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MANAGEMENT ACTIVITY

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**FINAL RULE**

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

**CHANGE TITLE:** TRICARE; REIMBURSEMENT OF SOLE COMMUNITY HOSPITALS AND  
ADJUSTMENT TO REIMBURSEMENT OF CRITICAL ACCESS HOSPITALS

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

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Double coverage plan. The specific insurance, medical service, or health plan under which a CHAMPUS beneficiary has entitlement to medical benefits that duplicate CHAMPUS benefits in whole or in part. Double coverage plans do not include:

- (i) Medicaid.
- (ii) Coverage specifically designed to supplement CHAMPUS benefits.
- (iii) Entitlement to receive care from the Uniformed Services medical facilities;
- (iv) Entitlement to receive care from Veterans Administration medical care facilities; or
- (v) Part C of the Individuals with Disabilities Education Act for services and items provided in accordance with Part C of the IDEA that are medically or psychologically necessary in accordance with the Individual Family Service Plan and that are otherwise allowable under the CHAMPUS Basic Program or the Extended Care Health Option (ECHO).

Dual Compensation. Federal Law (5 U.S.C. 5536) prohibits active duty members or civilian employees of the United States Government from receiving additional compensation from the government above their normal pay and allowances. This prohibition applies to CHAMPUS cost-sharing of medical care provided by active duty members or civilian government employees to CHAMPUS beneficiaries.

Duplicate equipment. An item of durable equipment or durable medical equipment, as defined in this section that serves the same purpose that is served by an item of durable equipment or durable medical equipment previously cost-shared by TRICARE. For example, various models of stationary oxygen concentrators with no essential functional differences are considered duplicate equipment, whereas stationary and portable oxygen concentrators are not considered duplicates of each other because the latter is intended to provide the user with mobility not afforded by the former. Also, a manual wheelchair and an electric wheelchair, both of which otherwise meet the definition of durable equipment or durable medical equipment, would not be considered duplicates of each other if each is found to provide an appropriate level of mobility. For the purpose of this Part, durable equipment or durable medical equipment that are essential to provide a fail-safe in-home life support system or that replaces in like kind an item of equipment that is not serviceable due to normal wear, accidental damage, a change in the beneficiary's condition, or has been declared adulterated by the U.S. FDA, or is being or has been recalled by the manufacturer, is not considered duplicate equipment.

Durable equipment. A device or apparatus which does not qualify as durable medical equipment and which is essential to the efficient arrest or reduction of functional loss resulting from, or the disabling effects of a qualifying condition as provided in Sec. 199.5

Durable medical equipment. Equipment that--

- (1) Can withstand repeated use;
- (2) Is primarily and customarily used to serve a medical purpose; and
- (3) Generally is not useful to an individual in the absence of an illness or injury.

Economic interest. (1) Any right, title, or share in the income, remuneration, payment, or profit of a CHAMPUS-authorized provider, or of an individual or entity eligible to be a CHAMPUS-authorized provider, resulting, directly or indirectly, from a referral relationship; or any direct or indirect ownership, right, title, or share, including a mortgage, deed of trust, note, or other obligation secured (in whole or in part) by one entity for another entity in a referral or accreditation relationship, which is equal to or exceeds 5 percent of the total property and assets of the other entity.

(2) A referral relationship exists when a CHAMPUS beneficiary is sent, directed, assigned or influenced to use a specific CHAMPUS-authorized provider, or a specific individual or entity eligible to be a CHAMPUS-authorized provider.

(3) An accreditation relationship exists when a CHAMPUS-authorized accreditation organization evaluates for accreditation an entity that is an applicant for, or recipient of CHAMPUS-authorized provider status.

Emergency inpatient admission. An unscheduled, unexpected, medically necessary admission to a hospital or other authorized institutional provider for treatment of a medical condition meeting the definition of medical emergency and which is determined to require immediate inpatient treatment by the attending physician.

Entity. For purposes of Sec. 199.9(f)(1), "entity" includes a corporation, trust, partnership, sole proprietorship or other kind of business enterprise that is or may be eligible to receive reimbursement either directly or indirectly from CHAMPUS.

**Essential Access Community Hospital (EACH).** A hospital that is designated by the Centers for Medicare and Medicaid Services (CMS) as an EACH and meets the applicable requirements established by Sec. 199.14(a)(7)(vi).

Extended Care Health Option (ECHO). The TRICARE program of supplemental benefits for qualifying active duty family members as described in Sec. 199.5.

External Partnership Agreement. The External Partnership Agreement is an agreement between a military treatment facility commander and a CHAMPUS authorized institutional provider, enabling Uniformed Services health care personnel to provide otherwise covered medical care to CHAMPUS beneficiaries in a civilian facility under the Military-Civilian Health Services Partnership Program. Authorized costs associated with the use of the facility will be financed through CHAMPUS under normal cost-sharing and reimbursement procedures currently applicable under the basic CHAMPUS.

External Resource Sharing Agreement. A type External Partnership Agreement, established in the context of the TRICARE program by agreement of a military medical treatment facility commander and an authorized TRICARE contractor. External Resource Sharing Agreements may incorporate TRICARE features in lieu of standard CHAMPUS features that would apply to standard External Partnership Agreements.

Extramedical individual providers of care. Individuals who do counseling or nonmedical therapy and whose training and therapeutic concepts are outside the medical field, as specified in Sec. 199.6 of this part.

Extraordinary physical or psychological condition. A complex physical or psychological clinical condition of such severity which results in the beneficiary being homebound as defined in this section.

Facility charge. The term “facility charge” means the charge, either inpatient or outpatient, made by a hospital or other institutional provider to cover the overhead costs of providing the service. These costs would include building costs, i.e. depreciation and interest; staffing costs; drugs and supplies; and overhead costs, i.e., utilities, housekeeping, maintenance, etc.

Former member. A retiree, deceased member, deceased retiree, or deceased reservist in certain circumstances (see section 199.3 for additional information related to certain deceased reservists’ dependents’ eligibility). Under conditions specified under Sec. 199.3 of this part, former member may also include a member of the Uniformed Services who has been discharged from active duty (or, in some cases, full-time National Guard duty), whether voluntarily or involuntarily, under other than adverse conditions and qualifies for CHAMPUS benefits under the Transitional Assistance Management Program or the Continued Health Care Benefit Program.

Former spouse. A former husband or wife of a Uniformed Service member or former member who meets the criteria as set forth in Sec. 199.3(b)(2)(ii) of this part.

Fraud. For purposes of this part, fraud is defined as (1) a deception or misrepresentation by a provider, beneficiary, sponsor, or any person acting on behalf of a provider, sponsor, or beneficiary with the knowledge (or who had reason to know or should have known) that the deception or misrepresentation could result in some unauthorized CHAMPUS benefit to self or some other person, or some unauthorized CHAMPUS payment, or (2) a claim that is false or fictitious, or includes or is supported by any written statement which asserts a material fact which is false or fictitious, or includes or is supported by any written statement that (a) omits a material fact and (b) is false or fictitious as a result of such omission and (c) is a statement in which the person making, presenting, or submitting such statement has a duty to include such material fact. It is presumed that, if a deception or misrepresentation is established *and* a CHAMPUS claim is filed, the person responsible for the claim had the requisite knowledge. This presumption is rebuttable only by substantial evidence. It is further presumed that the provider of the services is responsible for the actions of all individuals who file a claim on behalf of the provider (for example, billing clerks); this presumption may only be rebutted by clear and convincing evidence.

Freestanding. Not “institution-affiliated” or “institution-based.”

Full-time course of higher education. A complete, progressive series of studies to develop attributes such as knowledge, skill, mind, and character, by formal schooling at a college or university, and which meets the criteria set out in Sec. 199.3 of this part. To qualify as full-time, the student must be carrying a course load of a minimum of 12 credit hours or equivalent each semester.

General staff nursing service. 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 performed by nursing personnel on the payroll of the hospital or other authorized institution.

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Good faith payments. Those payments made to civilian sources of medical care who provided medical care to persons purporting to be eligible beneficiaries but who are determined later to be ineligible for CHAMPUS benefits. (The ineligible person usually possesses an erroneous or illegal identification card.) To be considered for good faith payments, the civilian source of care must have exercised reasonable precautions in identifying a person claiming to be an eligible beneficiary.

Habilitation. The provision of functional capacity, absent from birth due to congenital anomaly or developmental disorder, which facilitates performance of an activity in the manner, or within the range considered normal, for a human being.

Handicap. For the purposes of this part, the term "handicap" is synonymous with the term "disability."

High-risk pregnancy. A pregnancy is high-risk when the presence of a currently active or previously treated medical, anatomical, physiological illness or condition may create or increase the likelihood of a detrimental effect on the mother, fetus, or newborn and presents a reasonable possibility of the development of complications during labor or delivery.

Homebound. A beneficiary's condition is such that there exists a normal inability to leave home and, consequently, leaving home would require considerable and taxing effort. Any absence of an individual from the home attributable to the need to receive health care treatment--including regular absences for the purpose of participating in therapeutic, psychosocial, or medical treatment in an adult day-care program that is licensed or certified by a state, or accredited to furnish adult day-care services in the--state shall not disqualify an individual from being considered to be confined to his home. Any other absence of an individual from the home shall not disqualify an individual if the absence is infrequent or of relatively short duration. For purposes of the preceding sentence, any absence for the purpose of attending a religious service shall be deemed to be an absence of infrequent or short duration. Also, absences from the home for non-medical purposes, such as an occasional trip to the barber, a walk around the block or a drive, would not necessarily negate the beneficiary's homebound status if the absences are undertaken on an infrequent basis and are of relatively short duration. An exception is made to the above homebound definitional criteria for beneficiaries under the age of 18 and those receiving maternity care. The only homebound criteria for these special beneficiary categories is written certification from a physician attesting to the fact that leaving the home would place the beneficiary at medical risk. In addition to the above, absences, whether regular or infrequent, from the beneficiary's primary residence for the purpose of attending an educational program in a public or private school that is licensed and/or certified by a state, shall not negate the beneficiary's homebound status.

Home health discipline. One of six home health disciplines covered under the home health benefit (skilled nursing services, home health aide services, physical therapy services, occupational therapy services, speech-language pathology services, and medical social services).

Home health market basket index. An index that reflects changes over time in the prices of an appropriate mix of goods and services included in home health services.

Hospice care. Hospice care is a program which provides an integrated set of services and supplies designed to care for the terminally ill. This type of care emphasizes palliative care and supportive services, such as pain control and home care, rather than cure-oriented services provided in institutions that are otherwise the primary focus under CHAMPUS. The benefit provides coverage for a humane and sensible approach to care during the last days of life for some terminally ill patients.

Hospital, acute care (general and special). An institution that meets the criteria as set forth in Sec. 199.6(b)(4)(i) of this part.

Hospital, long-term (tuberculosis, chronic care, or rehabilitation). An institution that meets the criteria as set forth in Sec. 199.6(b)(4)(iii) of this part.

Hospital, psychiatric. An institution that meets the criteria as set forth in Sec. 199.6(b)(4)(ii) of this part.

Illegitimate child. A child not recognized as a lawful offspring; that is, a child born of parents not married to each other.

Immediate family. The spouse, natural parent, child and sibling, adopted child and adoptive parent, stepparent, stepchild, grandparent, grandchild, stepbrother and stepsister, father-in-law, mother-in-law of the beneficiary, or provider, as appropriate. For purposes of this definition only, to determine who may render services to a beneficiary, the step-relationship continues to exist even if the marriage upon which the relationship is based terminates through divorce or death of one of the parents.

Independent laboratory. A freestanding laboratory approved for participation under Medicare and certified by the Health Care Financing Administration.

Infirmaries. Facilities operated by student health departments of colleges and universities to provide inpatient or outpatient care to enrolled students. When specifically approved by the Director, OCHAMPUS, or a designee, a boarding school infirmary also is included.

Initial determination. A formal written decision on a CHAMPUS claim, a request for benefit authorization, a request by a provider for approval as an authorized CHAMPUS provider, or a decision disqualifying or excluding a provider as an authorized provider under CHAMPUS. Rejection of a claim or a request for benefit or provider authorization for failure to comply with administrative requirements, including failure to submit reasonably requested information, is not an initial determination. Responses to general or specific inquiries regarding CHAMPUS benefits are not initial determinations.

In-out surgery. Surgery performed in the outpatient department of a hospital or other institutional provider, in a physician's office or the office of another individual professional provider, in a clinic, or in a "freestanding" ambulatory surgical center which does not involve a formal inpatient admission for a period of 24 hours or more.

Inpatient. A patient who has been admitted to a hospital or other authorized institution for bed occupancy for purposes of receiving necessary medical care, with the reasonable expectation that the patient will remain in the institution at least 24 hours, and with the registration and assignment of an inpatient number or designation. Institutional care in

connection with in and out (ambulatory) surgery is not included within the meaning of inpatient whether or not an inpatient number or designation is made by the hospital or other institution. If the patient has been received at the hospital, but death occurs before the actual admission occurs, an inpatient admission exists as if the patient had lived and had been formally admitted.

Institution-affiliated. Related to a CHAMPUS-authorized institutional provider through a shared governing body but operating under a separate and distinct license or accreditation.

Institution-based. Related to a CHAMPUS-authorized institutional provider through a shared governing body and operating under a common license and shared accreditation.

Institutional provider. A health care provider which meets the applicable requirements established by Sec. 199.6(b) of this part.

Intensive care unit (ICU). 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 regularly and immediately are available within the unit, and patients are under continuous observation by a nursing staff specially trained and selected for the care of this type patient. The unit is maintained on a continuing rather than an intermittent or temporary basis. It is not a postoperative recovery room nor a postanesthesia room. In some large or highly specialized hospitals, the ICUs may be further refined for special purposes, such as for respiratory conditions, cardiac surgery, coronary care, burn care, or neurosurgery. For the purposes of CHAMPUS, these specialized units would be considered ICUs if they otherwise conformed to the definition of an ICU.

Intern. A graduate of a medical or dental school serving in a hospital in preparation to being licensed to practice medicine or dentistry.

Internal Partnership Agreement. The Internal Partnership Agreement is an agreement between a military treatment facility commander and a CHAMPUS-authorized civilian health care provider which enables the use of civilian health care personnel or other resources to provide medical care to CHAMPUS beneficiaries on the premises of a military treatment facility under the Military-Civilian Health Services Partnership Program. These internal agreements may be established when a military treatment facility is unable to provide sufficient health care services for CHAMPUS beneficiaries due to shortages of personnel and other required resources.

Internal Resource Sharing Agreement. A type of Internal Partnership Agreement, established in the context of the TRICARE program by agreement of a military medical treatment facility commander and authorized TRICARE contractor. Internal Resource Sharing Agreements may incorporate TRICARE features in lieu of standard CHAMPUS features that would apply to standard Internal Partnership Agreements.

Item, Service, or Supply. Includes (1) any item, device, medical supply, or service claimed to have been provided to a beneficiary (patient) and listed in an itemized claim for CHAMPUS payment or a request for payment, or (2) in the case of a claim based on costs, any entry or omission in a cost report, books of account, or other documents supporting the claim.

Laboratory and pathological services. Laboratory and pathological examinations (including machine diagnostic tests that produce hard-copy results) when necessary to, and rendered in connection with medical, obstetrical, or surgical diagnosis or treatment of an illness or injury, or in connection with well-baby care.

