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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 CERTIFIED MENTAL HEALTH COUNSELORS

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

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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,

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 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/m²), or a BMI equal to or greater than 35 kg/m² 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.

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.

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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.

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

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 certified mental health counselor. An allied health professional who meets the requirements outlined in Sec. 199.6.

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; **79 FR 41641, Jul 17, 2014**]

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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) The beneficiary did not know and could not reasonably have been expected to know that the services were excludable by reason of being not medically necessary; and

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

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

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(5) Criteria for determining that provider knew or could reasonably have been expected to have known that services were excludable. An institutional or individual provider will be found to have known or been reasonably expected to have known that services were excludable under this subsection under any one of the following circumstances:

(i) The PRO or fiscal intermediary had informed the provider that the services provided were excludable or that similar or reasonably comparable services were excludable.

(ii) The utilization review group or committee for an institutional provider or the beneficiary's attending physician had informed the provider that the services provided were excludable.

(iii) The provider had informed the beneficiary that the services were excludable.

(iv) The provider had received written materials, including notices, manual issuances, bulletins, guides, directives or other materials, providing notification of PRO screening criteria specific to the condition of the beneficiary. Attending physicians who are members of the medical staff of an institutional provider will be found to have also received written materials provided to the institutional provider.

(v) The services that are at issue are the subject of what are generally considered acceptable standards of practice by the local medical community.

(vi) Preadmission authorization was available but not requested, or concurrent review requirements were not followed.

[51 FR 24008, Jul 1, 1986; 67 FR 15725, Apr 3, 2002; 67 FR 18826, Apr 17, 2002; 67 FR 40602, Jun 13, 2002; 67 FR 42720, Jun 25, 2002; 67 FR 45311, Jul 9, 2002; 68 FR 44880, Jul 31, 2003; 68 FR 44883, Jul 31, 2003; 68 FR 65173, Nov 19, 2003; 69 FR 29229, May 21, 2004; 69 FR 44947, Jul 28, 2004; 69 FR 51564, Aug 20, 2004; 69 FR 55359, Sep 14, 2004; 69 FR 60554, Oct 12, 2004; 70 FR 12802, Mar 16, 2005; 70 FR 61377, Oct 24, 2005; 71 FR 31944, Jun 2, 2006; 71 FR 35390, Jun 20, 2006; 72 FR 54353, Sep 25, 2007; 73 FR 46809, Aug 12, 2008; 73 FR 74965, Dec 10, 2008; 74 FR 34696, Jul 17, 2009; 75 FR 47459, Aug 6, 2010; 75 FR 47461, Aug 6, 2010; 75 FR 50882, Aug 18, 2010; 75 FR 2253, Jan 13, 2011; 76 FR 8297, Feb 14, 2011; 76 FR 57642, Sep 16, 2011; 76 FR 80743, Dec 27, 2011; 76 FR 81370, Dec 28, 2011; 77 FR 38175, Jun 27, 2012; 77 FR 38178, Jun 27, 2012; 78 FR 12952, Feb 26, 2013; 78 FR 13240, Feb 27, 2013; 78 FR 62430, Oct 22, 2013; 79 FR 41641, Jul 17, 2014]

EDITORIAL NOTE: For Federal Register citations affecting Sec. 199.4, see the List of CFR Sections Affected, which appears in the Finding Aids section of the printed volume and on GPO Access.

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(N) TRICARE certified mental health counselor For the purposes of CHAMPUS, a TRICARE certified mental health counselor (TCMHC) 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 TCMHC must meet the requirements of either 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 TCMHC:

(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. Supervision must be provided by mental health counselors at the highest level of state licensure, psychiatrists, clinical psychologists, certified clinical social workers, or certified psychiatric nurse specialists who are licensed for independent practice in the jurisdiction where practicing and who are practicing within the scope of their licenses. Supervised clinical practice must be received in a manner that is consistent with the guidelines regarding knowledge, skills, and practice standards for supervision of the American Mental Health Counselors Association; and

(iv) Is licensed or certified for independent practice in mental health counseling by the jurisdiction where practicing (see paragraph (c)(2)(ii) of this section for more specific information).

(2) The requirements of this paragraph are that the TCMHC, prior to January 1, 2017:

(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. Supervision must be provided by mental health counselors at the highest level of state licensure, psychiatrists, clinical psychologists, certified clinical social workers, or certified psychiatric nurse specialists who are licensed for independent practice in the jurisdiction where practicing and who are practicing within the scope of their licenses. Supervised clinical practice must be received in a manner that is consistent with the guidelines regarding knowledge, skills, and practice standards for supervision of the American Mental Health Counselors Association; and

(iv) Is licensed or certified for independent practice in mental health counseling by the jurisdiction where practicing (see paragraph (c)(2)(ii) of this section for more specific information).

(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 TCMHCs continue to meet educational, licensing, and clinical training requirements considered appropriate.

(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 TRICARE certified mental health counselor in paragraph (c)(3)(iii)(N) of this section, but 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).

(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 Journal² at the time the service is provided.

² 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.

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(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.

