
 - (ii) All other beneficiaries. 65
 - (iii) Payment after cap is met. 66
- (11) Beneficiary or sponsor liability under the Pharmacy Benefits Program. 66
- (12) Elimination of cost-sharing for certain preventive services. 66

a third party, are specifically subject to the provisions of Sec. 199.8 or Sec. 199.12 of this part as appropriate.

(9) Nonavailability Statements within a 40-mile catchment area. Unless required by action of the Assistant Secretary of Defense for Health Affairs (ASD(HA)) under this paragraph (a)(9), nonavailability statements are not required. If they are required by ASD(HA) action, in some geographic locations, CHAMPUS beneficiaries not enrolled in TRICARE Prime may be required to obtain a nonavailability statement from a military medical treatment facility in order to receive specifically identified health care services from a civilian provider. If the required care cannot be provided through the Uniformed Service facility, the hospital commander, or a designee, will issue a Nonavailability Statement (NAS) (DD Form 1251). Failure to secure such a statement may waive the beneficiary's rights to benefits under CHAMPUS/TRICARE.

(i) With the exception of maternity services, the ASD(HA) may require an NAS prior to TRICARE cost-sharing for additional services from civilian sources if such services are to be provided to a beneficiary who lives within a 40-mile catchment area of an MTF where such services are available and the ASD(HA):

(A) Demonstrates that significant costs would be avoided by performing specific procedures at the affected MTF or MTFs; or

(B) Determines that a specific procedure must be provided at the affected MTF or MTFs to ensure the proficiency levels of the practitioners at the MTF or MTFs; or

(C) Determines that the lack of NAS data would significantly interfere with TRICARE contract administration; and

(D) Provides notification of the ASD(HA)'s intent to require an NAS under this authority to covered beneficiaries who receive care at the MTF or MTFs that will be affected by the decision to require an NAS under this authority; and

(E) Provides at least 60-day notification to the Committees on Armed Services of the House of Representatives and the Senate of the ASD(HA)'s intent to require an NAS under this authority, the reason for the NAS requirement, and the date that an NAS will be required.

(ii) Rules in effect at the time civilian medical care is provided apply. The applicable rules and regulations regarding Nonavailability Statements in effect at the time the civilian care is rendered apply in determining whether a NAS is required.

(iii) The Director, TMA is responsible for issuing the procedural rules and regulations regarding Nonavailability Statements. Such rules and regulations should address:

(A) When and for what services a NAS is required. However, a NAS may not be required for services otherwise available at an MTF located within a 40-mile radius of the beneficiary's residence when another insurance plan or program provides the beneficiary's primary coverage for the services. This requirement for an NAS does not apply to beneficiaries enrolled in TRICARE Prime, even when those beneficiaries use the point-of-service option under Sec. 199.17(n)(3) of this part; and

TMA Version - April 2005

(B) When and how notifications will be made to a beneficiary who is not enrolled in TRICARE Prime as to whether or not he or she resides in a geographic area that requires obtaining a NAS; and

(C) What information relating to claims submissions, including the documentation, if any, that is required to document that a valid NAS was issued. However, when documentation of a NAS is required, then that documentation shall be valid for the adjudication of CHAMPUS claims for all related care otherwise authorized by this part which is received from a civilian source while the beneficiary resided within the Uniformed Service facility catchment area which issued the NAS.

(iv) In the case of any service subject to a NAS requirement under this paragraph (a)(9) and also subject to a preadmission (or other pre-service) authorization requirement under Sec. 199.4 or Sec. 199.15 of this part, the administrative processes for the NAS and pre-service authorization may be combined.

(10) (Reserved)

(11) Quality and Utilization Review Peer Review Organization program. All benefits under the CHAMPUS program are subject to review under the CHAMPUS Quality and Utilization Review Peer Review Organization program pursuant to Sec. 199.15. (Utilization and quality review of mental health services are also part of the Peer Review Organization program, and are addressed in paragraph (a)(12) of this section.)

(12) Utilization review, quality assurance and reauthorization for inpatient mental health services and partial hospitalization. (i) In general. The Director, OCHAMPUS shall provide, either directly or through contract, a program of utilization and quality review for all mental health care services. Among other things, this program shall include mandatory preadmission authorization before nonemergency inpatient mental health services may be provided and mandatory approval of continuation of inpatient services within 72 hours of emergency admissions. This program shall also include requirements for other pretreatment authorization procedures, concurrent review of continuing inpatient and partial hospitalization, retrospective review, and other such procedures as determined appropriate by the Director, OCHAMPUS. The provisions of paragraph (h) of this section and Sec. 199.15(f) shall apply to this program. The Director, OCHAMPUS, shall establish, pursuant to that Sec. 199.15(f), procedures substantially comparable to requirements of paragraph (h) of this section and Sec. 199.15. If the utilization and quality review program for mental health care services is provided by contract, the contractor(s) need not be the same contractor(s) as are engaged under Sec. 199.15 in connection with the review of other services.

(ii) Preadmission authorization. (A) This section generally requires preadmission authorization for all non-emergency inpatient mental health services and prompt continued stay authorization after emergency admissions with the exception noted in paragraph (a)(12)(ii) of this section. It also requires preadmission authorization for all admissions to a partial hospitalization program, without exception, as the concept of an emergency admission does not pertain to a partial hospitalization level of care. Institutional services for which payment would otherwise be authorized, but which were provided without compliance with preadmission authorization requirements, do not qualify for the same payment that would be provided if the preadmission requirements had been met.

(B) In cases of noncompliance with preauthorization requirements, a payment reduction shall be made in accordance with Sec. 199.15(b)(4)(iii).

(C) For purposes of paragraph (a)(12)(ii)(B) of this section, a day of services without the appropriate preauthorization is any day of services provided prior to:

- (1) The receipt of an authorization; or
- (2) The effective date of an authorization subsequently received.

(D) Services for which payment is disallowed under paragraph (a)(12)(ii)(B) of this section may not be billed to the patient (or the patient's family).

(E) Preadmission authorization for inpatient mental health services is not required in the following cases:

- (1) In the case of an emergency.
- (2) In a case in which benefits are payable for such services under part A of title XVIII of the Social Security Act (42 U.S.C. 1395c *et seq.*) subject to paragraph (a)(12)(iii) of this section.
- (3) In a case of inpatient mental health services in which paragraph (a)(12)(ii) of this section applies, the Secretary shall require advance authorization for a continuation of the provision of such services after benefits cease to be payable for such services under such part A.

(13) Implementing instructions. The Director, OCHAMPUS shall issue policies, procedures, instructions, guidelines, standards and/or criteria to implement this section.

(b) Institutional benefits. (1) General. Services and supplies provided by an institutional provider authorized as set forth in Sec. 199.6 may be cost-shared only when such services or supplies: are otherwise authorized by this part; are medically necessary; are ordered, directed, prescribed, or delivered by an OCHAMPUS-authorized individual professional provider as set forth in Sec. 199.6 or by an employee of the authorized institutional provider who is otherwise eligible to be a CHAMPUS authorized individual professional provider; are delivered in accordance with generally accepted norms for clinical practice in the United States; meet established quality standards; and comply with applicable definitions, conditions, limitations, exceptions, or exclusions as otherwise set forth in this part.