Legitimized child. A formerly illegitimate child who is considered legitimate by reason of qualifying actions recognized in law.

Licensed practical nurse (L.P.N.). A person who is prepared specially in the scientific basis of nursing; who is a graduate of a school of practical nursing; whose qualifications have been examined by a state board of nursing; and who has been authorized legally to practice as an L.P.N. under the supervision of a physician.

Licensed vocational nurse (L.V.N.) A person who specifically is prepared in the scientific basis or nursing; who is a graduate of a school of vocational nursing; whose qualifications have been examined by a state board of nursing; and who has been authorized legally to practice as a L.V.N. under the supervision of a physician.

Long-term hospital care. Any inpatient hospital stay that exceeds 30 days.

Low-risk pregnancy. A pregnancy is low-risk when the basis for the ongoing clinical expectation of a normal uncomplicated birth, as defined by reasonable and generally accepted criteria of maternal and fetal health, is documented throughout a generally accepted course of prenatal care.

Major life activity. Breathing, cognition, hearing, seeing, and age appropriate ability essential to bathing, dressing, eating, grooming, speaking, stair use, toilet use, transferring, and walking.

Marriage and family therapist, certified. An extramedical individual provider who meets the requirements outlined in Sec. 199.6.

Maternity care. Care and treatment related to conception, delivery, and abortion, including prenatal and postnatal care (generally through the 6th post-delivery week), and also including treatment of the complications of pregnancy.

Medicaid. Those medical benefits authorized under Title XIX of the Social Security Act provided to welfare recipients and the medically indigent through programs administered by the various states.

Medical. The generally used term which pertains to the diagnosis and treatment of illness, injury, pregnancy, and mental disorders by trained and licensed or certified health professionals. For purposes of CHAMPUS, the term "medical" should be understood to include "medical, psychological, surgical, and obstetrical," unless it is specifically stated that a more restrictive meaning is intended.

Medical emergency. The sudden and unexpected onset of a medical condition or the acute exacerbation of a chronic condition that is threatening to life, limb, or sight, and requires immediate medical treatment or which manifests painful symptomatology requiring immediate palliative efforts to alleviate suffering. Medical emergencies include heart attacks,

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cardiovascular accidents, poisoning, convulsions, kidney stones, and such other acute medical conditions as may be determined to be medical emergencies by the Director, OCHAMPUS, or a designee. In the case of a pregnancy, a medical emergency must involve a sudden and unexpected medical complication that puts the mother, the baby, or both, at risk. Pain would not, however, qualify a maternity case as an emergency, nor would incipient birth after the 34th week of gestation, unless an otherwise qualifying medical condition is present. Examples of medical emergencies related to pregnancy or delivery are hemorrhage, ruptured membrane with prolapsed cord, placenta previa, abruptio placenta, presence of shock or unconsciousness, suspected heart attack or stroke, or trauma (such as injuries received in an automobile accident).

Medical supplies and dressings (consumables). Necessary medical or surgical supplies (exclusive of durable medical equipment) that do not withstand prolonged, repeated use and that are needed for the proper medical management of a condition for which benefits are otherwise authorized under CHAMPUS, on either an inpatient or outpatient basis. Examples include disposable syringes for a diabetic, colostomy sets, irrigation sets, and ace bandages.

Medically or psychologically necessary. The frequency, extent, and types of medical services or supplies which represent appropriate medical care and that are generally accepted by qualified professionals to be reasonable and adequate for the diagnosis and treatment of illness, injury, pregnancy, and mental disorders or that are reasonable and adequate for well-baby care.

Medically or psychologically necessary preauthorization. A pre (or prior) authorization for payment for medical/surgical or psychological services based upon criteria that are generally accepted by qualified professionals to be reasonable for diagnosis and treatment of an illness, injury, pregnancy, and mental disorder.

Medicare. These medical benefits authorized under Title XVIII of the Social Security Act provided to persons 65 or older, certain disabled persons, or persons with chronic renal disease, through a national program administered by the DHHS, Health Care Financing Administration, Medicare Bureau.

Member. A person on active duty in a Uniformed Service under a call or order that does not specify a period of 30 days or less. (For CHAMPUS cost-sharing purposes only, a former member who received a dishonorable or bad-conduct discharge or was dismissed from a Uniformed Service as a result of a court-martial conviction for an offense involving physical or emotional abuse or was administratively discharged as a result of such an offense is considered a member).

Mental disorder. For purposes of the payment of CHAMPUS benefits, a mental disorder is a nervous or mental condition that involves a clinically significant behavioral or psychological syndrome or pattern that is associated with a painful symptom, such as distress, and that impairs a patient's ability to function in one or more major life activities. Additionally, the mental disorder must be one of those conditions listed in the DSM-III.

Mental health counselor. An extramedical individual provider who meets the requirements outlined in Sec. 199.6.

Mental health therapeutic absence. A therapeutically planned absence from the inpatient setting. The patient is not discharged from the facility and may be away for periods of several hours to several days. The purpose of the therapeutic absence is to give the patient an opportunity to test his or her ability to function outside the inpatient setting before the actual discharge.

Missing in action (MIA). A battle casualty whose whereabouts and status are unknown, provided the absence appears to be involuntary and the service member is not known to be in a status of unauthorized absence.

NOTE: Claims for eligible CHAMPUS beneficiaries whose sponsor is classified as MIA are processed as dependents of an active duty service member.

Morbid obesity. A body mass index (BMI) equal to or greater than 40 kilograms per meter squared (kg/m<sup>2</sup>), or a BMI equal to or greater than 35 kg/m<sup>2</sup> in conjunction with high-risk co-morbidities, which is based on the guidelines established by the National Heart, Lung and Blood Institute on the Identification and Management of Patients with Obesity.

NOTE: Body mass index is equal to weight in kilograms divided by height in meters squared.

Most-favored rate. The lowest usual charge to any individual or third-party payer in effect on the date of the admission of a CHAMPUS beneficiary.

Natural childbirth. Childbirth without the use of chemical induction or augmentation of labor or surgical procedures other than episiotomy or perineal repair.

Naturopath. A person who practices naturopathy, that is, a drugless system of therapy making use of physical forces such as air, light, water, heat, and massage.

NOTE: Services of a naturopath are not covered by CHAMPUS.

NAVCARE clinics. Contractor owned, staffed, and operated primary clinics exclusively serving uniformed services beneficiaries pursuant to contracts awarded by a Military Department.

No-fault insurance. No-fault insurance means an insurance contract providing compensation for health and medical expenses relating to personal injury arising from the operation of a motor vehicle in which the compensation is not premised on whom may have been responsible for causing such injury. No-fault insurance includes personal injury protection and medical payments benefits in cases involving personal injuries resulting from operation of a motor vehicle.

Nonavailability statement. A certification by a commander (or a designee) of a Uniformed Services medical treatment facility, recorded on DEERS, generally for the reason that the needed medical care being requested by a non-TRICARE Prime enrolled beneficiary cannot be provided at the facility concerned because the necessary resources are not available in the time frame needed.

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Nonparticipating provider. A hospital or other authorized institutional provider, a physician or other authorized individual professional provider, or other authorized provider that furnished medical services or supplies to a CHAMPUS beneficiary, but who did not agree on the CHAMPUS claim form to participate or to accept the CHAMPUS-determined allowable cost or charge as the total charge for the services. A nonparticipating provider looks to the beneficiary or sponsor for payment of his or her charge, not CHAMPUS. In such cases, CHAMPUS pays the beneficiary or sponsor, not the provider.

North Atlantic Treaty Organization (NATO) member. A military member of an armed force of a foreign NATO nation who is on active duty and who, in connection with official duties, is stationed in or passing through the United States. The foreign NATO nations are Belgium, Canada, Denmark, France, Federal Republic of Germany, Greece, Iceland, Italy, Luxembourg, the Netherlands, Norway, Portugal, Spain, Turkey, and the United Kingdom.

Not-for-profit entity. An organization or institution owned and operated by one or more nonprofit corporations or associations formed pursuant to applicable state laws, no part of the net earnings of which inures, or may lawfully inure, to the benefit of any private shareholder or individual.

Occupational therapist. A person who is trained specially in the skills and techniques of occupational therapy (that is, the use of purposeful activity with individuals who are limited by physical injury or illness, psychosocial dysfunction, developmental or learning disabilities, poverty and cultural differences, or the aging process in order to maximize independence, prevent disability, and maintain health) and who is licensed to administer occupational therapy treatments prescribed by a physician.

Off-label use of a drug or device. A use other than an intended use for which the prescription drug, biologic or device is legally marketed under the Federal Food, Drug, and Cosmetic Act or the Public Health Services Act. This includes any use that is not included in the approved labeling for an approved drug, licensed biologic, approved device or combination product; any use that is not included in the cleared statement of intended use for a device that has been determined by the Food and Drug Administration (FDA) to be substantially equivalent to a legally marketed predicate device and cleared for marketing; and any use of a device for which a manufacturer or distributor would be required to seek pre-market review by the FDA in order to legally include that use in the device's labeling.

Official formularies. A book of official standards for certain pharmaceuticals and preparations that are not included in the U.S. Pharmacopeia.

Optometrist (Doctor of Optometry). A person trained and licensed to examine and test the eyes and to treat visual defects by prescribing and adapting corrective lenses and other optical aids, and by establishing programs of exercises.

Oral surgeon (D.D.S. or D.M.D.). A person who has received a degree in dentistry and who limits his or her practice to oral surgery, that is, that branch of the healing arts that deals with the diagnosis and the surgical correction and adjunctive treatment of diseases, injuries, and defects of the mouth, the jaws, and associated structures.

Orthopedic shoes. Shoes prescribed by an orthopedic surgeon to effect changes in foot or feet position and alignment and which are not an integral part of a brace.

Other allied health professionals. Individual professional providers other than physicians, dentists, or extramedical individual providers, as specified in Sec. 199.6 of this part.

Other special institutional providers. Certain specialized medical treatment facilities, either inpatient or outpatient, other than those specifically defined, that provide courses of treatment prescribed by a doctor of medicine or osteopathy; when the patient is under the supervision of a doctor of medicine or osteopathy during the entire course of the inpatient admission or the outpatient treatment; when the type and level of care and services rendered by the institution are otherwise authorized in this Regulation; when the facility meets all licensing or other certification requirements that are extant in the jurisdiction in which the facility is located geographically; which is accredited by the Joint Commission on Accreditation if an appropriate accreditation program for the given type of facility is available; and which is not a nursing home, intermediate facility, halfway house, home for the aged, or other institution of similar purpose.

Outpatient. A patient who has not been admitted to a hospital or other authorized institution as an inpatient.

Ownership or control interest. For purposes of Sec. 199.9(f)(1), a "person with an ownership or control interest" is anyone who

- (1) Has directly or indirectly a 5 percent or more ownership interest in the entity; or
- (2) Is the owner of a whole or part interest in any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the entity or any of the property or assets thereof, which whole or part interest is equal to or exceeds 5 percent of the total property and assets of the entity; or
- (3) Is an officer or director of the entity if the entity is organized as a corporation; or
- (4) Is a partner in the entity if the entity is organized as a partnership.

Partial hospitalization. A treatment setting capable of providing an interdisciplinary program of medical therapeutic services at least 3 hours per day, 5 days per week, which may embrace day, evening, night and weekend treatment programs which employ an integrated, comprehensive and complementary schedule of recognized treatment approaches. Partial hospitalization is a time-limited, ambulatory, active treatment program that offers therapeutically intensive, coordinated, and structured clinical services within a stable therapeutic environment. Partial hospitalization is an appropriate setting for crisis stabilization, treatment of partially stabilized mental health disorders, and a transition from an inpatient program when medically necessary. Such programs must enter into a participation agreement with CHAMPUS, and be accredited and in substantial compliance with the standards of the Mental Health Manual of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) (formerly known as the Consolidated Standards).

Participating provider. A CHAMPUS-authorized provider that is required, or has agreed by entering into a CHAMPUS participation agreement or by act of indicating "accept assignment" on the claim form, to accept the CHAMPUS-allowable amount as the maximum total charge for a service or item rendered to a CHAMPUS beneficiary, whether the amount is paid for fully by CHAMPUS or requires cost-sharing by the CHAMPUS beneficiary.

Part-time or intermittent home health aide and skilled nursing services. Part-time or intermittent means skilled nursing and home health aide services furnished any number of days per week as long as they are furnished (combined) less than 8 hours each day and 28 or fewer hours each week (or, subject to review on a case-by-case basis as to the need for care, less than 8 hours each day and 35 or fewer hours per week).

Party to a hearing. An appealing party or parties and CHAMPUS.

Party to the initial determination. Includes CHAMPUS and also refers to a CHAMPUS beneficiary and a participating provider of services whose interests have been adjudicated by the initial determination. In addition, a provider who has been denied approval as an authorized CHAMPUS provider is a party to that initial determination, as is a provider who is disqualified or excluded as an authorized provider under CHAMPUS, unless the provider is excluded based on a determination of abuse or fraudulent practices or procedures under another federal or federally funded program. See Sec. 199.10 for additional information concerning parties not entitled to administrative review under the CHAMPUS appeals and hearing procedures.

Pastoral counselor. An extramedical individual provider who meets the requirements outlined in Sec. 199.6.

Pharmaceutical Agent. Drugs, biological products, and medical devices under the regulatory authority of the Food and Drug Administration.

Pharmacist. A person who is trained specially in the scientific basis of pharmacology and who is licensed to prepare and sell or dispense drugs and compounds and to make up prescriptions ordered by a physician.

Physical medicine services or physiatry services. The treatment of disease or injury by physical means such as massage, hydrotherapy, or heat.

Physical therapist. A person who is trained specially in the skills and techniques of physical therapy (that is, the treatment of disease by physical agents and methods such as heat, massage, manipulation, therapeutic exercise, hydrotherapy, and various forms of energy such as electrotherapy and ultrasound), who has been authorized legally (that is, registered) to administer treatments prescribed by a physician and who is entitled legally to use the designation "Registered Physical Therapist." A physical therapist also may be called a physiotherapist.

Physician. A person with a degree of Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) who is licensed to practice medicine by an appropriate authority.

Physician in training. Interns, residents, and fellows participating in approved postgraduate training programs and physicians who are not in approved programs but who are authorized to practice only in a hospital or other institutional provider setting, e.g., individuals with temporary or restricted licenses, or unlicensed graduates of foreign medical schools.

**Representative.** Any person who has been appointed by a party to the initial determination as counsel or advisor and who is otherwise eligible to serve as the counsel or advisor of the party to the initial determination, particularly in connection with a hearing.

**Reservist.** A person who is under an active duty call or order to one of the Uniformed Services for a period of 30 days or less or is on inactive training.

**Resident (medical).** A graduate physician or dentist who has an M.D. or D.O. degree, or D.D.S. or D.M.D. degree, respectively, is licensed to practice, and who choose to remain on the house staff of a hospital to get further training that will qualify him or her for a medical or dental specialty.

**Residential treatment center (RTC).** A facility (or distinct part of a facility) which meets the criteria in Sec. 199.6(b)(4)(v).

**Respite care.** Respite care is short-term care for a patient in order to provide rest and change for those who have been caring for the patient at home, usually the patient's family.

**Retiree.** A member or former member of a Uniformed Service who is entitled to retired, retainer, or equivalent pay based on duty in a Uniformed Service.

**Routine eye examinations.** The services rendered in order to determine the refractive state of the eyes.

**Sanction.** For purpose of Sec. 199.9, "sanction" means a provider exclusion, suspension, or termination.

**Secondary payer.** The plan or program whose medical benefits are payable in double coverage situations only after the primary payer has adjudicated the claim.

**Semiprivate room.** A room containing at least two beds. If a room is designated publicly as a semiprivate accommodation by the hospital or other authorized institutional provider and contains multiple beds, it qualifies as a semiprivate room for the purposes of CHAMPUS.

**Serious physical disability.** Any physiological disorder or condition or anatomical loss affecting one or more body systems which has lasted, or with reasonable certainty is expected to last, for a minimum period of 12 contiguous months, and which precludes the person with the disorder, condition or anatomical loss from unaided performance of at least one Major Life Activity as defined in this section.

**Skilled nursing facility.** An institution (or a distinct part of an institution) that meets the criteria as set forth in Sec. 199.6(b)(4)(vi).

**Skilled nursing services.** Skilled nursing services includes application of professional nursing services and skills by an RN, LPN, or LVN, that are required to be performed under the general supervision/direction of a TRICARE-authorized physician to ensure the safety of the patient and achieve the medically desired result in accordance with accepted standards of practice.

**Sole community hospital (SCH).** A hospital that is designated by CMS as an SCH and meets the applicable requirements established by Sec. 199.6(b)(4)(xvii).

Spectacles, eyeglasses, and lenses. Lenses, including contact lenses, that help to correct faulty vision.

Speech generating device (SGD). See Augmentative Communication Device.

Sponsor. A member or former member of a Uniformed Service upon whose status his or her dependents' eligibility for CHAMPUS is based. A sponsor also includes a person who, while a member of the Uniformed Services and after becoming eligible to be retired on the basis of years of service, has his or her eligibility to receive retired pay terminated as a result of misconduct involving abuse of a spouse or dependent child. It also includes NATO members who are stationed in or passing through the United States on official business when authorized. It also includes individuals eligible for CHAMPUS under the Transitional Assistance Management Program.

Spouse. A lawful husband or wife, who meets the criteria in Sec. 199.3 of this part, regardless of whether or not dependent upon the member or former member for his or her own support.

State. For purposes of this part, any of the several States, the District of Columbia, the Commonwealth of Puerto Rico, the Commonwealth of the Northern Mariana Islands, and each territory and possession of the United States.

State victims of crime compensation programs. Benefits available to victims of crime under the Violent Crime Control and Law Enforcement Act.

Student status. A dependent of a member or former member of a Uniformed Service who has not passed his or her 23rd birthday, and is enrolled in a full-time course of study in an institution of higher learning.

Supplemental insurance plan. A health insurance policy or other health benefit plan offered by a private entity to a CHAMPUS beneficiary, that primarily is designed, advertised, marketed, or otherwise held out as providing payment for expenses incurred for services and items that are not reimbursed under CHAMPUS due to program limitations, or beneficiary liabilities imposed by law. CHAMPUS recognizes two types of supplemental plans, general indemnity plans, and those offered through a direct service health maintenance organization (HMO).

(1) An indemnity supplemental insurance plan must meet all of the following criteria:

(i) It provides insurance coverage, regulated by state insurance agencies, which is available only to beneficiaries of CHAMPUS.

(ii) It is premium based and all premiums relate only to the CHAMPUS supplemental coverage.

- (iii) Its benefits for all covered CHAMPUS beneficiaries are predominantly limited to non-covered services, to the deductible and cost-shared portions of the pre-determined allowable charges, and/or to amounts exceeding the allowable charges for covered services.
  - (iv) It provides insurance reimbursement by making payment directly to the CHAMPUS beneficiary or to the participating provider.
  - (v) It does not operate in a manner which results in lower deductibles or cost-shares than those imposed by law, or that waives the legally imposed deductibles or cost-shares.
- (2) A supplemental insurance plan offered by a Health Maintenance Organization (HMO) must meet all of the following criteria:
- (i) The HMO must be authorized and must operate under relevant provisions of state law.
  - (ii) The HMO supplemental plan must be premium based and all premiums must relate only to CHAMPUS supplemental coverage.
  - (iii) The HMO's benefits, above those which are directly reimbursed by CHAMPUS, must be limited predominantly to services not covered by CHAMPUS and CHAMPUS deductible and cost-share amounts.
  - (iv) The HMO must provide services directly to CHAMPUS beneficiaries through its affiliated providers who, in turn, are reimbursed by CHAMPUS.
  - (v) The HMO's premium structure must be designed so that no overall reduction in the amount of the beneficiary deductibles or cost-shares will result.

Suppliers of portable X-ray services. A supplier that meets the conditions of coverage of the Medicare program, set forth in the Medicare regulations (42 CFR 405.1411 through 405.1416 (as amended)) or the Medicaid program in the state in which the covered service is provided.

Surgery. Medically appropriate operative procedures, including related preoperative and postoperative care; reduction of fractures and dislocations; injections and needling procedures of the joints; laser surgery of the eye; and those certain procedures listed in Sec. 199.4(c)(2)(i) of this part.

Surgical assistant. A physician (or dentist or podiatrist) who assists the operating surgeon in the performance of a covered surgical service when such assistance is certified as necessary by the attending surgeon, when the type of surgical procedure being performed is of such complexity and seriousness as to require a surgical assistant, and when interns, residents, or other house staff are not available to provide the surgical assistance services in the specialty area required.

Suspension of claims processing. The temporary suspension of processing (to protect the government's interests) of claims for care furnished by a specific provider (whether the claims are submitted by the provider or beneficiary) or claims submitted by or on behalf of a specific CHAMPUS beneficiary pending action by the Director, OCHAMPUS, or a designee, in a case of suspected fraud or abuse. The action may include the administrative remedies

provided for in Sec. 199.9 or any other Department of Defense issuance (e.g. DoD issuances implementing the Program Fraud Civil Remedies Act), case development or investigation by OCHAMPUS, or referral to the Department of Defense-Inspector General or the Department of Justice for action within their cognizant jurisdictions.

Teaching physician. A teaching physician is any physician whose duties include providing medical training to physicians in training within a hospital or other institutional provider setting.

Third-party billing agent. Any entity that acts on behalf of a provider to prepare, submit and monitor claims, excluding those entities that act solely as a collection agency.

Third-party payer. Third-payer means an entity that provides an insurance, medical service, or health plan by contract or agreement, including an automobile liability insurance or no fault insurance carrier and a worker's compensation program or plan, and any other plan or program (e.g., homeowners insurance) that is designed to provide compensation or coverage for expenses incurred by a beneficiary for medical services or supplies. For purposes of the definition of "third-party payer," an insurance, medical service, or health plan includes a preferred provider organization, an insurance plan described as Medicare supplemental insurance, and a personal injury protection plan or medical payments benefit plan for personal injuries resulting from the operation of a motor vehicle.

NOTE: TRICARE is secondary payer to all third-party payers. Under limited circumstances described in Sec. 199.8(c)(2) of this part, TRICARE payment may be authorized to be paid in advance of adjudication of the claim by certain third-party payers. TRICARE advance payments will not be made when a third-party provider is determined to be a primary medical insurer under Sec. 199.8(c)(3) of this part.

Timely filing. The filing of CHAMPUS claims within the prescribed time limits as set forth in Sec. 199.7 of this part.

Transitional Assistance Management Program (TAMP). The program established under 10 U.S.C. Sec. 1145(a) and Sec. 199.3(e) of this part.

Treatment plan. A detailed description of the medical care being rendered or expected to be rendered a CHAMPUS beneficiary seeking approval for inpatient benefits for which preauthorization is required as set forth in Sec. 199.4(b) of this part. A treatment plan must include, at a minimum, a diagnosis (either ICD-9-CM or DSM-III); detailed reports of prior treatment, medical history, family history, social history, and physical examination; diagnostic test results; consultant's reports (if any); proposed treatment by type (such as surgical, medical, and psychiatric); a description of who is or will be providing treatment (by discipline or specialty); anticipated frequency, medications, and specific goals of treatment; type of inpatient facility required and why (including length of time the related inpatient stay will be required); and prognosis. If the treatment plan involves the transfer of a CHAMPUS patient from a hospital or another inpatient facility, medical records related to that inpatient stay also are required as a part of the treatment plan documentation.

TRICARE Extra plan. The health care option, provided as part of the TRICARE program under Sec. 199.17, under which beneficiaries may choose to receive care in facilities of the uniformed services, or from special civilian network providers (with reduced cost sharing), or from any other CHAMPUS-authorized provider (with standard cost sharing).

TRICARE Hospital Outpatient Prospective Payment System (OPPS). OPPS is a hospital outpatient prospective payment system, based on nationally established APC payment amounts and standardized for geographic wage differences that includes operating and capital-related costs that are directly related and integral to performing a procedure or furnishing a service in a hospital outpatient department.

TRICARE Prime plan. The health care option, provided as part of the TRICARE program under Sec. 199.17, under which beneficiaries enroll to receive all health care from facilities of the uniformed services and civilian network providers (with civilian care subject to substantially reduced cost sharing).

TRICARE program. The program establish under Sec. 199.17.

TRICARE Reserve Select. The program established under 10 U.S.C. 1076d and Sec. 199.24 of this Part.

TRICARE Retired Reserve. The program established to allow members of the Retired Reserve who are qualified for non-regular retirement, but are not yet 60 years of age, as well as certain survivors to qualify to purchase medical coverage equivalent to the TRICARE Standard (and Extra) benefit unless that member is either enrolled in, or eligible to enroll in, a health benefit plan under Chapter 89 of Title 5, United States Code. The program benefits and requirements are set forth in section 25 of this Part.

TRICARE standard plan. The health care option, provided as part of the TRICARE program under Sec. 199.17, under which beneficiaries are eligible for care in facilities of the uniformed services and CHAMPUS under standard rules and procedures.

TRICARE Young Adult. The program authorized by and described in Sec. 199.26 of this part.

Uniform HMO benefit. The health care benefit established by Sec. 199.18.

Uniformed Services. The Army, Navy, Air Force, Marine Corps, Coast Guard, Commissioned Corps of the USPHS, and the Commissioned Corps of the NOAA.

Veteran. A person who served in the active military, naval, or air service, and who was discharged or released therefrom under conditions other than dishonorable.

NOTE: Unless the veteran is eligible for "retired pay," "retirement pay," or "retainer pay," which refers to payments of a continuing nature and are payable at fixed intervals from the government for military service neither the veteran nor his or her dependents are eligible for benefits under CHAMPUS.

Waiver of benefit limits. Extension of current benefit limitations under the Case Management Program, of medical care, services, and/or equipment, not otherwise a benefit under the TRICARE/CHAMPUS program.

Well-child care. A specific program of periodic health screening, developmental assessment, and routine immunization for dependents under six years of age.

Widow or Widower. A person who was a spouse at the time of death of a member or former member and who has not remarried.

Worker's compensation benefits. Medical benefits available under any worker's compensation law (including the Federal Employees Compensation Act), occupational disease law, employers liability law, or any other legislation of similar purpose, or under the maritime doctrine of maintenance, wages, and cure.

X-ray services. An x-ray examination from which an x-ray film or other image is produced, ordered by the attending physician when necessary and rendered in connection with a medical or surgical diagnosis or treatment of an illness or injury, or in connection with maternity or well-baby care.

[51 FR 24008, Jul 1, 1986, as amended at 64 FR 46134, Aug 24, 1999; 66 FR 40606, Aug 3, 2001; 66 FR 45172, Aug 28, 2001; 67 FR 18826, Apr 17, 2002; 67 FR 40602, Jun 13, 2002; 68 FR 6618, Feb 10, 2003; 68 FR 23032, Apr 30, 2003; 68 FR 32361, May 30, 2003; 68 FR 44880, Jul 31, 2003; 69 FR 17048, Apr 1, 2004; 69 FR 44946, Jul 28, 2004; 69 FR 51563, Aug 20, 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 35532, Jun 21, 2006; 71 FR 47092, Aug 16, 2006; 72 FR 46383, Aug 20, 2007; 73 FR 74964, Dec 10, 2008; 74 FR 44755, Aug 31, 2009; 75 FR 47455, Aug 6, 2010; 75 FR 47458, Aug 6, 2010; 76 FR 8297, Feb 14, 2011; 76 FR 23483, Apr 27, 2011; 77 FR 38178, Jun 27, 2012; 78 FR 12954, Feb 26, 2013; [78 FR 48309, Aug 8, 2013](#)]

**EDITORIAL NOTE:** For Federal Register citations affecting Sec. 199.2, see the List of CFR Sections Affected, which appears in the Finding Aids section of the printed volume and on GPO Access.

**EDITORIAL NOTE:** At 66 FR 45172, Aug. 28, 2001, Sec. 199.2, was amended in part by revising the definition of "Director, OCHAMPUS". However, because of inaccurate amendatory language, this amendment could not be incorporated.

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

(xvii) Sole community hospitals (SCHs). SCHs must meet all the criteria for classification as an SCH under 42 CFR 412.92, in order to be considered an SCH under the TRICARE program.

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

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

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

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

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

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

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

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

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

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

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

- (i) Physicians. (A) Doctors of Medicine (M.D.).
- (B) Doctors of Osteopathy (D.O.).

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

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

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

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

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

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

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

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

(B) Doctors of Optometry.

(C) Doctors of Podiatry or Surgical Chiropody.

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

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

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

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

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

(1) A licensed, registered nurse; and

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

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

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

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

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

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

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

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

(1) Is a licensed, registered nurse; and

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

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

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

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

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

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

successor organization; and

(ii) Includes approximately two years of specialized basic science and clinical education in anesthesia at a level that builds on a premedical undergraduate science background.

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

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

(1) Is a licensed, registered nurse; and

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

(K) Other individual paramedical providers.(1) The services of the following individual professional providers of care to be considered for benefits on a fee-for-service basis may be provided only if the beneficiary is referred by a physician for the treatment of a medically diagnosed condition and a physician must also provide continuing and ongoing oversight and supervision of the program or episode of treatment provided by these individual paramedical providers.

(i) Licensed registered nurses.

(ii) Audiologists.

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

(i) Licensed registered physical therapist and occupational therapist.

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

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

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

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(N) Certified mental health counselor. For the purposes of CHAMPUS, a certified mental health counselor (CMHC) must be licensed for independent practice in mental health counseling by the jurisdiction where practicing. In jurisdictions with two or more licenses allowing for differing scopes of independent practice, the licensed mental health counselor may only practice within the scope of the license he or she possesses. In addition, a CMHC must meet all of the requirements contained in this paragraph (c)(3)(iii)(N)(1) or the requirements of paragraph (c)(3)(iii)(N)(2) of this section.

(1) The requirements of this paragraph are that the CMHC:

(i) Must have passed the National Clinical Mental Health Counselor Examination (NCMHCE) or its successor as determined by the Director, TMA; and

(ii) Must possess a master's or higher-level degree from a mental health counseling program of education and training accredited by the Council for Accreditation of Counseling and Related Educational Programs (CACREP); and

(iii) Must have a minimum of two (2) years of post-master's degree supervised mental health counseling practice which includes a minimum of 3,000 hours of supervised clinical practice and 100 hours of face-to-face supervision. This supervision must be provided by a mental health counselor who is licensed for independent practice in mental health counseling in the jurisdiction where practicing and must be conducted in a manner that is consistent with the guidelines for supervision of the American Mental Health Counselors Association.