(i) Billing practices. To be considered for benefits under Sec. 199.4(b), covered services and supplies must be provided and billed for by a hospital or other authorized institutional provider. Such billings must be fully itemized and sufficiently descriptive to permit CHAMPUS to determine whether benefits are authorized by this part. Depending on the individual circumstances, teaching physician services may be considered an institutional benefit in accordance with Sec. 199.4(b) or a professional benefit under Sec. 199.4(c). See paragraph (c)(3)(xiii) of this section for the CHAMPUS requirements regarding teaching physicians. In the case of continuous care, claims shall be submitted to the appropriate CHAMPUS fiscal intermediary at least every 30 days either by the beneficiary or sponsor or, on a participating basis, directly by the facility on behalf of the beneficiary (refer to Sec. 199.7).

(ii) Successive inpatient admissions. Successive inpatient admissions shall be deemed one inpatient confinement for the purpose of computing the active duty dependent's share of the inpatient institutional charges, provided not more than 60 days have elapsed between the successive admissions, except that successive inpatient admissions related to a single maternity episode shall be considered one confinement, regardless of the number of days between admissions. For the purpose of applying benefits, successive admissions will be determined separately for maternity admissions and admissions related to an accidental injury (refer to Sec. 199.4(f)).

(iii) Related services and supplies. Covered services and supplies must be rendered in connection with and related directly to a covered diagnosis or definitive set of symptoms requiring otherwise authorized medically necessary treatment.

(iv) Inpatient, appropriate level required. For purposes of inpatient care, the level of institutional care for which Basic Program benefits may be extended must be at the appropriate level required to provide the medically necessary treatment except for patients requiring skilled nursing facility care. For patients for whom skilled nursing facility care is adequate, but is not available in the general locality, benefits may be continued in the higher level care facility. General locality means an area that includes all the skilled nursing facilities within 50 miles of the higher level facility, unless the higher level facility can demonstrate that the skilled nursing facilities are inaccessible to its patients. The decision as to whether a skilled nursing facility is within the higher level facility's general locality, or the skilled nursing facility is inaccessible to the higher level facility's patients shall be a CHAMPUS contractor initial determination for the purposes of appeal under Sec. 199.10 of this part. CHAMPUS institutional benefit payments shall be limited to the allowable cost that would have been incurred in the skilled nursing facility, as determined by the Director, OCHAMPUS, or a designee. If it is determined that the institutional care can be provided reasonably in the home setting, no CHAMPUS institutional benefits are payable.

(v) General or special education not covered. Services and supplies related to the provision of either regular or special education generally are not covered. Such exclusion applies whether a separate charge is made for education or whether it is included as a part of an overall combined daily charge of an institution. In the latter instance, that portion of the overall combined daily charge related to education must be determined, based on the allowable costs of the educational component, and deleted from the institution's charges before CHAMPUS benefits can be extended. The only exception is when appropriate education is not available from or not payable by the cognizant public entity. Each case must be referred to the Director, OCHAMPUS, or a designee, for review and a determination of the applicability of CHAMPUS benefits.

(2) Covered hospital services and supplies--(i) Room and board. Includes special diets, laundry services, and other general housekeeping support services (inpatient only).

(ii) General staff nursing services.

(iii) ICU. Includes specialized units, such as for respiratory conditions, cardiac surgery, coronary care, burn care, or neurosurgery (inpatient only).

(iv) Operating room, recovery room. Operating room and recovery room, including other special treatment rooms and equipment, and hyperbaric chamber.

TMA Version - April 2005

(v) Drugs and medicines. Includes sera, biologicals, and pharmaceutical preparations (including insulin) that are listed in the official formularies of the institution or facility at the time of use. (To be considered as an inpatient supply, drugs and medicines must be consumed during the specific period the beneficiary is a registered inpatient. Drugs and medicines prescribed for use outside the hospital, even though prescribed and obtained while still a registered inpatient, will be considered outpatient supplies and the provisions of paragraph (d) of this section will apply.)

(vi) Durable medical equipment, medical supplies, and dressings. Includes durable medical equipment, medical supplies essential to a surgical procedure (such as artificial heart valve and artificial ball and socket joint), sterile trays, casts, and orthopedic hardware. Use of durable medical equipment is restricted to an inpatient basis.

NOTE: If durable medical equipment is to be used on an outpatient basis or continued in outpatient status after use as an inpatient, benefits will be provided as set forth in paragraph (d) of this section and cost-sharing will be on an outpatient basis (refer to paragraph (a)(4) of this section).

(vii) Diagnostic services. Includes clinical laboratory examinations, x-ray examinations, pathological examinations, and machine tests that produce hard-copy results. Also includes CT scanning under certain limited conditions.

(viii) Anesthesia. Includes both the anesthetic agent and its administration.

(ix) Blood. Includes blood, plasma and its derivatives, including equipment and supplies, and its administration.

(x) Radiation therapy. Includes radioisotopes.

(xi) Physical therapy.

(xii) Oxygen. Includes equipment for its administration.

(xiii) Intravenous injections. Includes solution.

(xiv) Shock therapy.

(xv) Chemotherapy.

(xvi) Renal and peritoneal dialysis.

(xvii) Psychological evaluation tests. When required by the diagnosis.

(xviii) Other medical services. Includes such other medical services as may be authorized by the Director, OCHAMPUS, or a designee, provided they are related directly to the diagnosis or definitive set of symptoms and rendered by a member of the institution's medical or professional staff (either salaried or contractual) and billed for by the hospital.

(3) Covered services and supplies provided by special medical treatment institutions or facilities, other than hospitals or RTCs--(i) Room and board. Includes special diets, laundry services, and other general housekeeping support services (inpatient only).

(ii) General staff nursing services.

(iii) Drugs and medicines. Includes sera, biologicals, and pharmaceutical preparations (including insulin) that are listed in the official formularies of the institution or facility at the time of use. (To be considered as an inpatient supply, drugs and medicines must be consumed during the specific period the beneficiary is a registered inpatient. Drugs and medicines prescribed for use outside the authorized institutional provider, even though prescribed and obtained while still a registered inpatient, will be considered outpatient supplies and the provisions of paragraph (d) of this section will apply.)

(iv) Durable medical equipment, medical supplies, and dressings. Includes durable medical equipment, sterile trays, casts, orthopedic hardware and dressings. Use of durable medical equipment is restricted to an inpatient basis.

NOTE: If the durable medical equipment is to be used on an outpatient basis or continued in outpatient status after use as an inpatient, benefits will be provided as set forth in paragraph (d) of this section, and cost-sharing will be on an outpatient basis (refer to paragraph (a)(4) of this section).

(v) Diagnostic services. Includes clinical laboratory examinations, x-ray examinations, pathological examination, and machine tests that produce hard-copy results.

(vi) Blood. Includes blood, plasma and its derivatives, including equipment and supplies, and its administration.

(vii) Physical therapy.

(viii) Oxygen. Includes equipment for its administration.

(ix) Intravenous injections. Includes solution.

(x) Shock therapy.

(xi) Chemotherapy.

(xii) Psychological evaluation tests. When required by the diagnosis.

(xiii) Renal and peritoneal dialysis.

(xiv) Skilled nursing facility (SNF) services. Covered services in SNFs are the same as provided under Medicare under section 1861(h) and (i) of the Social Security Act (42 U.S.C. 1395x(h) and (i)) and 42 CFR part 409, subparts C and D, except that the Medicare limitation on the number of days of coverage under section 1812(a) and (b) of the Social Security Act (42 U.S.C. 1395d(a) and (b)) and 42 CFR 409.61(b) shall not be applicable under TRICARE. Skilled nursing facility care for each spell of illness shall continue to be provided for as long

as medically necessary and appropriate. For a SNF admission to be covered under TRICARE, the beneficiary must have a qualifying hospital stay meaning an inpatient hospital stay of three consecutive days or more, not including the hospital leave day. The beneficiary must enter the SNF within 30 days of leaving the hospital, or within such time as it would be medically appropriate to begin an active course of treatment, where the individual's condition is such that SNF care would not be medically appropriate within 30 days after discharge from a hospital. The skilled services must be for a medical condition that was either treated during the qualifying three-day hospital stay, or started while the beneficiary was already receiving covered SNF care. Additionally, an individual shall be deemed not to have been discharged from a SNF, if within 30 days after discharge from a SNF, the individual is again admitted to a SNF. Adoption by TRICARE of most Medicare coverage standards does not include Medicare coinsurance amounts. Extended care services furnished to an inpatient of a SNF by such SNF (except as provided in paragraphs (b)(3)(xiv)(C), (b)(3)(xiv)(F), and (b)(3)(xiv)(G) of this section) include:

- (A) Nursing care provided by or under the supervision of a registered professional nurse;
 - (B) Bed and board in connection with the furnishing of such nursing care;
 - (C) Physical or occupational therapy or speech-language pathology services furnished by the SNF or by others under arrangements with them by the facility;
 - (D) Medical social services;
 - (E) Such drugs, biological, supplies, appliances, and equipment, furnished for use in the SNF, as are ordinarily furnished for the care and treatment of inpatients;
 - (F) Medical services provided by an intern or resident-in-training of a hospital with which the facility has such an agreement in effect; and
 - (G) Such other services necessary to the health of the patients as are generally provided by SNFs, or by others under arrangements with them made by the facility.
- (xv) Other medical services. Other medical services may be authorized by the Director, OCHAMPUS, or a designee, provided they are related directly to the diagnosis or definitive set of symptoms and rendered by a member of the institution's medical or professional staff (either salaried or contractual) and billed for by the authorized institutional provider of care.
- (4) Services and supplies provided by RTCs--(i) Room and board. Includes use of residential facilities such as food service (including special diets), laundry services, supervised reasonable recreational and social activity services, and other general services as considered appropriate by the Director, OCHAMPUS, or a designee.
 - (ii) Patient assessment. Includes the assessment of each child or adolescent accepted by the RTC, including clinical consideration of each of his or her fundamental needs, that is, physical, psychological, chronological age, developmental level, family, educational, social, environmental, and recreational.
 - (iii) Diagnostic services. Includes clinical laboratory examinations, x-ray examinations, pathological examinations, and machine tests that produce hard-copy results.

TMA Version - April 2005

- (iv) Psychological evaluation tests.
- (v) Treatment of mental disorders. Services and supplies that are medically or psychologically necessary to diagnose and treat the mental disorder for which the patient was admitted to the RTC. Covered services and requirements for qualifications of providers are as listed in paragraph (c)(3)(ix) of this section.
- (vi) Other necessary medical care. Emergency medical services or other authorized medical care may be rendered by the RTC provided it is professionally capable of rendering such services and meets standards required by the Director, OCHAMPUS. It is intended, however, that CHAMPUS payments to an RTC should primarily cover those services and supplies directly related to the treatment of mental disorders that require residential care.
- (vii) Criteria for determining medical or psychological necessity. In determining the medical or psychological necessity of services and supplies provided by RTCs, the evaluation conducted by the Director, OCHAMPUS (or designee) shall consider the appropriate level of care for the patient, the intensity of services required by the patient, and the availability of that care. In addition to the criteria set forth in this paragraph (b)(4) of this section, additional evaluation standards, consistent with such criteria, may be adopted by the Director, OCHAMPUS (or designee). RTC services and supplies shall not be considered medically or psychologically necessary unless, at a minimum, all the following criteria are clinically determined in the evaluation to be fully met:
 - (A) Patient has a diagnosable psychiatric disorder.
 - (B) Patient exhibits patterns of disruptive behavior with evidence of disturbances in family functioning or social relationships and persistent psychological and/or emotional disturbances.
 - (C) RTC services involve active clinical treatment under an individualized treatment plan that provides for:
 - (1) Specific level of care, and measurable goals/objectives relevant to each of the problems identified;
 - (2) Skilled interventions by qualified mental health professionals to assist the patient and/or family;
 - (3) Time frames for achieving proposed outcomes; and
 - (4) Evaluation of treatment progress to include timely reviews and updates as appropriate of the patient's treatment plan that reflects alterations in the treatment regimen, the measurable goals/objectives, and the level of care required for each of the patient's problems, and explanations of any failure to achieve the treatment goals/objectives.
 - (D) Unless therapeutically contraindicated, the family and/or guardian must actively participate in the continuing care of the patient either through direct involvement at the facility or geographically distant family therapy. (In the latter case, the treatment center must document that there has been collaboration with the family and/or guardian in all reviews.)

(viii) Preauthorization requirement.(A) All admissions to RTC care are elective and must be certified as medically/psychologically necessary prior to admission. The criteria for preauthorization shall be those set forth in paragraph (b)(4)(vii) of this section. In applying those criteria in the context of preadmission authorization review, special emphasis is placed on the development of a specific diagnosis/treatment plan, consistent with those criteria and reasonably expected to be effective, for that individual patient.

(B) The timetable for development of the individualized treatment plan shall be as follows:

(1) The plan must be under development at the time of the admission.

(2) A preliminary treatment plan must be established within 24 hours of the admission.

(3) A master treatment plan must be established within ten calendar days of the admission.

(C) The elements of the individualized treatment plan must include:

(1) The diagnostic evaluation that establishes the necessity for the admission;

(2) An assessment regarding the inappropriateness of services at a less intensive level of care;

(3) A comprehensive, biopsychosocial assessment and diagnostic formulation;

(4) A specific individualized treatment plan that integrates measurable goals/objectives and their required level of care for each of the patient's problems that are a focus of treatment;

(5) A specific plan for involvement of family members, unless therapeutically contraindicated; and

(6) A discharge plan, including an objective of referring the patient to further services, if needed, at less intensive levels of care within the benefit limited period.