(2) The requirements of this paragraph are that the CMHC, prior to January 1, 2015:

(i) Possess a master's or higher-level degree from a mental health counseling program of education and training accredited by CACREP and must have passed the National Counselor Examination (NCE); or

(ii) Possess a master's or higher-level degree from a mental health counseling program of education and training from either a CACREP or regionally accredited institution and have passed the NCMHCE; and

(iii) Must have a minimum of two (2) years of post-master's degree supervised mental health counseling practice which includes a minimum of 3,000 hours of supervised clinical practice and 100 hours of face-to-face supervision. This supervision must be provided by a mental health counselor who is licensed for independent practice in mental health counseling in the jurisdiction where practicing and must be conducted in a manner that is consistent with the guidelines for supervision of the American Mental Health Counselors Association.

(3) The Director, TRICARE Management Activity may amend or modify existing or specify additional certification requirements as needed to accommodate future practice and licensing standards and to ensure that all CMHCs continue to meet educational, licensing and clinical training requirements considered appropriate.

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

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

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

(2) The following experience:

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

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

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

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

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

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

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

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

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

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

(2) The following experience:

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

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

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

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

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

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

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

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

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

as required by the referring physician (refer to Sec. 199.7).

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

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

(C) Supervised mental health counselor. For the purposes of TRICARE, a supervised mental health counselor is an individual who does not meet the requirements of a certified mental health counselor in paragraph (c)(3)(iii)(N) of this section, but meets the requirements of this paragraph (c)(3)(iv)(C). After December 31, 2014, this category of provider will no longer be recognized by TRICARE and no reimbursement may be made to any person for services provided by this category of provider. However, prior to January 1, 2015, a supervised mental health counselor is one who meets all of the following requirements and conditions of practice:

- (1) Minimum of a master's degree in mental health counseling or allied mental health field from a regionally accredited institution; and
- (2) Two years of post-masters experience which includes 3,000 hours of clinical work and 100 hours of face-to-face supervision; and
- (3) Is licensed or certified to practice as a mental health counselor by the jurisdiction where practicing (see paragraph (c)(3)(iv)(D) of this section for more specific information); and
- (4) May only be reimbursed when:
  - (i) The TRICARE beneficiary is referred for therapy by a physician; and
  - (ii) A physician is providing ongoing oversight and supervision of the therapy being provided; and
  - (iii) The mental health counselor certifies on each claim for reimbursement that a written communication has been made or will be made to the referring physician of the results of the treatment. Such communication will be made at the end of the treatment, or more frequently, as required by the referring physician (refer to Sec. 199.7 of this part); and

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(iv) The date of services provided is on or before December 31, 2014.

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

(1) These providers must also be licensed or certified to practice as a certified marriage and family therapist, pastoral counselor or mental health counselor by the jurisdiction where practicing. In jurisdictions that do not provide for licensure or certification, the provider must be certified by or eligible for full clinical membership in the appropriate national professional association that sets standards for the specific profession.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(B) Located within a state; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- (i) Be a corporation or a foundation, but not a professional corporation or professional association; and
- (ii) Be institution-affiliated or freestanding as defined in Sec. 199.2; and
- (iii) Provide:

(A) Services and related supplies of a type rendered by CHAMPUS individual professional providers or diagnostic technical services and related supplies of a type which requires direct patient contact and a technologist who is licensed by the state in which the procedure is rendered or who is certified by a Qualified Accreditation Organization as defined in Sec. 199.2; and

(B) A level of care which does not necessitate that the beneficiary be provided with on-site sleeping accommodations and food in conjunction with the delivery of services; and

(iv) Complies with all applicable organizational and individual licensing or certification requirements that are extant in the state, county, municipality, or other political jurisdiction in which the provider renders services; and

(v) Be approved for Medicare payment when determined to be substantially comparable under the provisions of paragraph (f)(1)(iv)(D) of this section or, when Medicare approved status is not required, be accredited by a qualified accreditation organization, as defined in Sec. 199.2; and

(vi) Has entered into a participation agreement approved by the Director, OCHAMPUS, or designee, which at least complies with the minimum participation agreement requirements of this section.

(3) Transfer of participation agreement. In order to provide continuity of care for beneficiaries when there is a change of provider ownership, the provider agreement is automatically assigned to the new owner, subject to all the terms and conditions under which the original agreement was made.

(i) The merger of the provider corporation or foundation into another corporation or foundation, or the consolidation of two or more corporations or foundations resulting in the creation of a new corporation or foundation, constitutes a change of ownership.

(ii) Transfer of corporate stock or the merger of another corporation or foundation into the provider corporation or foundation does not constitute change of ownership.

(iii) The surviving corporation or foundation shall notify the Director, OCHAMPUS, or designee, in writing of the change of ownership promptly after the effective date of the transfer or change in ownership.

(4) Pricing and payment methodology: The pricing and payment of procedures rendered by a provider authorized under this paragraph (f) shall be limited to those methods for pricing and payment allowed by this part which the Director, OCHAMPUS, or designee, determines contribute to the efficient management of CHAMPUS.

(5) Termination of participation agreement. A provider may terminate a participation agreement upon 45 days written notice to the Director, OCHAMPUS, or designee, and to the public.

[51 FR 24008, Jul 1, 1986; 67 FR 40602, Jun 13, 2002; 67 FR 42720, Jun 25, 2002; 68 FR 65174, Nov 19, 2003; 69 FR 29229, May 21, 2004; 69 FR 44591, Jul 28, 2004; 69 FR 51568, Aug 20, 2004; 69 FR 55359, Sep 14, 2004; 70 FR 61378, Oct 24, 2005; 72 FR 63988, Nov 14, 2007; 74 FR 44755, Aug 31, 2009; 74 FR 55777, Oct 29, 2009; 74 FR 65438, Dec 10, 2009; 75 FR 47460, Aug 6, 2010; 75 FR 50882, Aug 18, 2010; 76 FR 41065, Jul 13, 2011; 76 FR 80743, Dec 27, 2011; 78 FR 48309, Aug 8, 2013]

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



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

(6) Sole community hospitals (SCHs). Prior to implementation of the SCH reimbursement method described in paragraph (a)(7) of this section, any hospital that has qualified for special treatment under the Medicare prospective payment system as an SCH (see subpart G of 42 CFR part 412) and has not given up that classification is exempt from the CHAMPUS DRG-based payment system.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

should refer to paragraph (a)(1) of this section for provisions pertinent to the CHAMPUS DRG-based payment system.

(B) DRG 424. Admissions for operating room procedures involving a principal diagnosis of mental illness (services which group into DRG 424) are exempt from the per diem payment system. They will be reimbursed pursuant to the provisions of paragraph (a)(3) of this section.

(C) Non-mental health services. Admissions for non-mental health procedures in specialty psychiatric hospitals and units are exempt from the per diem payment system. They will be reimbursed pursuant to the provisions of paragraph (a)(3) of this section.

(D) Sole community hospitals (SCHs). Prior to implementation of the SCH reimbursement method described in paragraph (a)(7) of this section, any hospital that has qualified for special treatment under the Medicare prospective payment system as an SCH and has not given up that classification is exempt.

(E) Hospitals outside the U.S. A hospital is exempt if it is not located in one of the 50 states, the District of Columbia or Puerto Rico.

(ix) Per diem payment for psychiatric and substance use disorder rehabilitation partial hospitalization services--(A) In general. Psychiatric and substance use disorder rehabilitation partial hospitalization services authorized by Sec. 199.4(b)(10) and (e)(4) and provided by institutional providers authorized under Sec. 199.6 (b)(4)(xii) and (b)(4)(xiv) are reimbursed on the basis of prospectively determined, all-inclusive per diem rates pursuant to the provisions of paragraph (a)(2)(ix)(C) of this section, with the exception of hospital-based psychiatric and substance use disorder rehabilitation partial hospitalization services which are reimbursed in accordance with provisions of paragraph (a)(5)(ii) of this section. The per diem payment amount must be accepted as payment in full for all institutional services provided, including board, routine nursing service, ancillary services (includes music, dance, occupational and other such therapies), psychological testing and assessment, overhead and any other services for which the customary practice among similar providers is included as part of the institutional charges.

(B) Services which may be billed separately. The following services are not considered as included within the per diem payment amount and may be separately billed when provided by an authorized independent professional provider:

(1) Psychotherapy sessions not included. Professional services provided by an authorized professional provider (who is not employed by or under contract with the partial hospitalization program) for purposes of providing clinical patient care to a patient in the partial hospitalization program are not included in the per diem rate. They may be separately billed. Professional mental health benefits are limited to a maximum of one session (60 minutes individual, 90 minutes family, etc.) per authorized treatment day not to exceed five sessions in any calendar week.

(2) Non-mental health related medical services. Those services not normally included in the evaluation and assessment of a partial hospitalization program, non-mental health related medical services, may be separately billed when provided by an authorized

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independent professional provider. This includes ambulance services when medically necessary for emergency transport.

(C) Per diem rate. For any full day partial hospitalization program (minimum of 6 hours), the maximum per diem payment amount is 40 percent of the average inpatient per diem amount per case established under the CHAMPUS mental health per diem reimbursement system for both high and low volume psychiatric hospitals and units (as defined in Sec. 199.14(a)(2)) for the fiscal year. A partial hospitalization program of less than 6 hours (with a minimum of three hours) will be paid a per diem rate of 75 percent of the rate for a full-day program.

(D) Other requirements. No payment is due for leave days, for days in which treatment is not provided, or for days in which the duration of the program services was less than three hours.

(3) Reimbursement for inpatient services provided by a CAH. (i) For admissions on or after December 1, 2009, inpatient services provided by a CAH, other than services provided in psychiatric and rehabilitation distinct part units, shall be reimbursed at allowable cost (i.e., 101 percent of reasonable cost) under procedures, guidelines and instructions issued by the TMA Director, or designee. This does not include any costs of physician services or other professional services provided to CAH inpatients. Inpatient services provided in psychiatric distinct part units would be subject to the CHAMPUS mental health payment system. Inpatient services provided in rehabilitation distinct part units would be subject to billed charges.

(ii) The percentage amount stated in paragraph (a)(3)(i) of this section is subject to possible upward adjustment based on a inpatient GTMCPA for TRICARE network hospitals deemed essential for military readiness and support during contingency operations under paragraph (a)(8) of this section.

(4) Billed charges and set rates. The allowable costs for authorized care in all hospitals not subject to the CHAMPUS DRG-based payment system, the CHAMPUS mental health per-diem system, the reasonable cost method for CAHs, or the reimbursement rules for SCHs shall be determined on the basis of billed charges or set rates.

(i) The actual charge for such service made to the general public; or

(ii) The allowed charge applicable to the policyholders or subscribers of the CHAMPUS fiscal intermediary for comparable services under comparable circumstances, when extended to CHAMPUS beneficiaries by consent or agreement; or

(iii) The allowed charge applicable to the citizens of the community or state as established by local or state regulatory authority, excluding title XIX of the Social Security Act or other welfare program, when extended to CHAMPUS beneficiaries by consent or agreement.

(5) CHAMPUS discount rates. The CHAMPUS-determined allowable cost for authorized care in any hospital may be based on discount rates established under paragraph (l) of this section.

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(6) Hospital outpatient services. This paragraph (a)(6) identifies and clarifies payment methods for certain outpatient services, including emergency services, provided by hospitals.

(i) Outpatient Services Not Subject to Hospital Outpatient Prospective Payment System (OPPS). The following are payment methods for outpatient services that are either provided in an OPPS exempt hospital or paid outside the OPPS payment methodology under existing fee schedules or other prospectively determined rates in a hospital subject to OPPS reimbursement.

(A) Laboratory services. TRICARE payments for hospital outpatient laboratory services including clinical laboratory services are based on the allowable charge method under paragraph (j)(1) of the section. In the case of laboratory services for which the CMAC rates are established under that paragraph, a payment rate for the technical component of the laboratory services is provided. Hospital charges for an outpatient laboratory service are reimbursed using the CMAC technical component rate.

(B) Rehabilitation therapy services. Rehabilitation therapy services provided on an outpatient basis by hospitals are paid on the same basis as rehabilitation therapy services covered by the allowable charge method under paragraph (j)(1) of this section.

(C) Venipuncture. Routine venipuncture services provided on an outpatient basis by hospitals are paid on the same basis as such services covered by the allowable charge method under paragraph (j)(1) of this section. Routine venipuncture services provided on an outpatient basis by institutional providers other than hospitals are also paid on this basis.

(D) Radiology services. TRICARE payments for hospital outpatient radiology services are based on the allowable charge method under paragraph (j)(1) of the section. In the case of radiology services for which the CMAC rates are established under that paragraph, a payment rate for the technical component of the radiology services is provided. Hospital charges for an outpatient radiology service are reimbursed using the CMAC technical component rate.

(E) Diagnostic services. TRICARE payments for hospital outpatient diagnostic services are based on the allowable charge method under paragraph (j)(1) of the section. In the case of diagnostic services for which the CMAC rates are established under that paragraph, a payment rate for the technical component of the diagnostic services is provided. Hospital charges for an outpatient diagnostic service are reimbursed using the CMAC technical component rate.

(F) Ambulance services. Ambulance services provided on an outpatient basis by hospitals are paid on the same basis as ambulance services covered by the allowable charge method under paragraph (j)(1) of this section.

(G) Durable medical equipment (DME) and supplies. Durable medical equipment and supplies provided on an outpatient basis by hospitals are paid on the same basis as durable medical equipment and supplies covered by the allowable charge method under paragraph (j)(1) of this section.

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(H) Oxygen and related supplies. Oxygen and related supplies provided on an outpatient basis by hospitals are paid on the same basis as oxygen and related supplies covered by the allowable charge method under paragraph (j)(1) of this section.

(I) Drugs administered other than oral method. Drugs administered other than oral method provided on an outpatient basis by hospitals are paid on the same basis as drugs administered other than oral method covered by the allowable charge method under paragraph (j)(1) of this section. The allowable charge for drugs administered other than oral method is established from a schedule of allowable charges based on a formulary of the average wholesale price.

(J) Professional provider services. TRICARE payments for hospital outpatient professional provider services rendered in an emergency room, clinic, or hospital outpatient department, etc., are based on the allowable charge method under paragraph (j)(1) of the section. In the case of professional services for which the CMAC rates are established under that paragraph, a payment rate for the professional component of the services is provided. Hospital charges for an outpatient professional service are reimbursed using the CMAC professional component rate. If the professional outpatient hospital services are billed by a professional provider group, not by the hospital, no payment shall be made to the hospital for these services.

(K) Facility charges. TRICARE payments for hospital outpatient facility charges that would include the overhead costs of providing the outpatient service would be paid as billed. For the definition of facility charge, see Sec. 199.2(b).

(L) Ambulatory surgery services. Hospital outpatient ambulatory surgery services shall be paid in accordance with Sec. 199.14(d).

(ii) Outpatient Services Subject to OPSS. Outpatient services provided in hospitals subject to Medicare OPSS as specified in 42 CFR 413.65 and 42 CFR Sec. 419.20 will be paid in accordance with the provisions outlined in sections 1833(t) of the Social Security Act and its implementing Medicare regulation (42 CFR Part 419) subject to exceptions as authorized by Sec. 199.14(a)(5)(ii). Under the above governing provisions, CHAMPUS will recognize to the extent practicable, in accordance with 10 U.S.C. 1079(j)(2), Medicare's OPSS reimbursement methodology to include specific coding requirements, ambulatory payment classifications (APCs), nationally established APC amounts and associated adjustments (e.g., discounting for multiple surgery procedures, wage adjustments for variations in labor-related costs across geographical regions and outlier calculations). While CHAMPUS intends to remain as true as possible to Medicare's basic OPSS methodology, there will be some deviations required to accommodate CHAMPUS' unique benefit structure and beneficiary population as authorized under the provisions of 10 U.S.C. 1079(j)(2). Temporary transitional payment adjustments (TTPAs) will be in place for all hospitals, both network and non-network in order to buffer the initial decline in payments upon implementation of TRICARE's OPSS. For network hospitals, the temporary transitional payment adjustments (TTPAs) will cover a four-year period. The four-year transition will set higher payment percentages for the ten Ambulatory Payment Classification (APC) codes 604-609 and 613-616, with reductions in each of the transition years. For non-network hospitals, the adjustments will cover a three year period, with reductions in each of the transition years. For network hospitals, under the TTPAs, the APC payment level for the five clinic visit APCs would be set at 175 percent of the Medicare APC level, while the five ER visit APCs would be increased by 200 percent in the

first year of OPSS implementation. In the second year, the APC payment levels would be set at 150 percent of the Medicare APC level for clinic visits and 175 percent for ER APCs. In the third year, the APC visit amounts would be set at 130 percent of the Medicare APC level for clinic visits and 150 percent for ER APCs. In the fourth year, the APC visit amounts would be set at 115 percent of the Medicare APC level for clinic visits and 130 per cent for ER APCs. In the fifth year, the TRICARE and Medicare payment levels for the 10 APC visit codes would be identical.

For non-network hospitals, under the TTPAs, the APC payment level for the five clinic and ER visit APCs would be set at 140 percent of the Medicare APC level in the first year of OPSS implementation. In the second year, the APC payment levels would be set at 125 percent of the Medicare APC level for clinic and ER visits. In the third year, the APC visit amounts would be set at 110 percent of the Medicare APC level for clinic and ER visits. In the fourth year, the TRICARE and Medicare payment levels for the 10 APC visit codes would be identical.

An additional temporary military contingency payment adjustment (TMCPA) will also be available at the discretion of the Director, TMA, or a designee, at any time after implementation to adopt, modify and/or extend temporary adjustments to OPSS payments for TRICARE network hospitals deemed essential for military readiness and deployment in time of contingency operations. Any TMCPAs to OPSS payments shall be made only on the basis of a determination that it is impracticable to support military readiness or contingency operations by making OPSS payments in accordance with the same reimbursement rules implemented by Medicare. The criteria for adopting, modifying, and/or extending deviations and/or adjustments to OPSS payments shall be issued through CHAMPUS policies, instructions, procedures and guidelines as deemed appropriate by the Director, TMA, or a designee. TMCPAs may also be extended to non-network hospitals on a case-by-case basis for specific procedures where it is determined that the procedures cannot be obtained timely enough from a network hospital. For such case-by-case extensions, "Temporary" might be less than three years at the discretion of the TMA Director, or designee.

(iii) Outpatient Services Subject to CAH Reasonable Cost Method. For services on or after December 1, 2009, outpatient services provided by a CAH, shall be reimbursed at 101 percent of reasonable cost. This does not include any costs of physician services or other professional services provided to CAH outpatients.

(iv) CAH Ambulance Services. Effective for services provided on or after December 1, 2009, payment for ambulance services furnished by a CAH or an entity that is owned and operated by a CAH is the reasonable costs of the CAH or the entity in furnishing those services, but only if the CAH or the entity is the only provider or supplier of ambulance services located within a 35-mile drive of the CAH or the entity as specified under 42 CFR part 413.70(b)(5)(ii).

(7) Reimbursement for inpatient services provided by an SCH. (i) In accordance with 10 U.S.C. 1079(j)(2), TRICARE payment methods for institutional care shall be determined, to the extent practicable, in accordance with the same reimbursement rules as those that apply to payments to providers of services of the same type under Medicare. TRICARE's SCH reimbursements approximate Medicare's for SCHs. Inpatient services provided by an SCH, other than services provided in psychiatric and rehabilitation distinct part units, shall be

reimbursed through a two-step process.

(ii) The first step referred to in paragraph (a)(7)(i) of this section will be to calculate the TRICARE allowable cost by multiplying the applicable TRICARE percentage by the billed charge amount on each institutional inpatient claim. The applicable TRICARE percentage is the greater of: the SCH's most recently available cost-to-charge ratio (CCR) from the Centers for Medicare and Medicaid Services' (CMS') inpatient Provider Specific File (after the ratio has been converted to a percentage), or the TRICARE allowed-to-billed ratio, defined as the ratio of the TRICARE allowed amounts (including discounts) to the amount of billed charges for TRICARE inpatient admissions at the SCH in FY 2012 (after it has been converted to a percentage). The TRICARE allowed-to-billed ratio in FY 2012 shall be reduced as follows (after the ratio has been converted to a percentage):

(A) In the first year of implementation, 10 percentage points for network SCHs and 15 percentage points for non-network SCHs.

(B) In the second year of implementation, 20 percentage points for network SCHs and 30 percentage points for non-network SCHs.

(C) In the third year of implementation, 30 percentage points for network SCHs and 45 percentage points for non-network SCHs.

(D) In the fourth year of implementation, 40 percentage points for network SCHs and 60 percentage points for non-network SCHs.

(E) In the fifth year of implementation, 50 percentage points for network SCHs and 75 percentage points for non-network SCHs.

(F) In the sixth year of implementation, 60 percentage points for network SCHs and 90 percentage points for non-network SCHs.

(G) In the seventh year of implementation, 70 percentage points for network SCHs and 100 percentage points for non-network SCHs.

(H) In the eighth year of implementation, 80 percentage points for network SCHs and 100 percentage points for non-network SCHs.

(I) In the ninth year of implementation, 90 percentage points for network SCHs and 100 percentage points for non-network SCHs.

(J) In the tenth year of implementation, 100 percentage points for network SCHs and 100 percentage points for non-network SCHs.

(iii) The second step referred to in paragraph (a)(7)(i) of this section is a year-end adjustment. The year-end adjustment will compare the aggregate allowable costs over a 12-month period under paragraph (a)(7)(ii) of this section to the aggregate amount that would have been allowed for the same care using the TRICARE DRG-method (under paragraph (a)(1) of this section). In the event that the DRG method amount is the greater, the year-end adjustment will be the amount by which it exceeds the aggregate allowable costs. In addition, the year-end adjustment also may incorporate a possible upward adjustment for inpatient

services based on a GTMCPA for TRICARE network hospitals under paragraph (a)(8) of this section.

(iv) At the end of an SCH's transition period, when the SCH reaches its Medicare CCR, a special allowable cost shall be applicable for discharges that group to inpatient nursery and labor/delivery DRGs. For these discharges, instead of using the percentage of the SCH's Medicare cost-to-charge ratio (as described in paragraph (a)(7)(ii) of this section), the percentage will be 130 percent of the Medicare CCR.

(v) The SCH reimbursement provisions of paragraphs (a)(7)(i) through (iv) of this section do not apply to any costs of physician services or other professional services provided to SCH inpatients (which are subject to individual provider payment provisions of this section), inpatient services provided in psychiatric distinct part units (which are subject to the CHAMPUS mental health per-diem payment system), or inpatient services provided in rehabilitation distinct part units (which are reimbursed on the basis of billed charges or set rates).

(vi) The SCH payment system under this paragraph (a)(7) applies to hospitals classified by CMS as Essential Access Community Hospitals (EACHs).

(vii) The SCH payment system under this paragraph (a)(7) does not apply to hospitals in States that are paid by Medicare and TRICARE under a cost containment waiver.

(8) General temporary military contingency payment adjustment for SCHs and CAHs. (i) Payments under paragraph (a) of this section for inpatient services provided by SCHs and CAHs may be supplemented by a GTMCPA. This is a year-end discretionary, temporary adjustment that the TMA Director may approve based on all the following criteria:

(A) The hospital serves a disproportionate share of ADSMs and ADDs;

(B) The hospital is a TRICARE network hospital;

(C) The hospital's actual costs for inpatient services exceed TRICARE payments or other extraordinary economic circumstance exists; and,

(D) Without the GTMCPA, DoD's ability to meet military contingency mission requirements will be significantly compromised.

(ii) Policy and procedural instructions implementing the GTMCPA will be issued as deemed appropriate by the Director, TMA, or a designee. As with other discretionary authority under this Part, a decision to allow or deny a GTMCPA to a hospital is not subject to the appeal and hearing procedures of § 199.10.

**(b) Skilled nursing facilities (SNFs).** (1) Use of Medicare prospective payment system and rates. TRICARE payments to SNFs are determined using the same methods and rates used under the Medicare prospective payment system for SNFs under 42 CFR part 413, subpart J, except for children under age ten. SNFs receive a per diem payment of a predetermined Federal payment rate appropriate for the case based on patient classification

(using the RUG classification system), urban or rural location of the facility, and area wage index.

(2) Payment in full. The SNF payment rates represent payment in full (subject to any applicable beneficiary cost shares) for all costs (routine, ancillary, and capital-related) associated with furnishing inpatient SNF services to TRICARE beneficiaries other than costs associated with operating approved educational activities.

(3) Education costs. Costs for approved educational activities shall be subject to separate payment under procedures established by the Director, TRICARE Management Activity. Such procedures shall be similar to procedures for payments for direct medical education costs of hospitals under paragraph (a)(1)(iii)(G)(2) of this section.

(4) Resident assessment data. SNFs are required to submit the same resident assessment data as is required under the Medicare program. (The residential assessment is addressed in the Medicare regulations at 42 CFR 483.20.) SNFs must submit assessments according to an assessment schedule. This schedule must include performance of patient assessments on the 5th, 14th, and 30th days of SNF care and at each successive 30 day interval of SNF admissions that are longer than 30 days. It must also include such other assessments that are necessary to account for changes in patient care needs. TRICARE pays a default rate for the days of a patient's care for which the SNF has failed to comply with the assessment schedule.

**(c) Reimbursement for Other Than Hospitals and SNFs.** The Director, OCHAMPUS, or a designee, shall establish such other methods of determining allowable cost or charge reimbursement for those institutions, other than hospitals and SNFs, as may be required.

**(d) Payment of institutional facility costs for ambulatory surgery.** (1) In general. CHAMPUS pays institutional facility costs for ambulatory surgery on the basis of prospectively determined amounts, as provided in this paragraph, with the exception of ambulatory surgery procedures performed in hospital outpatient departments or in CAHs, which are to be reimbursed in accordance with the provisions of paragraph (a)(6)(ii) or (a)(6)(iii) respectively, of this section.

(2) Payment in full. The payment provided for under this paragraph is the payment in full for services covered by this paragraph. Facilities may not charge beneficiaries for amounts, if any, in excess of the payment amounts determined pursuant to this paragraph.

(3) Calculation of standard payment rates. Standard payment rates are calculated for groups of procedures under the following steps:

(i) Step 1: Calculate a median standardized cost for each procedure. For each ambulatory surgery procedure, a median standardized cost will be calculated on the basis of all ambulatory surgery charges nationally under CHAMPUS during a recent one-year base period. The steps in this calculation include standardizing for local labor costs by reference to the same wage index and labor/non-labor-related cost ratio as applies to the facility under Medicare, applying a cost-to-charge ratio, calculating a median cost for each procedure, and updating to the year for which the payment rates will be in effect by the Consumer Price Index-Urban. In applying a cost-to-charge ratio, the Medicare cost-to-charge ratio for freestanding ambulatory surgery centers (FASCs) will be used for all charges from FASCs,

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and the Medicare cost-to-charge ratio for hospital outpatient settings will be used for all charges from hospitals.

(ii) Step 2: Grouping procedures. Procedures will then be placed into one of ten groups by their median per procedure cost, starting with \$0 to \$299 for group 1 and ending with \$1000 to \$1299 for group 9 and \$1300 and above for group 10, with groups 2 through 8 set on the basis of \$100 fixed intervals.

(iii) Step 3: Adjustments to groups. The Director, OCHAMPUS may make adjustments to the groupings resulting from step 2 to account for any ambulatory surgery procedures for which there were insufficient data to allow a grouping or to correct for any anomalies resulting from data or statistical factors or other special factors that fairness requires be specially recognized. In making any such adjustments, the Director may take into consideration the placing of particular procedures in the ambulatory surgery groups under Medicare.

(iv) Step 4: Standard payment amount per group. The standard payment amount per group will be the volume weighted median per procedure cost for the procedures in that group. For cases in which the standard payment amount per group exceeds the CHAMPUS-determined inpatient allowable amount, the Director, TSO or his designee, may make adjustments.

(v) Step 5: Actual payments. Actual payment for a procedure will be the standard payment amount for the group which covers that procedure, adjusted for local labor costs by reference to the same labor/non-labor-related cost ratio and hospital wage index as used for ambulatory surgery centers by Medicare.

(4) Multiple procedures. In cases in which authorized multiple procedures are performed during the same operative session, payment shall be based on 100 percent of the payment amount for the procedure with the highest ambulatory surgery payment amount, plus, for each other procedure performed during the session, 50 percent of its payment amount.

(5) Annual updates. The standard payment amounts will be updated annually by the same update factor as is used in the Medicare annual updates for ambulatory surgery center payments.

(6) Recalculation of rates. The Director, OCHAMPUS may periodically recalculate standard payment rates for ambulatory surgery using the steps set forth in paragraph (d)(3) of this section.

**(e) Reimbursement of Birthing Centers.** (1) Reimbursement for maternity care and childbirth services furnished by an authorized birthing center shall be limited to the lower of the CHAMPUS established all-inclusive rate or the center's most-favored all-inclusive rate. The all-inclusive rate shall include the following to the extent that they are usually associated with a normal pregnancy and childbirth: Laboratory studies, prenatal management, labor management, delivery, post-partum management, newborn care, birth assistant, certified nurse-midwife professional services, physician professional services, and the use of the facility.

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(2) The CHAMPUS established all-inclusive rate is equal to the sum of the CHAMPUS area prevailing professional charge for total obstetrical care for a normal pregnancy and delivery and the sum of the average CHAMPUS allowable institutional charges for supplies, laboratory, and delivery room for a hospital inpatient normal delivery. The CHAMPUS established all-inclusive rate areas will coincide with those established for prevailing professional charges and will be updated concurrently with the CHAMPUS area prevailing professional charge database.

(3) Extraordinary maternity care services, when otherwise authorized, may be reimbursed at the lesser of the billed charge or the CHAMPUS allowable charge.

(4) Reimbursement for an incomplete course of care will be limited to claims for professional services and tests where the beneficiary has been screened but rejected for admission into the birthing center program, or where the woman has been admitted but is discharged from the birthing center program prior to delivery, adjudicated as individual professional services and items.