(D) Preauthorization requests should be made not fewer than two business days prior to the planned admission. In general, the decision regarding preauthorization shall be made within one business day of receipt of a request for preauthorization, and shall be followed with written confirmation. Preauthorizations are valid for the period of time, appropriate to the type of care involved, stated when the preauthorization is issued. In general, preauthorizations are valid for 30 days.

(ix) Concurrent review. Concurrent review of the necessity for continued stay will be conducted no less frequently than every 30 days. The criteria for concurrent review shall be those set forth in paragraph (b)(4)(vii) of this section. In applying those criteria in the context of concurrent review, special emphasis is placed on evaluating the progress being made in the active individualized clinical treatment being provided and on developing appropriate discharge plans.

TMA Version - April 2005

(5) Extent of institutional benefits--(i) Inpatient room accommodations--

(A) Semiprivate. The allowable costs for room and board furnished an individual patient are payable for semiprivate accommodations in a hospital or other authorized institution, subject to appropriate cost-sharing provisions (refer to paragraph (f) of this section). A semiprivate accommodation is a room containing at least two beds. Therefore, if a room publicly is designated by the institution as a semiprivate accommodation and contains multiple beds, it qualifies as semiprivate for the purpose of CHAMPUS.

(B) Private. A room with one bed that is designated as a private room by the hospital or other authorized institutional provider. The allowable cost of a private room accommodation is covered only under the following conditions:

(1) When its use is required medically and when the attending physician certifies that a private room is necessary medically for the proper care and treatment of a patient; or

(2) When a patient's medical condition requires isolation; or

(3) When a patient (in need of immediate inpatient care but not requiring a private room) is admitted to a hospital or other authorized institution that has semiprivate accommodations, but at the time of admission, such accommodations are occupied; or

(4) When a patient is admitted to an acute care hospital (general or special) without semiprivate rooms.

(C) Duration of private room stay. The allowable cost of private accommodations is covered under the circumstances described in paragraph (b)(5)(i)(B) of this section until the patient's condition no longer requires the private room for medical reasons or medical isolation; or, in the case of the patient not requiring a private room, when a semiprivate accommodation becomes available; or, in the case of an acute care hospital (general or special) which does not have semiprivate rooms, for the duration of an otherwise covered inpatient stay.

(D) Hospital (except an acute care hospital, general or special) or other authorized institutional provider without semiprivate accommodations. When a beneficiary is admitted to a hospital (except an acute care hospital, general or special) or other institution that has no semiprivate accommodations, for any inpatient day when the patient qualifies for use of a private room (as set forth in paragraphs (b)(5)(i)(B)(1) and (2) of this section) the allowable cost of private accommodations is covered. For any inpatient day in such a hospital or other authorized institution when the patient does not require medically the private room, the allowable cost of semiprivate accommodations is covered, such allowable costs to be determined by the Director, OCHAMPUS, or a designee.

(ii) General staff nursing services. General staff nursing services cover all nursing care (other than that provided by private duty nurses) including, but not limited to, general duty nursing, emergency room nursing, recovery room nursing, intensive nursing care, and group nursing arrangements. Only nursing services provided by nursing personnel on the payroll of the hospital or other authorized institution are eligible under paragraph (b) of this section. If a nurse who is not on the payroll of the hospital or other authorized institution is called in specifically to care for a single patient (individual nursing) or more than one patient (group nursing), whether the patient is billed for the nursing services directly or through the

hospital or other institution, such services constitute private duty (special) nursing services and are not eligible for benefits under this paragraph (the provisions of paragraph (c)(2)(xv) of this section would apply).

(iii) ICU. An ICU is a special segregated unit of a hospital in which patients are concentrated, by reason of serious illness, usually without regard to diagnosis. Special lifesaving techniques and equipment are available regularly and immediately within the unit, and patients are under continuous observation by a nursing staff specially trained and selected for the care of this type of patient. The unit is maintained on a continuing, rather than an intermittent or temporary, basis. It is not a postoperative recovery room or a postanesthesia room. In some large or highly specialized hospitals, the ICUs may be refined further for special purposes, such as for respiratory conditions, cardiac surgery, coronary care, burn care, or neurosurgery. For purposes of CHAMPUS, these specialized units would be considered ICUs if they otherwise conformed to the definition of an ICU.

(iv) Treatment rooms. Standard treatment rooms include emergency rooms, operating rooms, recovery rooms, special treatment rooms, and hyperbaric chambers and all related necessary medical staff and equipment. To be recognized for purposes of CHAMPUS, treatment rooms must be so designated and maintained by the hospital or other authorized institutions on a continuing basis. A treatment room set up on an intermittent or temporary basis would not be so recognized.

(v) Drugs and medicines. Drugs and medicines are included as a supply of a hospital or other authorized institution only under the following conditions:

- (A) They represent a cost to the facility rendering treatment;
- (B) They are furnished to a patient receiving treatment, and are related directly to that treatment; and
- (C) They are ordinarily furnished by the facility for the care and treatment of inpatients.

(vi) Durable medical equipment, medical supplies, and dressings. Durable medical equipment, medical supplies, and dressings are included as a supply of a hospital or other authorized institution only under the following conditions:

- (A) If ordinarily furnished by the facility for the care and treatment of patients; and
- (B) If specifically related to, and in connection with, the condition for which the patient is being treated; and
- (C) If ordinarily furnished to a patient for use in the hospital or other authorized institution (except in the case of a temporary or disposable item); and

(D) Use of durable medical equipment is limited to those items provided while the patient is an inpatient. If such equipment is provided for use on an outpatient basis, the provisions of paragraph (d) of this section apply.

(vii) Transitional use items. Under certain circumstances, a temporary or disposable item may be provided for use beyond an inpatient stay, when such item is necessary medically to permit or facilitate the patient's departure from the hospital or other authorized institution, or which may be required until such time as the patient can obtain a continuing supply; or it would be unreasonable or impossible from a medical standpoint to discontinue the patient's use of the item at the time of termination of his or her stay as an inpatient.

(viii) Anesthetics and oxygen. Anesthetics and oxygen and their administration are considered a service or supply if furnished by the hospital or other authorized institution, or by others under arrangements made by the facility under which the billing for such services is made through the facility.

(6) Inpatient mental health services. Inpatient mental health services are those services furnished by institutional and professional providers for treatment of a nervous or mental disorder (as defined in Sec. 199.2) to a patient admitted to a CHAMPUS-authorized acute care general hospital; a psychiatric hospital; or, unless otherwise exempted, a special institutional provider.