(5) The beneficiary's share of the total reimbursement to a birthing center is limited to the cost-share amount plus the amount billed for non-covered services and supplies.

**(f) Reimbursement of Residential Treatment Centers.** The CHAMPUS rate is the per diem rate that CHAMPUS will authorize for all mental health services rendered to a patient and the patient's family as part of the total treatment plan submitted by a CHAMPUS-approved RTC, and approved by the Director, OCHAMPUS, or designee.

(1) The all-inclusive per diem rate for RTCs operating or participating in CHAMPUS during the base period of July 1, 1987, through June 30, 1988, will be the lowest of the following conditions:

(i) The CHAMPUS rate paid to the RTC for all-inclusive services as of June 30, 1988, adjusted by the Consumer Price Index--Urban (CPI-U) for medical care as determined applicable by the Director, OCHAMPUS, or designee; or

(ii) The per diem rate accepted by the RTC from any other agency or organization (public or private) that is high enough to cover one-third of the total patient days during the 12-month period ending June 30, 1988, adjusted by the CPI-U; or

NOTE: The per diem rate accepted by the RTC from any other agency or organization includes the rates accepted from entities such as Government contractors in CHAMPUS demonstration projects.

(iii) An OCHAMPUS determined capped per diem amount not to exceed the 80th percentile of all established CHAMPUS RTC rates nationally, weighted by total CHAMPUS days provided at each rate during the base period discussed in paragraph (f)(1) of this section.

(2) The all-inclusive per diem rates for RTCs which began operation after June 30, 1988, or began operation before July 1, 1988, but had less than 6 months of operation by June 30, 1988, will be calculated based on the lower of the per diem rate accepted by the RTC that is high enough to cover one-third of the total patient days during its first 6 to 12 consecutive months

of operation, or the CHAMPUS determined capped amount. Rates for RTCs beginning operation prior to July 1, 1988, will be adjusted by an appropriate CPI-U inflation factor for the period ending June 30, 1988. A period of less than 12 months will be used only when the RTC has been in operation for less than 12 months. Once a full 12 months is available, the rate will be recalculated.

(3) For care on or after April 6, 1995, the per diem amount may not exceed a cap of the 70th percentile of all established Federal fiscal year 1994 RTC rates nationally, weighted by total CHAMPUS days provided at each rate during the first half of Federal fiscal year 1994, and updated to FY95. For Federal fiscal years 1996 and 1997, the cap shall remain unchanged. For Federal fiscal years after fiscal year 1997, the cap shall be adjusted by the Medicare update factor for hospitals and units exempt from the Medicare prospective payment system.

(4) All educational costs, whether they include routine education or special education costs, are excluded from reimbursement except when appropriate education is not available from, or not payable by, a cognizant public entity.

(i) The RTC shall exclude educational costs from its daily costs.

(ii) The RTC's accounting system must be adequate to assure CHAMPUS is not billed for educational costs.

(iii) The RTC may request payment of educational costs on an individual case basis from the Director, OCHAMPUS, or designee, when appropriate education is not available from, or not payable by, a cognizant public entity. To qualify for reimbursement of educational costs in individual cases, the RTC shall comply with the application procedures established by the Director, OCHAMPUS, or designee, including, but not limited to, the following:

(A) As part of its admission procedures, the RTC must counsel and assist the beneficiary and the beneficiary's family in the necessary procedures for assuring their rights to a free and appropriate public education.

(B) The RTC must document any reasons why an individual beneficiary cannot attend public educational facilities and, in such a case, why alternative educational arrangements have not been provided by the cognizant public entity.

(C) If reimbursement of educational costs is approved for an individual beneficiary by the Director, OCHAMPUS, or designee, such educational costs shall be shown separately from the RTC's daily costs on the CHAMPUS claim. The amount paid shall not exceed the RTC's most-favorable rate to any other patient, agency, or organization for special or general educational services whichever is appropriate.

(D) If the RTC fails to request CHAMPUS approval of the educational costs on an individual case, the RTC agrees not to bill the beneficiary or the beneficiary's family for any amounts disallowed by CHAMPUS. Requests for payment of educational costs must be referred to the Director, OCHAMPUS, or designee for review and a determination of the applicability of CHAMPUS benefits.

(5) Subject to the applicable RTC cap, adjustments to the RTC rates may be made annually.

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(i) For Federal fiscal years through 1995, the adjustment shall be based on the Consumer Price Index-Urban (CPI-U) for medical care as determined applicable by the Director, OCHAMPUS.

(ii) For purposes of rates for Federal fiscal years 1996 and 1997:

(A) For any RTC whose 1995 rate was at or above the thirtieth percentile of all established Federal fiscal year 1995 RTC rates normally, weighted by total CHAMPUS days provided at each rate during the first half of Federal fiscal year 1994, that rate shall remain in effect, with no additional update, throughout fiscal years 1996 and 1997; and

(B) For any RTC whose 1995 rate was below the 30th percentile level determined under paragraph (f)(5)(ii)(A) of this section, the rate shall be adjusted by the lesser of: the CPI-U for medical care, or the amount that brings the rate up to that 30th percentile level.

(iii) For subsequent Federal fiscal years after fiscal year 1997, RTC rates shall be updated by the Medicare update factor for hospitals and units exempt from the Medicare prospective payment system.

(6) For care provided on or after July 1, 1995, CHAMPUS will not pay for days in which the patient is absent on leave from the RTC. The RTC must identify these days when claiming reimbursement.

**(g) Reimbursement of hospice programs.** Hospice care will be reimbursed at one of four predetermined national CHAMPUS rates based on the type and intensity of services furnished to the beneficiary. A single rate is applicable for each day of care except for continuous home care where payment is based on the number of hours of care furnished during a 24-hour period. These rates will be adjusted for regional differences in wages using wage indices for hospice care.

(1) National hospice rates. CHAMPUS will use the national hospice rates for reimbursement of each of the following levels of care provided by or under arrangement with a CHAMPUS approved hospice program:

(i) Routine home care. The hospice will be paid the routine home care rate for each day the patient is at home, under the care of the hospice, and not receiving continuous home care. This rate is paid without regard to the volume or intensity of routine home care services provided on any given day.

(ii) Continuous home care. The hospice will be paid the continuous home care rate when continuous home care is provided. The continuous home care rate is divided by 24 hours in order to arrive at an hourly rate.

(A) A minimum of 8 hours of care must be provided within a 24-hour day starting and ending at midnight.

(B) More than half of the total actual hours being billed for each 24-hour period must be provided by either a registered or licensed practical nurse.

(C) Homemaker and home health aide services may be provided to supplement the

nursing care to enable the beneficiary to remain at home.

(D) For every hour or part of an hour of continuous care furnished, the hourly rate will be reimbursed to the hospice up to 24 hours a day.

(iii) Inpatient respite care. The hospice will be paid at the inpatient respite care rate for each day on which the beneficiary is in an approved inpatient facility and is receiving respite care.

(A) Payment for respite care may be made for a maximum of 5 days at a time, including the date of admission but not counting the date of discharge. The necessity and frequency of respite care will be determined by the hospice interdisciplinary group with input from the patient's attending physician and the hospice's medical director.

(B) Payment for the sixth and any subsequent days is to be made at the routine home care rate.

(iv) General inpatient care. Payment at the inpatient rate will be made when general inpatient care is provided for pain control or acute or chronic symptom management which cannot be managed in other settings. None of the other fixed payment rates (i.e., routine home care) will be applicable for a day on which the patient receives general inpatient care except on the date of discharge.

(v) Date of discharge. For the day of discharge from an inpatient unit, the appropriate home care rate is to be paid unless the patient dies as an inpatient. When the patient is discharged deceased, the inpatient rate (general or respite) is to be paid for the discharge date.

(2) Use of Medicare rates. CHAMPUS will use the most current Medicare rates to reimburse hospice programs for services provided to CHAMPUS beneficiaries. It is CHAMPUS' intent to adopt changes in the Medicare reimbursement methodology as they occur; e.g., Medicare's adoption of an updated, more accurate wage index.

(3) Physician reimbursement. Payment is dependent on the physician's relationship with both the beneficiary and the hospice program.

(i) Physicians employed by, or contracted with, the hospice. (A) Administrative and supervisory activities (i.e., establishment, review and updating of plans of care, supervising care and services, and establishing governing policies) are included in the adjusted national payment rate.

(B) Direct patient care services are paid in addition to the adjusted national payment rate.

(1) Physician services will be reimbursed an amount equivalent to 100 percent of the CHAMPUS' allowable charge; i.e., there will be no cost-sharing and/or deductibles for hospice physician services.

(2) Physician payments will be counted toward the hospice cap limitation.

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- (ii) Independent attending physician. Patient care services rendered by an independent attending physician (a physician who is not considered employed by or under contract with the hospice) are not part of the hospice benefit.
  - (A) Attending physician may bill in his/her own right.
  - (B) Services will be subject to the appropriate allowable charge methodology.
  - (C) Reimbursement is not counted toward the hospice cap limitation.
  - (D) Services provided by an independent attending physician must be coordinated with any direct care services provided by hospice physicians.
  - (E) The hospice must notify the CHAMPUS contractor of the name of the physician whenever the attending physician is not a hospice employee.
- (iii) Voluntary physician services. No payment will be allowed for physician services furnished voluntarily (both physicians employed by, and under contract with, the hospice and independent attending physicians). Physicians may not discriminate against CHAMPUS beneficiaries; e.g., designate all services rendered to non-CHAMPUS patients as volunteer and at the same time bill for CHAMPUS patients.
- (4) Unrelated medical treatment. Any covered CHAMPUS services not related to the treatment of the terminal condition for which hospice care was elected will be paid in accordance with standard reimbursement methodologies; i.e., payment for these services will be subject to standard deductible and cost-sharing provisions under the CHAMPUS. A determination must be made whether or not services provided are related to the individual's terminal illness. Many illnesses may occur when an individual is terminally ill which are brought on by the underlying condition of the ill patient. For example, it is not unusual for a terminally ill patient to develop pneumonia or some other illness as a result of his or her weakened condition. Similarly, the setting of bones after fractures occur in a bone cancer patient would be treatment of a related condition. Thus, if the treatment or control of an upper respiratory tract infection is due to the weakened state of the terminal patient, it will be considered a related condition, and as such, will be included in the hospice daily rates.
- (5) Cap amount. Each CHAMPUS-approved hospice program will be subject to a cap on aggregate CHAMPUS payments from November 1 through October 31 of each year, hereafter known as "the cap period."
  - (i) The cap amount will be adjusted annually by the percent of increase or decrease in the medical expenditure category of the Consumer Price Index for all urban consumers (CPI-U).
  - (ii) The aggregate cap amount (i.e., the statutory cap amount times the number of CHAMPUS beneficiaries electing hospice care during the cap period) will be compared with total actual CHAMPUS payments made during the same cap period.
  - (iii) Payments in excess of the cap amount must be refunded by the hospice program. The adjusted cap amount will be obtained from the Health Care Financing Administration (HCFA) prior to the end of each cap period.

(iv) Calculation of the cap amount for a hospice which has not participated in the program for an entire cap year (November 1 through October 31) will be based on a period of at least 12 months but no more than 23 months. For example, the first cap period for a hospice entering the program on October 1, 1994, would run from October 1, 1994 through October 31, 1995. Similarly, the first cap period for hospice providers entering the program after November 1, 1993 but before November 1, 1994 would end October 31, 1995.

(6) Inpatient limitation. During the 12-month period beginning November 1 of each year and ending October 31, the aggregate number of inpatient days, both for general inpatient care and respite care, may not exceed 20 percent of the aggregate total number of days of hospice care provided to all CHAMPUS beneficiaries during the same period.

(i) If the number of days of inpatient care furnished to CHAMPUS beneficiaries exceeds 20 percent of the total days of hospice care to CHAMPUS beneficiaries, the total payment for inpatient care is determined follows:

(A) Calculate the ratio of the maximum number of allowable inpatient days of the actual number of inpatient care days furnished by the hospice to Medicare patients.

(B) Multiply this ratio by the total reimbursement for inpatient care made by the CHAMPUS contractor.

(C) Multiply the number of actual inpatient days in excess of the limitation by the routine home care rate.

(D) Add the amounts calculated in paragraphs (g)(6)(i)(B) and (C) of this section.

(ii) Compare the total payment for inpatient care calculated in paragraph (g)(6)(i)(D) of this section to actual payments made to the hospice for inpatient care during the cap period.

(iii) Payments in excess of the inpatient limitation must be refunded by the hospice program.

(7) Hospice reporting responsibilities. The hospice is responsible for reporting the following data within 30 days after the end of the cap period:

(i) Total reimbursement received and receivable for services furnished CHAMPUS beneficiaries during the cap period, including physician's services not of an administrative or general supervisory nature.

(ii) Total reimbursement received and receivable for general inpatient care and inpatient respite care furnished to CHAMPUS beneficiaries during the cap period.

(iii) Total number of inpatient days furnished to CHAMPUS hospice patients (both general inpatient and inpatient respite days) during the cap period.

(iv) Total number of CHAMPUS hospice days (both inpatient and home care) during the cap period.

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(v) Total number of beneficiaries electing hospice care. The following rules must be adhered to by the hospice in determining the number of CHAMPUS beneficiaries who have elected hospice care during the period:

(A) The beneficiary must not have been counted previously in either another hospice's cap or another reporting year.

(B) The beneficiary must file an initial election statement during the period beginning September 28 of the previous cap year through September 27 of the current cap year in order to be counted as an electing CHAMPUS beneficiary during the current cap year.

(C) Once a beneficiary has been included in the calculation of a hospice cap amount, he or she may not be included in the cap for that hospice again, even if the number of covered days in a subsequent reporting period exceeds that of the period where the beneficiary was included.

(D) There will be proportional application of the cap amount when a beneficiary elects to receive hospice benefits from two or more different CHAMPUS-certified hospices. A calculation must be made to determine the percentage of the patient's length of stay in each hospice relative to the total length of hospice stay.

(8) Reconsideration of cap amount and inpatient limit. A hospice dissatisfied with the contractor's calculation and application of its cap amount and/or inpatient limitation may request and obtain a contractor review if the amount of program reimbursement in controversy--with respect to matters which the hospice has a right to review--is at least \$1000. The administrative review by the contractor of the calculation and application of the cap amount and inpatient limitation is the only administrative review available. These calculations are not subject to the appeal procedures set forth in Sec. 199.10. The methods and standards for calculation of the hospice payment rates established by CHAMPUS, as well as questions as to the validity of the applicable law, regulations or CHAMPUS decisions, are not subject to administrative review, including the appeal procedures of Sec. 199.10.

(9) Beneficiary cost-sharing. There are no deductibles under the CHAMPUS hospice benefit. CHAMPUS pays the full cost of all covered services for the terminal illness, except for small cost-share amounts which may be collected by the individual hospice for outpatient drugs and biologicals and inpatient respite care.

(i) The patient is responsible for 5 percent of the cost of outpatient drugs or \$5 toward each prescription, whichever is less. Additionally, the cost of prescription drugs (drugs or biologicals) may not exceed that which a prudent buyer would pay in similar circumstances; that is, a buyer who refuses to pay more than the going price for an item or service and also seeks to economize by minimizing costs.

(ii) For inpatient respite care, the cost-share for each respite care day is equal to 5 percent of the amount CHAMPUS has estimated to be the cost of respite care, after adjusting the national rate for local wage differences.

(iii) The amount of the individual cost-share liability for respite care during a hospice cost-share period may not exceed the Medicare inpatient hospital deductible applicable for the year in which the hospice cost-share period began. The individual hospice cost-share period

begins on the first day an election is in effect for the beneficiary and ends with the close of the first period of 14 consecutive days on each of which an election is not in effect for the beneficiary.

**(h) Reimbursement of Home Health Agencies (HHAs).** HHAs will be reimbursed using the same methods and rates as used under the Medicare HHA prospective payment system under Section 1895 of the Social Security Act (42 U.S.C. 1395fff) and 42 CFR Part 484, Subpart E except as otherwise necessary to recognize distinct characteristics of TRICARE beneficiaries and as described in instructions issued by the Director, TMA. Under this methodology, an HHA will receive a fixed case-mix and wage-adjusted national 60-day episode payment amount as payment in full for all costs associated with furnishing home health services to TRICARE-eligible beneficiaries with the exception of osteoporosis drugs and DME. The full case-mix and wage-adjusted 60-day episode amount will be payment in full subject to the following adjustments and additional payments:

(1) Split percentage payments. The initial percentage payment for initial episodes is paid to an HHA at 60 percent of the case-mix and wage adjusted 60-day episode rate. The residual final payment for initial episodes is paid at 40 percent of the case-mix and wage adjusted 60-day episode rate subject to appropriate adjustments. The initial percentage payment for subsequent episodes is paid at 50 percent of the case-mix and wage-adjusted 60-day episode rate. The residual final payment for subsequent episodes is paid at 50 percent of the case-mix and wage-adjusted 60-day episode rate subject to appropriate adjustments.

(2) Low-utilization payment. A low utilization payment is applied when a HHA furnishes four or fewer visits to a beneficiary during the 60-day episode. The visits are paid at the national per-visit amount by discipline updated annually by the applicable market basket for each visit type.

(3) Partial episode payment (PEP). A PEP adjustment is used for payment of an episode of less than 60 days resulting from a beneficiary's elected transfer to another HHA prior to the end of the 60-day episode or discharge and readmission of a beneficiary to the same HHA before the end of the 60-day episode. The PEP payment is calculated by multiplying the proportion of the 60-day episode during which the beneficiary remained under the care of the original HHA by the beneficiary's assigned 60-day episode payment.

(4) Significant change in condition (SCIC). The full-episode payment amount is adjusted if a beneficiary experiences a significant change in condition during the 60-day episode that was not envisioned in the initial treatment plan. The total significant change in condition payment adjustment is a proportional payment adjustment reflecting the time both prior to and after the patient experienced a significant change in condition during the 60-day episode. The initial percentage payment provided at the start of the 60-day episode will be adjusted at the end of the episode to reflect the first and second parts of the total SCIC adjustment determined at the end of the 60-day episode. The SCIC payment adjustment is calculated in two parts:

(i) The first part of the SCIC payment adjustment reflects the adjustment to the level of payment prior to the significant change in the patient's condition during the 60-day episode.

(ii) The second part of the SCIC payment adjustment reflects the adjustment to the level of payment after the significant change in the patient's condition occurs during the 60-day

episode.

(5) Outlier payment. Outlier payments are allowed in addition to regular 60-day episode payments for beneficiaries generating excessively high treatment costs. The following methodology is used for calculation of the outlier payment:

(i) TRICARE makes an outlier payment for an episode whose estimated cost exceeds a threshold amount for each case-mix group.

(ii) The outlier threshold for each case-mix group is the episode payment amount for that group, the PEP adjustment amount for the episode or the total significant change in condition adjustment amount for the episode plus a fixed dollar loss amount that is the same for all case-mix groups.

(iii) The outlier payment is a proportion of the amount of estimated cost beyond the threshold.

(iv) TRICARE imputes the cost for each episode by multiplying the national per-visit amount of each discipline by the number of visits in the discipline and computing the total imputed cost for all disciplines.

(v) The fixed dollar loss amount and the loss sharing proportion are chosen so that the estimated total outlier payment is no more than the predetermined percentage of total payment under the home health PPS as set by the Centers for Medicare & Medicaid Services (CMS).

(6) Services paid outside the HHA prospective payment system. The following are services that receive a separate payment amount in addition to the prospective payment amount for home health services:

(i) Durable medical equipment (DME). Reimbursement of DME is based on the same amounts established under the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule under 42 CFR part 414, subpart D.

(ii) Osteoporosis drugs. Although osteoporosis drugs are subject to home health consolidated billing, they continue to be paid on a cost basis, in addition to episode payments.

(7) Accelerated payments. Upon request, an accelerated payment may be made to an HHA that is receiving payment under the home health prospective payment system if the HHA is experiencing financial difficulties because there is a delay by the contractor in making payment to the HHA. The following are criteria for making accelerated payments:

(i) Approval of payment. An HHA's request for an accelerated payment must be approved by the contractor and TRICARE Management Activity (TMA).

(ii) Amount of payment. The amount of the accelerated payment is computed as a percentage of the net payment for unbilled or unpaid covered services.

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(iii) Recovery of payment. Recovery of the accelerated payment is made by recoupment as HHA bills are processed or by direct payment by the HHA.

(8) Assessment data. Beneficiary assessment data, incorporating the use of the current version of the OASIS items, must be submitted to the contractor for payment under the HHA prospective payment system.

(9) Administrative review. An HHA is not entitled to judicial or administrative review with regard to:

(i) Establishment of the payment unit, including the national 60-day prospective episode payment rate, adjustments and outlier payment.

(ii) Establishment of transition period, definition and application of the unit of payment.

(iii) Computation of the initial standard prospective payment amounts.

(iv) Establishment of case-mix and area wage adjustment factors.

**(i) Changes in Federal Law affecting Medicare.** With regard to paragraph (b) and (h) of this section, the Department of Defense must, within the time frame specified in law and to the extent it is practicable, bring the TRICARE program into compliance with any changes in Federal Law affecting the Medicare program that occur after the effective date of the DoD rule to implement the prospective payment systems for skilled nursing facilities and home health agencies.

**(j) Reimbursement of individual health care professionals and other non-institutional, non-professional providers.** The CHAMPUS-determined reasonable charge (the amount allowed by CHAMPUS) for the service of an individual health care professional or other non-institutional, non-professional provider (even if employed by or under contract to an institutional provider) shall be determined by one of the following methodologies, that is, whichever is in effect in the specific geographic location at the time covered services and supplies are provided to a CHAMPUS beneficiary.

(1) Allowable charge method--(i) Introduction--(A) In general. The allowable charge method is the preferred and primary method for reimbursement of individual health care professionals and other non-institutional health care providers (covered by 10 U.S.C. 1079(h)(1)). The allowable charge for authorized care shall be the lower of the billed charge or the local CHAMPUS Maximum Allowable Charge (CMAC).

(B) CHAMPUS Maximum Allowable Charge. Beginning in calendar year 1992, prevailing charge levels and appropriate charge levels will be calculated on a national level. There will then be calculated a national CHAMPUS Maximum Allowable Charge (CMAC) level for each procedure, which shall be the lesser of the national prevailing charge level or the national appropriate charge level. The national CMAC will then be adjusted for localities in accordance with paragraph (j)(1)(iv) of this section.

(C) Limits on balance billing by nonparticipating providers. Nonparticipating providers may not balance bill a beneficiary an amount which exceeds the applicable balance billing limit. The balance billing limit shall be the same percentage as the Medicare limiting

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charge percentage for nonparticipating physicians. The balance billing limit may be waived by the Director, OCHAMPUS on a case-by-case basis if requested by the CHAMPUS beneficiary (or sponsor) involved. A decision by the Director to waive or not waive the limit in any particular case is not subject to the appeal and hearing procedures of Sec. 199.10.

(D) Special rule for TRICARE Prime Enrollees. In the case of a TRICARE Prime enrollee (see section 199.17) who receives authorized care from a non-participating provider, the CHAMPUS determined reasonable charge will be the CMAC level as established in paragraph (j)(1)(i)(B) of this section plus any balance billing amount up to the balance billing limit as referred to in paragraph (j)(1)(i)(C) of this section. The authorization for such care shall be pursuant to the procedures established by the Director, OCHAMPUS (also referred to as the TRICARE Support Office).

(E) Special rule for certain TRICARE Standard Beneficiaries. In the case of dependent spouse or child, as defined in paragraphs (b)(2)(ii)(A) through (F) and (b)(2)(ii)(H)(1), (2), and (4) of Sec. 199.3, of a Reserve Component member serving on active duty pursuant to a call or order to active duty for a period of more than 30 days in support of a contingency operation under a provision of law referred to in section 101(a)(13)(B) of title 10, United States Code, the Director, TRICARE Management Activity, may authorize non-participating providers the allowable charge to be the CMAC level as established in paragraph (j)(1)(i)(B) of this section plus any balance billing amount up to the balance billing limit as referred to in paragraph (j)(1)(i)(C) of this section.

(ii) Prevailing charge level. (A) Beginning in calendar year 1992, the prevailing charge level shall be calculated on a national basis.

(B) The national prevailing charge level referred to in paragraph (j)(1)(ii)(A) of this section is the level that does not exceed the amount equivalent to the 80th percentile of billed charges made for similar services during the base period. The 80th percentile of charges shall be determined on the basis of statistical data and methodology acceptable to the Director, OCHAMPUS (or a designee).

(C) For purposes of paragraph (j)(1)(ii)(B) of this section, the base period shall be a period of 12 calendar months and shall be adjusted once a year, unless the Director, OCHAMPUS, determines that a different period for adjustment is appropriate and publishes a notice to that effect in the Federal Register.

(iii) Appropriate charge level. Beginning in calendar year 1992, the appropriate charge level shall be calculated on a national basis. The appropriate charge level for each procedure is the product of the two-step process set forth in paragraphs (j)(1)(iii)(A) and (B) of this section. This process involves comparing the prior year's CMAC with the fully phased in Medicare fee. For years after the Medicare fee has been fully phased in, the comparison shall be to the current year Medicare fee. For any particular procedure for which comparable Medicare fee and CHAMPUS data are unavailable, but for which alternative data are available that the Director, OCHAMPUS (or designee) determines provide a reasonable approximation of relative value or price, the comparison may be based on such alternative data.

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(A) Step 1: Procedures classified. All procedures are classified into one of three categories, as follows:

(1) Overpriced procedures. These are the procedures for which the prior year's national CMAC exceeds the Medicare fee.

(2) Other procedures. These are procedures subject to the allowable charge method that are not included in either the overpriced procedures group or the underpriced procedures group.

(3) Underpriced procedures. These are the procedures for which the prior year's national CMAC is less than the Medicare fee.

(B) Step 2: Calculating appropriate charge levels. For each year, appropriate charge levels will be calculated by adjusting the prior year's CMAC as follows:

(1) For overpriced procedures, the appropriate charge level for each procedure shall be the prior year's CMAC, reduced by the lesser of: the percentage by which it exceeds the Medicare fee or fifteen percent.

(2) For other procedures, the appropriate charge level for each procedure shall be the same as the prior year's CMAC.

(3) For underpriced procedures, the appropriate charge level for each procedure shall be the prior year's CMAC, increased by the lesser of: the percentage by which it is exceeded by the Medicare fee or the Medicare Economic Index.

(C) Special rule for cases in which the CHAMPUS appropriate charge was prematurely reduced. In any case in which a recalculation of the Medicare fee results in a Medicare rate higher than the CHAMPUS appropriate charge for a procedure that had been considered an overpriced procedure, the reduction in the CHAMPUS appropriate charge shall be restored up to the level of the recalculated Medicare rate.

(D) Special rule for cases in which the national CMAC is less than the Medicare rate.

NOTE: This paragraph will be implemented when CMAC rates are published.

In any case in which the national CMAC calculated in accordance with paragraphs (j)(1)(i) through (iii) of this section is less than the Medicare rate, the Director, TSO, may determine that the use of the Medicare Economic Index under paragraph (j)(1)(iii)(B) of this section will result in a CMAC rate below the level necessary to assure that beneficiaries will retain adequate access to health care services. Upon making such a determination, the Director, TSO, may increase the national CMAC to a level not greater than the Medicare rate.

(iv) Calculating CHAMPUS Maximum Allowable Charge levels for localities. (A) In general. The national CHAMPUS Maximum Allowable Charge level for each procedure will be adjusted for localities using the same (or similar) geographical areas and the same geographic adjustment factors as are used for determining allowable charges under Medicare.

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(B) Special locality-based phase-in provision. (1) In general. Beginning with the recalculation of CMACS for calendar year 1993, the CMAC in a locality will not be less than 72.25 percent of the maximum charge level in effect for that locality on December 31, 1991. For recalculations of CMACs for calendar years after 1993, the CMAC in a locality will not be less than 85 percent of the CMAC in effect for that locality at the end of the prior calendar year.

(2) Exception. The special locality-based phase-in provision established by paragraph (j)(1)(iv)(B)(1) of this section shall not be applicable in the case of any procedure code for which there were not CHAMPUS claims in the locality accounting for at least 50 services.

(C) Special locality-based waivers of reductions to assure adequate access to care. Beginning with the recalculation of CMACs for calendar year 1993, in the case of any procedure classified as an overpriced procedure pursuant to paragraph (j)(1)(iii)(A)(1) of this section, a reduction in the CMAC in a locality below the level in effect at the end of the previous calendar year that would otherwise occur pursuant to paragraphs (j)(1)(iii) and (j)(1)(iv) of this section may be waived pursuant to paragraph (j)(1)(iii)(C) of this section.

(1) Waiver based on balanced billing rates. Except as provided in paragraph (j)(1)(iv)(C)(2) of this section such a reduction will be waived if there has been excessive balance billing in the locality for the procedure involved. For this purpose, the extent of balance billing will be determined based on a review of all services under the procedure code involved in the prior year (or most recent period for which data are available). If the number of services for which balance billing was not required was less than 60 percent of all services provided, the Director will determine that there was excessive balance billing with respect to that procedure in that locality and will waive the reduction in the CMAC that would otherwise occur. A decision by the Director to waive or not waive the reduction is not subject to the appeal and hearing procedures of Sec. 199.10.

(2) Exception. As an exception to the paragraph (j)(1)(iv)(C)(1) of this section, the waiver required by that paragraph shall not be applicable in the case of any procedure code for which there were not CHAMPUS claims in the locality accounting for at least 50 services. A waiver may, however, be granted in such cases pursuant to paragraph (j)(1)(iv)(C)(3) of this section.

(3) Waiver based on other evidence that adequate access to care would be impaired. The Director, OCHAMPUS may waive a reduction that would otherwise occur (or restore a reduction that was already taken) if the Director determines that available evidence shows that the reduction would impair adequate access. For this purpose, such evidence may include consideration of the number of providers in the locality who provide the affected services, the number of such providers who are CHAMPUS Participating Providers, the number of CHAMPUS beneficiaries in the area, and other relevant factors. Providers or beneficiaries in a locality may submit to the Director, OCHAMPUS a petition, together with appropriate documentation regarding relevant factors, for a determination that adequate access would be impaired. The Director, OCHAMPUS will consider and respond to all such petitions. Petitions may be filed at any time. Any petition received by the date which is 120 days prior to the implementation of a recalculation of CMACs will be assured of consideration prior to that implementation. The Director, OCHAMPUS may establish procedures for handling petitions. A decision by the Director to waive or not waive a reduction is not subject to the appeal and hearing procedures of Sec. 199.10.