(i) Criteria for determining medical or psychological necessity. In determining the medical or psychological necessity of acute inpatient mental health services, the evaluation conducted by the Director, OCHAMPUS (or designee) shall consider the appropriate level of care for the patient, the intensity of services required by the patient, and the availability of that care. The purpose of such acute inpatient care is to stabilize a life-threatening or severely disabling condition within the context of a brief, intensive model of inpatient care in order to permit management of the patient's condition at a less intensive level of care. Such care is appropriate only if the patient requires services of an intensity and nature that are generally recognized as being effectively and safely provided only in an acute inpatient hospital setting. In addition to the criteria set forth in this paragraph (b)(6) of this section, additional evaluation standards, consistent with such criteria, may be adopted by the Director, OCHAMPUS (or designee). Acute inpatient care shall not be considered necessary unless the patient needs to be observed and assessed on a 24-hour basis by skilled nursing staff, and/or requires continued intervention by a multidisciplinary treatment team; and in addition, at least one of the following criteria is determined to be met:

(A) Patient poses a serious risk of harm to self and/or others.

(B) Patient is in need of high dosage, intensive medication or somatic and/or psychological treatment, with potentially serious side effects.

(C) Patient has acute disturbances of mood, behavior, or thinking.

(ii) Emergency admissions. Admission to an acute inpatient hospital setting may be on an emergency or on a non-emergency basis. In order for an admission to qualify as an emergency, the following criteria, in addition to those in paragraph (b)(6)(i) of this section, must be met:

(A) The patient must be at immediate risk of serious harm to self and or others based on a psychiatric evaluation performed by a physician (or other qualified mental health professional with hospital admission authority); and

(B) The patient requires immediate continuous skilled observation and treatment at the acute psychiatric level of care.

(iii) Preauthorization requirements. (A) With the exception noted in paragraph (a)(12)(ii)(E) of this section, all non-emergency admissions to an acute inpatient hospital level of care must be authorized prior to the admission. The criteria for preauthorization shall be those set forth in paragraph (b)(6)(i) of this section. In applying those criteria in the context of preauthorization review, special emphasis is placed on the development of a specific individualized treatment plan, consistent with those criteria and reasonably expected to be effective, for that individual patient.

(B) The timetable for development of the individualized treatment plan shall be as follows:

(1) The development of the plan must begin immediately upon admission.

(2) A preliminary treatment plan must be established within 24 hours of the admission.

(3) A master treatment plan must be established within five calendar days of the admission.

(C) The elements of the individualized treatment plan must include:

(1) The diagnostic evaluation that establishes the necessity for the admission;

(2) An assessment regarding the inappropriateness of services at a less intensive level of care;

(3) A comprehensive biopsychosocial assessment and diagnostic formulation;

(4) A specific individualized treatment plan that integrates measurable goals/objectives and their required level of care for each of the patient's problems that are a focus of treatment;

(5) A specific plan for involvement of family members, unless therapeutically contraindicated; and

(6) A discharge plan, including an objective of referring the patient to further services, if needed, at less intensive levels of care within the benefit limit period.

(D) The request for preauthorization must be received by the reviewer designated by the Director, OCHAMPUS prior to the planned admission. In general, the decision regarding preauthorization shall be made within one business day of receipt of a request for preauthorization, and shall be followed with written confirmation. In the case of an authorization issued after an admission resulting from approval of a request made prior to the admission, the effective date of the certification shall be the date of the receipt of the request. However, if the request on which the approved authorization is based was made after the admission (and the case was not an emergency admission), the effective date of the authorization shall be the date of approval.

TMA Version - April 2005

(E) Authorization prior to admission is not required in the case of a psychiatric emergency requiring an inpatient acute level of care, but authorization for a continuation of services must be obtained promptly. Admissions resulting from a bona fide psychiatric emergency should be reported within 24 hours of the admission or the next business day after the admission, but must be reported to the Director, OCHAMPUS or a designee, within 72 hours of the admission. In the case of an emergency admission authorization resulting from approval of a request made within 72 hours of the admission, the effective date of the authorization shall be the date of the admission. However, if it is determined that the case was not a bona fide psychiatric emergency admission (but the admission can be authorized as medically or psychologically necessary), the effective date of the authorization shall be the date of the receipt of the request.

(iv) Concurrent review. Concurrent review of the necessity for continued stay will be conducted. The criteria for concurrent review shall be those set forth in paragraph (b)(6)(i) of this section. In applying those criteria in the context of concurrent review, special emphasis is placed on evaluating the progress being made in the active clinical treatment being provided and on developing/refining appropriate discharge plans. In general, the decision regarding concurrent review shall be made within one business day of the review, and shall be followed with written confirmation.

(7) Emergency inpatient hospital services. In the case of a medical emergency, benefits can be extended for medically necessary inpatient services and supplies provided to a beneficiary by a hospital, including hospitals that do not meet CHAMPUS standards or comply with the provisions of title VI of the Civil Rights Act, or satisfy other conditions herein set forth. In a medical emergency, medically necessary inpatient services and supplies are those that are necessary to prevent the death or serious impairment of the health of the patient, and that, because of the threat to the life or health of the patient, necessitate, the use of the most accessible hospital available and equipped to furnish such services. The availability of benefits depends upon the following three separate findings and continues only as long as the emergency exists, as determined by medical review. If the case qualified as an emergency at the time of admission to an unauthorized institutional provider and the emergency subsequently is determined no longer to exist, benefits will be extended up through the date of notice to the beneficiary and provider that CHAMPUS benefits no longer are payable in that hospital.

(i) Existence of medical emergency. A determination that a medical emergency existed with regard to the patient's condition;

(ii) Immediate admission required. A determination that the condition causing the medical emergency required immediate admission to a hospital to provide the emergency care; and

(iii) Closest hospital utilized. A determination that diagnosis or treatment was received at the most accessible (closest) hospital available and equipped to furnish the medically necessary care.

(8) RTC day limit. (i) With respect to mental health services provided on or after October 1, 1991, benefits for residential treatment are generally limited to 150 days in a fiscal year or 150 days in an admission (not including days of care prior to October 1, 1991). The RTC benefit limit is separate from the benefit limit for acute inpatient mental health care.

(ii) Waiver of the RTC day limit. (A) There is a statutory presumption against the appropriateness of residential treatment services in excess of the 150 day limit. However, the Director, OCHAMPUS, (or designee) may in special cases, after considering the opinion of the peer review designated by the Director (involving a health professional who is not a federal employee) confirming that applicable criteria have been met, waive the RTC benefit limit in paragraph (b)(8)(i) of this section and authorize payment for care beyond that limit.

(B) The criteria for waiver shall be those set forth in paragraph (b)(4)(vii) of this section. In applying those criteria to the context of waiver request reviews, special emphasis is placed on assuring that the record documents that:

(1) Active treatment has taken place for the past 150 days and substantial progress has been made according to the plan of treatment.

(2) The progress made is insufficient, due to the complexity of the illness, for the patient to be discharged to a less intensive level of care.

(3) Specific evidence is presented to explain the factors which interfered with treatment progress during the 150 days of RTC care.

(4) The waiver request includes specific timeframes and a specific plan of treatment which will lead to discharge.