(D) Special locality-based exception to applicable CMACs to assure adequate beneficiary access to care. In addition to the authority to waive reductions under paragraph (j)(1)(iv)(C) of this section, the Director may authorize establishment of higher payment rates for specific services than would otherwise be allowable, under paragraph (j)(1) of this section, if the Director determines that available evidence shows that access to health care services is severely impaired. For this purpose, such evidence may include consideration of the number of providers in the locality who provide the affected services, the number of providers who are CHAMPUS participating providers, the number of CHAMPUS beneficiaries in the locality, the availability of military providers in the location or nearby, and any other factors the Director determines relevant.

(1) Procedure. Providers or beneficiaries in a locality may submit to the Director, a petition, together with appropriate documentation regarding relevant factors, for a determination that adequate access to health care services is severely impaired. The Director, will consider and respond to all petitions. A decision to authorize a higher payment amount is subject to review and determination or modification by the Director at any time if circumstances change so that adequate access to health care services would no longer be severely impaired. A decision by the Director, to authorize, not authorize, terminate, or modify authorization of higher payment amounts is not subject to the appeal and hearing procedures of Sec. 199.10 of the part.

(2) Establishing the higher payment rate(s). When the Director, determines that beneficiary access to health care services in a locality is severely impaired, the Director may establish the higher payment rate(s) as he or she deems appropriate and cost-effective through one of the following methodologies to assure adequate access:

(i) A percent factor may be added to the otherwise applicable payment amount allowable under paragraph (j)(1) of this section;

(ii) A prevailing charge may be calculated, by applying the prevailing charge methodology of paragraph (j)(1)(ii) of this section to a specific locality (which need not be the same as the localities used for purposes of paragraph (j)(1)(iv)(A) of this section; or another government payment rate may be adopted, for example, an applicable state Medicaid rate).

(3) Application of higher payment rates. Higher payment rates defined under paragraph (j)(1)(iv)(D) of this section may be applied to all similar services performed in a locality, or, if circumstances warrant, a new locality may be defined for application of the higher payments. Establishment of a new locality may be undertaken where access impairment is localized and not pervasive across the existing locality. Generally, establishment of a new, more specific locality will occur when the area is remote so that geographical characteristics and other factors significantly impair transportation through normal means to health care services routinely available within the existing locality.

(E) Special locality-based exception to applicable CMACs to ensure an adequate TRICARE Prime preferred network. The Director, may authorize reimbursements to health care providers participating in a TRICARE preferred provider network under Sec. 199.17(p) of this part at rates higher than would otherwise be allowable under paragraph (j)(1) of this section, if the Director, determines that application of the higher rates is necessary to ensure the availability of an adequate number and mix of qualified health care providers in a network in a specific locality. This authority may only be used to ensure adequate networks

in those localities designated by the Director, as requiring TRICARE preferred provider networks, not in localities in which preferred provider networks have been suggested or established but are not determined by the Director to be necessary. Appropriate evidence for determining that higher rates are necessary may include consideration of the number of available primary care and specialist providers in the network locality, availability (including reassignment) of military providers in the location or nearby, the appropriate mix of primary care and specialists needed to satisfy demand and meet appropriate patient access standards (appointment/waiting time, travel distance, etc.), the efforts that have been made to create an adequate network, other cost-effective alternatives, and other relevant factors. The Director, may establish procedures by which exceptions to applicable CMACs are requested and approved or denied under paragraph (j)(1)(iv)(E) of this section. A decision by the Director, to authorize or deny an exception is not subject to the appeal and hearing procedures of Sec. 199.10. When the Director, determines that it is necessary and cost-effective to approve a higher rate or rates in order to ensure the availability of an adequate number of qualified health care providers in a network in a specific locality, the higher rate may not exceed the lesser of the following:

(1) The amount equal to the local fee for service charge for the service in the service area in which the service is provided as determined by the Director, based on one or more of the following payment rates:

- (i) Usual, customary, and reasonable;
- (ii) The Health Care Financing Administration's Resource Based Relative Value Scale;
- (iii) Negotiated fee schedules;
- (iv) Global fees; or
- (v) Sliding scale individual fee allowances.

(2) The amount equal to 115 percent of the otherwise allowable charge under paragraph (j)(1) of the section for the service.

(v) Special rules for 1991. (A) Appropriate charge levels for care provided on or after January 1, 1991, and before the 1992 appropriate levels take effect shall be the same as those in effect on December 31, 1990, except that appropriate charge levels for care provided on or after October 7, 1991, shall be those established pursuant to this paragraph (j)(1)(v) of this section.

(B) Appropriate charge levels will be established for each locality for which a appropriate charge level was in effect immediately prior to October 7, 1991. For each procedure, the appropriate charge level shall be the prevailing charge level in effect immediately prior to October 7, 1991, adjusted as provided in (j)(1)(v)(B)(1) through (3) of this section.

(1) For each overpriced procedure, the level shall be reduced by fifteen percent. For this purpose, overpriced procedures are the procedures determined by the Physician Payment Review Commission to be overvalued pursuant to the process established under the Medicare program, other procedures considered overvalued in the Medicare program (for which Congress directed reductions in Medicare allowable levels for 1991), radiology

procedures and pathology procedures.

(2) For each other procedure, the level shall remain unchanged. For this purpose, other procedures are procedures which are not overpriced procedures or primary care procedures.

(3) For each primary care procedure, the level shall be adjusted by the MEI, as the MEI is applied to Medicare prevailing charge levels. For this purpose, primary care procedures include maternity care and delivery services and well baby care services.

(C) For purposes of this paragraph (j)(i)(v), "appropriate charge levels" in effect at any time prior to October 7, 1991 shall mean the lesser of:

(1) The prevailing charge levels then in effect, or

(2) The fiscal year 1988 prevailing charge levels adjusted by the Medicare Economic Index (MEI), as the MEI was applied beginning in the fiscal year 1989.

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

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

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

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

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

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

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

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

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

(C) For purposes of establishing laboratory service local CMACs pursuant to paragraph (j)(1)(iv) of this section, the adjustment factor shall equal the ratio of the local average charge (standardized for the distribution of clinical laboratory services) to the national average charge for all clinical laboratory services during the base period.

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

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

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

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

Health and Human Services acts to amend or remove the provision for bonus payments under Medicare, TRICARE likewise may follow Medicare in amending or removing provision for such payments.

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

(4) Alternative method. The Director, OCHAMPUS, or a designee, may, subject to the approval of the ASD(HA), establish an alternative method of reimbursement designed to produce reasonable control over health care costs and to ensure a high level of acceptance of the CHAMPUS-determined charge by the individual health-care professionals or other noninstitutional health-care providers furnishing services and supplies to CHAMPUS beneficiaries. Alternative methods may not result in reimbursement greater than the allowable charge method above.

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

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

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

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

**(m) Accommodation of Discounts Under Provider Reimbursement Methods.**

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

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

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

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

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

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

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

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

[55 FR 13266, Apr 10, 1990, as amended at 55 FR 31180, Aug 1, 1990; 55 FR 42562, Oct 22, 1990; 55 FR 43342, Oct 29, 1990; 56 FR 44006, Sep 6, 1991; 56 FR 50273, Oct 4, 1991; 58 FR 35408, Jul 1, 1993; 58 FR 51239, Oct 1, 1993; 58 FR 58961, Nov 5, 1993; 60 FR 6019, Feb 1, 1995; 60 FR 12437, Mar 7, 1995; 60 FR 52094, Oct 5, 1995; 63 FR 7287, Feb 13, 1998; 63 FR 48446, Sep 10, 1998; 63 FR 56082, Oct 21, 1998; 64 FR 60671, Nov 8, 1999; 65 FR 41003, Jul 3, 2000; 67 FR 45172, Aug 28, 2001; 67 FR 18115, Apr 15, 2002; 67 FR 40604, Jun 13, 2002; 69 FR 60555, Oct 12, 2004; 70 FR 61378, Oct 24, 2005; 72 FR 63988, Nov 14, 2007; 73 FR 46809, Aug 12, 2008; 73 FR 74965, Dec 10, 2008; 74 FR 44755, Aug 31, 2009; 77 FR 38175, Jun 27, 2012; 78 FR 48309, Aug 8, 2013]

**EDITORIAL NOTE:** The following text, appearing at 63 FR 48445, Sept. 10, 1998, could not be incorporated into Sec. 199.14 because it was not mentioned in the amendatory instruction.

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For the convenience of the user, the text is set forth as follows: Sec. 199.14 Provider reimbursement methods.

(a) \* \* \*

(1) \* \* \*

\* \* \* \* \*

(iii) \* \* \*

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

\* \* \* \* \*

(D) \* \* \*

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

\* \* \* \* \*

(5) Preliminary base year standardized amount. A preliminary base year standardized amount shall be calculated by summing all costs in the database applicable to the large urban or other area group and dividing by the total number of discharges in the respective group.

\* \* \* \* \*

(E) \* \* \*

(1) \* \* \*

(i) \* \* \*

(A) Short-stay outliers. Any discharge with a length-of-stay (LOS) less than 1.94 standard deviations from the DRG's arithmetic LOS shall be classified as a short-stay outlier. Short-stay outliers shall be reimbursed at 200 percent of the per diem rate for the DRG for each covered day of the hospital stay, not to exceed the DRG amount. The per diem rate shall equal the DRG amount divided by the arithmetic mean length-of-stay for the DRG.

(B) Long-stay outliers. Any discharge (except for neonatal services and services in children's hospitals) which has a length-of-stay (LOS) exceeding a threshold established in accordance with the criteria used for the Medicare Prospective Payment System as contained in 42 CFR 412.82 shall be classified as a long-stay outlier. Any discharge for neonatal services or for services in a children's hospital which has a LOS exceeding the lesser of 1.94 standard deviations or 17 days from the DRG's arithmetic mean LOS also shall be classified as a long-stay outlier. Long-stay outliers shall be reimbursed the DRG-based amount plus a

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percentage (as established for the Medicare Prospective Payment System) of the per diem rate for the DRG for each covered day of care beyond the long-stay outlier threshold. The per diem rate shall equal the DRG amount divided by the arithmetic mean LOS for the DRG. For admissions on or after October 1, 1997, the long stay outlier has been eliminated for all cases except children's hospitals and neonates. For admissions on or after October 1, 1998, the long stay outlier has been eliminated for children's hospitals and neonates.

(ii) \* \* \*

(A) Cost outliers except those in children's hospitals or for neonatal services. Any discharge which has standardized costs that exceed a threshold established in accordance with the criteria used for the Medicare Prospective Payment System as contained in 42 CFR 412.84 shall qualify as a cost outlier. The standardized costs shall be calculated by multiplying the total charges by the factor described in Sec. 199.14(a)(1)(iii)(D)(4) and adjusting this amount for indirect medical education costs. Cost outliers shall be reimbursed the DRG-based amount plus a percentage (as established for the Medicare Prospective Payment System) of all costs exceeding the threshold. Effective with admissions occurring on or after October 1, 1997, the standardized costs are no longer adjusted for indirect medical education costs.

(B) Cost outliers in children's hospitals and for neonatal services. Any discharge for services in a children's hospital or for neonatal services which has standardized costs that exceed a threshold of the greater of two times the DRG-based amount or \$13,500 shall qualify as a cost outlier. The standardized costs shall be calculated by multiplying the total charges by the factor described in Sec. 199.14(a)(1)(iii)(D)(4) (adjusted to include average capital and direct medical education costs) and adjusting this amount for indirect medical education costs. Cost outliers for services in children's hospitals and for neonatal services shall be reimbursed the DRG-based amount plus a percentage (as established for the Medicare Prospective Payment System) of all costs exceeding the threshold. Effective with admissions occurring on or after October 1, 1998, standardized costs are no longer adjusted for indirect medical education costs. In addition, CHAMPUS will calculate the outlier payments that would have occurred at each of the 59 Children's hospitals under the FY99 outlier policy for all cases that would have been outliers under the FY94 policies using the most accurate data available in September 1998. A ratio will be calculated which equals the level of outlier payments that would have been made under the FY94 outlier policies and the outlier payments that would be made if the FY99 outlier policies had applied to each of these potential outlier cases for these hospitals. The ratio will be calculated across all outlier claims for the 59 hospitals and will not be hospital specific. The ratio will be used to increase cost outlier payments in FY 1999 and FY 2000, unless the hospital has a negotiated agreement with a managed care support contractor which would affect this payment. For hospitals with managed care support agreements which affect these payments, CHAMPUS will apply these payments if the increased payments would be consistent with the agreements. In FY 2000 the ratio of outlier payments (long stay and cost) that would have occurred under the FY 94 policy and actual cost outlier payments made under the FY 99 policy will be recalculated. If the ratio has changed significantly, the ratio will be revised for use in FY 2001 and thereafter. In FY 2002, the actual cost outlier cases in FY 2000 and 2001 will be reexamined. The ratio of outlier payments that would have occurred under the FY94 policy and the actual cost outlier payments made under the FY 2000 and FY 2001 policies. If the ratio has changed significantly, the ratio will be revised for use in FY 2003.

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(G) \* \* \*

(3) Information necessary for payment of capital and direct medical education costs. All hospitals subject to the CHAMPUS DRG-based payment system, except for children's hospitals, may be reimbursed for allowed capital and direct medical education costs by submitting a request to the CHAMPUS contractor. Beginning October 1, 1998, such request shall be filed with CHAMPUS on or before the last day of the twelfth month following the close of the hospitals' cost reporting period, and shall cover the one-year period corresponding to the hospital's Medicare cost-reporting period. The first such request may cover a period of less than a full year--from the effective date of the CHAMPUS DRG-based payment system to the end of the hospital's Medicare cost-reporting period. All costs reported to the CHAMPUS contractor must correspond to the costs reported on the hospital's Medicare cost report. An extension of the due date for filing the request may only be granted if an extension has been granted by HCFA due to a provider's operations being significantly adversely affected due to extraordinary circumstances over which the provider has no control, such as flood or fire. (If these costs change as a result of a subsequent audit by Medicare, the revised costs are to be reported to the hospital's CHAMPUS contractor within 30 days of the date the hospital is notified of the change.) The request must be signed by the hospital official responsible for verifying the amounts and shall contain the following information.

\* \* \* \* \*

(d) \* \* \*

(3) \* \* \*

(iv) Step 4: standard payment amount per group. The standard payment amount per group will be the volume weighted median per procedure cost for the procedures in that group. For cases in which the standard payment amount per group exceeds the CHAMPUS-determined inpatient allowable amount, the Director, TSO or his designee, may make adjustments.

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(h) Reimbursement of individual health care professionals and other non-institutional, non-professional providers. The CHAMPUS-determined reasonable charge (the amount allowed by CHAMPUS) for the service of an individual health care professional or other non-institutional, non-professional provider (even if employed by or under contract to an institutional provider) shall be determined by one of the following methodologies, that is, whichever is in effect in the specific geographic location at the time covered services and supplies are provided to a CHAMPUS beneficiary.

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