(C) Where family or social issues complicate transfer to a lower level of intensity, the RTC is responsible for determining and arranging the supportive and adjunctive resources required to permit appropriate transfer. If the RTC fails adequately to meet this responsibility, the existence of such family or social issues shall be an inadequate basis for a waiver of the benefit limit.

(D) It is the responsibility of the patient's primary care provider to establish, through actual documentation from the medical record and other sources, that the conditions for waiver exist.

(iii) RTC day limits do not apply to services provided under the Program for Persons with Disabilities (Sec. 199.5) or services provided as partial hospitalization care.

(9) Acute care day limits. (i) With respect to mental health care services provided on or after October 1, 1991, payment for inpatient acute hospital care is, in general, statutorily limited as follows:

(A) Adults, aged 19 and over--30 days in a fiscal year or 30 days in an admission (excluding days provided prior to October 1, 1991).

(B) Children and adolescents, aged 18 and under--45 days in a fiscal year or 45 days in an admission (excluding days provided prior to October 1, 1991).

(ii) It is the patient's age at the time of admission that determines the number of days available.

(iii) Waiver of the acute care day limits. (A) There is a statutory presumption against the appropriateness of inpatient acute services in excess of the day limits set forth in paragraph (b)(9)(i) of this section. However, the Director, OCHAMPUS (or designee) may in special cases, after considering the opinion of the peer review designated by the Director (involving a health professional who is not a federal employee) confirming that applicable criteria have been met, waive the acute inpatient limits described in paragraph (b)(9)(i) of this section and authorize payment for care beyond those limits.

(B) The criteria for waiver of the acute inpatient limit shall be those set forth in paragraph (b)(6)(i) of this section. In applying those criteria in the context of waiver request review, special emphasis is placed on determining whether additional days of acute inpatient mental health care are medically/psychologically necessary to complete necessary elements of the treatment plan prior to implementing appropriate discharge planning. A waiver may also be granted in cases in which a patient exhibits well-documented new symptoms, maladaptive behavior, or medical complications which have appeared in the inpatient setting requiring a significant revision to the treatment plan.

(C) The clinician responsible for the patient's care is responsible for documenting that a waiver criterion has been met and must establish an estimated length of stay beyond the date of the inpatient limit. There must be evidence of a coherent and specific plan for assessment, intervention and reassessment that reasonably can be accomplished within the time frame of the additional days of coverage requested under the waiver provision.

(D) For patients in care at the time the inpatient limit is reached, a waiver must be requested prior to the limit. For patients being readmitted after having received 30 or 45 days in the fiscal year, the waiver review will be conducted at the time of the preadmission authorization.

(iv) Acute care day limits do not apply to services provided under the Program for Persons with Disabilities (Sec. 199.5) or services provided as partial hospitalization care.

(10) Psychiatric partial hospitalization services.

(i) In general. Partial hospitalization services are those services furnished by a CHAMPUS-authorized partial hospitalization program and authorized mental health providers for the active treatment of a mental disorder. All services must follow a medical model and vest patient care under the general direction of a licensed psychiatrist employed by the partial hospitalization center to ensure medication and physical needs of all the patients are considered. The primary or attending provider must be a CHAMPUS authorized mental health provider, operating within the scope of his/her license. These categories include physicians, clinical psychologists, certified psychiatric nurse specialists, clinical social workers, marriage and family counselors, pastoral counselors and mental health counselors. Partial hospitalization services are covered as a basic program benefit only if they are provided in accordance with paragraph (b)(10) of this section.

(ii) Criteria for determining medical or psychological necessity of psychiatric partial hospitalization services. Psychiatric partial hospitalization services will be considered necessary only if all of the following conditions are present:

(A) The patient is suffering significant impairment from a mental disorder (as defined in Sec. 199.2) which interferes with age appropriate functioning.

(B) The patient is unable to maintain himself or herself in the community, with appropriate support, at a sufficient level of functioning to permit an adequate course of therapy exclusively on an outpatient basis (but is able, with appropriate support, to maintain a basic level of functioning to permit partial hospitalization services and presents no substantial imminent risk of harm to self or others).

(C) The patient is in need of crisis stabilization, treatment of partially stabilized mental health disorders, or services as a transition from an inpatient program.

(D) The admission into the partial hospitalization program is based on the development of an individualized diagnosis and treatment plan expected to be effective for that patient and permit treatment at a less intensive level.

(iii) Preauthorization and concurrent review requirements. All preadmission authorization and concurrent review requirements and procedures applicable to acute mental health inpatient hospital care in paragraphs (a)(12) and (b) of this section are applicable to the partial hospitalization program, except that the criteria for considering medical or psychological necessity shall be those set forth in paragraph (b)(10)(ii) of this section, and no emergency admissions will be recognized.

(iv) Institutional benefits limited to 60 days. Benefits for institutional services for partial hospitalization are limited to 60 treatment days (whether a full day or partial day program) in a fiscal year or in an admission. This limit may be extended by waiver.

(v) Waiver of the 60-day partial hospitalization program limit. The Director, OCHAMPUS (or designee) may, in special cases, waive the 60-day partial hospitalization benefit and authorize payment for care beyond the 60-day limit.

(A) the criteria for waiver are set forth in paragraph (b)(10)(ii) of this section. In applying these criteria in the context of waiver request review, special emphasis is placed on determining whether additional days of partial hospitalization are medically/psychologically necessary to complete essential elements of the treatment plan prior to discharge. Consideration is also given in cases in which a patient exhibits well-documented new symptoms or maladaptive behaviors which have appeared in the partial hospitalization setting requiring significant revisions to the treatment plan.

(B) The clinician responsible for the patient's care is responsible for documenting the need for additional days and must establish an estimated length of stay beyond the date of the 60-day limit. There must be evidence of a coherent and specific plan for assessment, intervention and reassessment that reasonably can be accomplished within the time frame of the additional days of coverage requested under the waiver provisions.

(C) For patients in care at the time the partial hospitalization program limit is reached, a waiver must be requested prior to the limit. For patients being preadmitted after having received 60 days in the fiscal year, the waiver review will be conducted at the time of the preadmission authorization.

(vi) Services and supplies. The following services and supplies are included in the per diem rate approved for an authorized partial hospitalization program:

(A) Board. Includes use of the partial hospital facilities such as food service, supervised therapeutically constructed recreational and social activities, and other general services as considered appropriate by the Director, OCHAMPUS, or a designee.

(B) Patient assessment. Includes the assessment of each individual accepted by the facility, and must, at a minimum, consist of a physical examination; psychiatric examination; psychological assessment; assessment of physiological, biological and cognitive processes; developmental assessment; family history and assessment; social history and assessment; educational or vocational history and assessment; environmental assessment; and recreational/activities assessment. Assessments conducted within 30 days prior to admission to a partial program may be used if approved and deemed adequate to permit treatment planning by the partial hospital program.

(C) Psychological testing.

(D) Treatment services. All services, supplies, equipment and space necessary to fulfill the requirements of each patient's individualized diagnosis and treatment plan (with the exception of the five psychotherapy sessions per week which may be allowed separately for individual or family psychotherapy based upon the provisions of paragraph (b)(10)(vii) of this section). All mental health services must be provided by a CHAMPUS authorized individual professional provider of mental health services. [Exception: PHPs that employ individuals with master's or doctoral level degrees in a mental health discipline who do not meet the licensure, certification and experience requirements for a qualified mental health provider but are actively working toward licensure or certification, may provide services within the all-inclusive per diem rate but the individual must work under the clinical supervision of a fully qualified mental health provider employed by the PHP.]

(vii) Social services required. The facility must provide an active social services component which assures the patient appropriate living arrangements after treatment hours, transportation to and from the facility, arrangement of community based support services, referral of suspected child abuse to the appropriate state agencies, and effective after care arrangements, at a minimum.

(viii) Educational services required. Programs treating children and adolescents must ensure the provision of a state certified educational component which assures that patients do not fall behind in educational placement while receiving partial hospital treatment. CHAMPUS will not fund the cost of educational services separately from the per diem rate. The hours devoted to education do not count toward the therapeutic half or full day program.

(ix) Family therapy required. The facility must ensure the provision of an active family therapy treatment component which assures that each patient and family participate at least weekly in family therapy provided by the institution and rendered by a CHAMPUS authorized individual professional provider of mental health services. There is no acceptable substitute for family therapy. An exception to this requirement may be granted on a case-by-case basis by the Director, OCHAMPUS, or designee, only if family therapy is clinically contraindicated.

(x) Professional mental health benefits limited. Professional mental health benefits are limited to a maximum of one session (60 minutes individual, 90 minutes family) per authorized treatment day not to exceed five sessions in any calendar week. These may be billed separately from the partial hospitalization per diem rate only when rendered by an attending, CHAMPUS-authorized mental health professional who is not an employee of, or under contract with, the partial hospitalization program for purposes of providing clinical patient care.

(xi) Non-mental health related medical services. Separate billing will be allowed for otherwise covered, non-mental health related medical services.

(c) Professional services benefit--(1) General. Benefits may be extended for those covered services described in paragraph (c) of this section that are provided in accordance with good medical practice and established standards of quality by physicians or other authorized individual professional providers, as set forth in Sec. 199.6 of this part. Such benefits are subject to all applicable definitions, conditions, exceptions, limitations, or exclusions as maybe otherwise set forth in this or other Sections of this part. Except as otherwise specifically authorized, to be considered for benefits under paragraph (c) of this section, the described services must be rendered by a physician, or prescribed, ordered, and referred medically by a physician to other authorized individual professional providers. Further, except under specifically defined circumstances, there should be an attending physician in any episode of care. (For example, certain services of a clinical psychologist are exempt from this requirement. For these exceptions, refer to Sec. 199.6.)

(i) Billing practices. To be considered for benefits under paragraph (c) of this section, covered professional services must be performed personally by the physician or other authorized individual professional provider, who is other than a salaried or contractual staff member of a hospital or other authorized institution, and who ordinarily and customarily bills on a fee-for-service basis for professional services rendered. Such billings must be itemized fully and be sufficiently descriptive to permit CHAMPUS to determine whether benefits are authorized by this part. See paragraph (c)(3)(xiii) of this section for the requirements regarding the special circumstances for teaching physicians. For continuing professional care, claims should be submitted to the appropriate CHAMPUS fiscal intermediary at least every 30 days either by the beneficiary or sponsor, or directly by the physician or other authorized individual professional provider on behalf of a beneficiary (refer to Sec. 199.7).

(ii) Services must be related. Covered professional services must be rendered in connection with and directly related to a covered diagnosis or definitive set of symptoms requiring medically necessary treatment.

(2) Covered services of physicians and other authorized profession providers.

(i) Surgery. Surgery means operative procedures, including related preoperative and postoperative care; reduction of fractures and dislocations; injection and needling procedures of the joints; laser surgery of the eye; and the following procedures:

Bronchoscopy

Laryngoscopy

TMA Version - April 2005

Thoracoscopy

Catheterization of the heart

Arteriograph thoracic lumbar

Esophagoscopy

Gastrosocopy

Proctoscopy

Sigmoidoscopy

Peritoneoscopy

Cystoscopy

Colonscopy

Upper G.I. panendoscopy

Encephalograph

Myelography

Discography

Visualization of intracranial aneurysm by intracarotid injection of dye, with exposure of carotid artery, unilateral

Ventriculography

Insufflation of uterus and fallopian tubes for determination of tubal patency (Rubin's test of injection of radiopaque medium or for dilation)

Introduction of opaque media into the cranial arterial system, preliminary to cerebral arteriography, or into vertebral and subclavian systems

Intraspinal introduction of air preliminary to pneumoencephalography

Intraspinal introduction of opaque media preliminary to myelography

Intraventricular introduction of air preliminary to ventriculography

NOTE: The Director, OCHAMPUS, or a designee, shall determine such additional procedures that may fall within the intent of this definition of "surgery."

- (ii) Surgical assistance.
- (iii) Inpatient medical services.
- (iv) Outpatient medical services.
- (v) Psychiatric services.
- (vi) Consultation services.
- (vii) Anesthesia services.
- (viii) Radiation therapy services.
- (ix) X-ray services.
- (x) Laboratory and pathological services.
- (xi) Physical medicine services or physiatry services.
- (xii) Maternity care.
- (xiii) Well-child care.

(xiv) Other medical care. Other medical care includes, but is not limited to, hemodialysis, inhalation therapy, shock therapy, and chemotherapy. The Director, OCHAMPUS, or a designee, shall determine those additional medical services for which benefits may be extended under this paragraph.

NOTE: A separate professional charge for the oral administration of approved antineoplastic drugs is not covered.

(xv) (Reserved)

(xvi) Routine eye examinations. Coverage for routine eye examinations is limited to dependents of active duty members, to one examination per calendar year per person, and to services rendered on or after October 1, 1984, except as provided under paragraph (c)(3)(xi) of this section.

(3) Extent of professional benefits--(i) Multiple Surgery. In cases of multiple surgical procedures performed during the same operative session, benefits shall be extended as follows:

(A) One hundred (100) percent of the CHAMPUS-determined allowable charge for the major surgical procedure (the procedure for which the greatest amount is payable under the applicable reimbursement method); and

(B) Fifty (50) percent of the CHAMPUS-determined allowable charge for each of the other surgical procedures;

(C) Except that:

(1) If the multiple surgical procedures include an incidental procedure, no benefits shall be allowed for the incidental procedure.

(2) If the multiple surgical procedures involve specific procedures identified by the Director, OCHAMPUS, benefits shall be limited as set forth in CHAMPUS instructions.

(ii) Different types of inpatient care, concurrent. If a beneficiary receives inpatient medical care during the same admission in which he or she also receives surgical care or maternity care, the beneficiary shall be entitled to the greater of the CHAMPUS-determined allowable charge for either the inpatient medical care or surgical or maternity care received, as the case may be, but not both; except that the provisions of this paragraph (c)(3)(ii) shall not apply if such inpatient medical care is for a diagnosed condition requiring inpatient medical care not related to the condition for which surgical care or maternity care is received, and is received from a physician other than the one rendering the surgical care or maternity care.

NOTE: This provision is not meant to imply that when extra time and special effort are required due to postsurgical or postdelivery complications, the attending physician may not request special consideration for a higher than usual charge.

(iii) Need for surgical assistance. Surgical assistance is payable only when the complexity of the procedure warrants a surgical assistant (other than the surgical nurse or other such operating room personnel), subject to utilization review. In order for benefits to be extended for surgical assistance service, the primary surgeon may be required to certify in writing to the nonavailability of a qualified intern, resident, or other house physician. When a claim is received for a surgical assistant involving the following circumstances, special review is required to ascertain whether the surgical assistance service meets the medical necessity and other requirements of paragraph (c) of this section.

(A) If the surgical assistance occurred in a hospital that has a residency program in a specialty appropriate to the surgery;

(B) If the surgery was performed by a team of surgeons;

(C) If there were multiple surgical assistants; or

(D) If the surgical assistant was a partner of or from the same group of practicing physicians as the attending surgeon.

(iv) Aftercare following surgery. Except for those diagnostic procedures classified as surgery in paragraph (c) of this section, and injection and needling procedures involving the joints, the benefit payments made for surgery (regardless of the setting in which it is rendered) include normal aftercare, whether the aftercare is billed for by the physician or other authorized individual professional provider on a global, all-inclusive basis, or billed for separately.

TMA Version - April 2005

(v) Cast and sutures, removal. The benefit payments made for the application of a cast or of sutures normally covers the postoperative care including the removal of the cast or sutures. When the application is made in one geographical location and the removal of the cast or sutures must be done in another geographical location, a separate benefit payment may be provided for the removal. The intent of this provision is to provide a separate benefit only when it is impracticable for the beneficiary to use the services of the provider that applied the cast originally. Benefits are not available for the services of a second provider if those services reasonably could have been rendered by the individual professional provider who applied the cast or sutures initially.

(vi) Inpatient care, concurrent. Concurrent inpatient care by more than one individual professional provider is covered if required because of the severity and complexity of the beneficiary's condition or because the beneficiary has multiple conditions that require treatment by providers of different specialities. Any claim for concurrent care must be reviewed before extending benefits in order to ascertain the condition of the beneficiary at the time the concurrent care was rendered. In the absence of such determination, benefits are payable only for inpatient care rendered by one attending physician or other authorized individual professional provider.

(vii) Consultants who become the attending surgeon. A consultation performed within 3 days of surgery by the attending physician is considered a preoperative examination. Preoperative examinations are an integral part of the surgery and a separate benefit is not payable for the consultation. If more than 3 days elapse between the consultation and surgery (performed by the same physician), benefits may be extended for the consultation, subject to review.

(viii) Anesthesia administered by the attending physician. A separate benefit is not payable for anesthesia administered by the attending physician (surgeon or obstetrician) or dentist, or by the surgical, obstetrical, or dental assistant.

(ix) Treatment of mental disorders. CHAMPUS benefits for the treatment of mental disorders are payable for beneficiaries who are outpatients or inpatients of CHAMPUS-authorized general or psychiatric hospitals, RTCs, or specialized treatment facilities, as authorized by the Director, OCHAMPUS, or a designee. All such services are subject to review for medical or psychological necessity and for quality of care. The Director, OCHAMPUS, reserves the right to require preauthorization of mental health services. Preauthorization may be conducted by the Director, OCHAMPUS, or a designee. In order to qualify for CHAMPUS mental health benefits, the patient must be diagnosed by a CHAMPUS-authorized licensed, qualified mental health professional to be suffering from a mental disorder, according to the criteria listed in the most current edition of the Diagnostic and Statistical Manual of Mental Disorders which may be purchased from the American Psychiatric Press, Inc., 1400 K Street, NW., suite 1101, Washington, DC 20005. Benefits are limited for certain mental disorders, such as specific developmental disorders. No benefits are payable for "Conditions Not Attributable to a Mental Disorder," or V codes. In order for treatment of a mental disorder to be medically or psychologically necessary, the patient must, as a result of a diagnosed mental disorder, be experiencing both physical or psychological distress and an impairment in his or her ability to function in appropriate occupational, educational or social roles. It is generally the degree to which the patient's ability to function is impaired that determines the level of care (if any) required to treat the patient's condition.

(A) Covered diagnostic and therapeutic services. Subject to the requirements and limitations stated, CHAMPUS benefits are payable for the following services when rendered in the diagnosis or treatment of a covered mental disorder by a CHAMPUS-authorized, qualified mental health provider practicing within the scope of his or her license. Qualified mental health providers are: psychiatrists or other physicians; clinical psychologists, certified psychiatric nurse specialists, certified clinical social workers, certified marriage and family therapists, certified mental health counselors, pastoral counselors under a physician's supervision, and until December 31, 2014, mental health counselors under a physician's supervision. No payment will be made for any service listed in paragraph (c)(3)(ix)(A) of this section rendered by an individual who does not meet the criteria of Sec. 199.6 of this part for his or her respective profession, regardless of whether the provider is an independent professional provider or an employee of an authorized professional or institutional provider.

(1) Individual psychotherapy, adult or child. A covered individual psychotherapy session is no more than 60 minutes in length. An individual psychotherapy session of up to 120 minutes in length is payable for crisis intervention.

(2) Group psychotherapy. A covered group psychotherapy session is no more than 90 minutes in length.

(3) Family or conjoint psychotherapy. A covered family or conjoint psychotherapy session is no more than 90 minutes in length. A family or conjoint psychotherapy session of up to 180 minutes in length is payable for crisis intervention.

(4) Psychoanalysis. Psychoanalysis is covered when provided by a graduate or candidate of a psychoanalytic training institution recognized by the American Psychoanalytic Association and when preauthorized by the Director, OCHAMPUS, or a designee.

(5) Psychological testing and assessment. Psychological testing and assessment is generally limited to six hours of testing in a fiscal year when medically or psychologically necessary and in conjunction with otherwise covered psychotherapy. Testing or assessment in excess of these limits requires review for medical necessity. Benefits will not be provided for the Reitan-Indiana battery when administered to a patient under age five, for self-administered tests administered to patients under age 13, or for psychological testing and assessment as part of an assessment for academic placement.

(6) Administration of psychotropic drugs. When prescribed by an authorized provider qualified by licensure to prescribe drugs.

(7) Electroconvulsive treatment. When provided in accordance with guidelines issued by the Director, OCHAMPUS.

(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

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.

(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; 77 FR 38178, Jun 27, 2012; 78 FR 12952, Feb 26, 2013]