(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; **79 FR 41641, Jul 17, 2014**]

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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CHAMPUS beneficiary or sponsor that could result from a retroactive denial, the following additional claims filing procedures are recommended or required.

(1) Continuing care. Except for claims subject to the CHAMPUS DRG-based payment system, whenever medical services and supplies are being rendered on a continuing basis, an appropriate claim or claims should be submitted every 30 days (monthly) whether submitted directly by the beneficiary or sponsor or by the provider on behalf of the beneficiary. Such claims may be submitted more frequently if the beneficiary or provider so elects. The Director, OCHAMPUS, or a designee, also may require more frequent claims submission based on dollars. Examples of care that may be rendered on a continuing basis are outpatient physical therapy, private duty (special) nursing, or inpatient stays. For claims subject to the CHAMPUS DRG-based payment system, claims may be submitted only after the beneficiary has been discharged or transferred from the hospital.

(2) Inpatient mental health services. Under most circumstances, the 60-day inpatient mental health limit applies to the first 60 days of care paid in a calendar year. The patient will be notified when the first 30 days of inpatient mental health benefits have been paid. The beneficiary is responsible for assuring that all claims for care are submitted sequentially and on a regular basis. Once payment has been made for care determined to be medically appropriate and a program benefit, the decision will not be reopened solely on the basis that previous inpatient mental health care had been rendered but not yet billed during the same calendar year by a different provider.

(3) Claims involving the services of marriage and family counselors, pastoral counselors, and supervised mental health counselors. CHAMPUS requires that marriage and family counselors, pastoral counselors, and supervised mental health counselors make a written report to the referring physician concerning the CHAMPUS beneficiary's progress. Therefore, each claim for reimbursement for services of marriage and family counselors, pastoral counselors, and supervised mental health counselors must include certification to the effect that a written communication has been made or will be made to the referring physician at the end of treatment, or more frequently, as required by the referring physician.

(f) Preauthorization. When specifically required in other sections of this part, preauthorization requires the following:

(1) Preauthorization must be granted before benefits can be extended. In those situations requiring preauthorization, the request for such preauthorization shall be submitted and approved before benefits may be extended, except as provided in Sec. 199.4(a)(11). If a claim for services or supplies is submitted without the required preauthorization, no benefits shall be paid, unless the Director, OCHAMPUS, or a designee, has granted an exception to the requirement for preauthorization.

(i) Specifically preauthorized services. An approved preauthorization specifies the exact services or supplies for which authorization is being given. In a preauthorization situation, benefits cannot be extended for services or supplies provided beyond the specific authorization.

(ii) Time limit on preauthorization. Approved preauthorizations are valid for specific periods of time, appropriate for the circumstances presented and specified at the time the

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preauthorization is approved. In general, preauthorizations are valid for 30 days. If the preauthorized service or supplies are not obtained or commenced within the specified time limit, a new preauthorization is required before benefits may be extended. For organ and stem cell transplants, the preauthorization shall remain in effect as long as the beneficiary continues to meet the specific transplant criteria set forth in the TRICARE/CHAMPUS Policy Manual, or until the approved transplant occurs.

(2) Treatment plan. Each preauthorization request shall be accompanied by a proposed medical treatment plan (for inpatient stays under the Basic Program) which shall include generally a diagnosis; a detailed summary of complete history and physical; a detailed statement of the problem; the proposed treatment modality, including anticipated length of time the proposed modality will be required; any available test results; consultant's reports; and the prognosis. When the preauthorization request involves transfer from a hospital to another inpatient facility, medical records related to the inpatient stay also must be provided.

(3) Claims for services and supplies that have been preauthorized. Whenever a claim is submitted for benefits under CHAMPUS involving preauthorized services and supplies, the date of the approved preauthorization must be indicated on the claim form and a copy of the written preauthorization must be attached to the appropriate CHAMPUS claim.

(4) Advance payment prohibited. No CHAMPUS payment shall be made for otherwise authorized services or items not yet rendered or delivered to the beneficiary.

(g) Claims review. It is the responsibility of the CHAMPUS fiscal intermediary (or OCHAMPUS, including OCHAMPUSEUR) to review each CHAMPUS claim submitted for benefit consideration to ensure compliance with all applicable definitions, conditions, limitations, or exclusions specified or enumerated in this part. It is also required that before any CHAMPUS benefits may be extended, claims for medical services and supplies will be subject to utilization review and quality assurance standards, norms, and criteria issued by the Director, OCHAMPUS, or a designee (see paragraph (a)(1)(v) of Sec. 199.14 for review standards for claims subject to the CHAMPUS DRG-based payment system).

(h) Benefit payments. CHAMPUS benefit payments are made either directly to the beneficiary or sponsor or to the provider, depending on the manner in which the CHAMPUS claim is submitted.

(1) Benefit payments made to beneficiary or sponsor. When the CHAMPUS beneficiary or sponsor signs and submits a specific claim form directly to the appropriate CHAMPUS fiscal intermediary (or OCHAMPUS, including OCHAMPUSEUR), any CHAMPUS benefit payments due as a result of that specific claim submission will be made in the name of, and mailed to, the beneficiary or sponsor. In such circumstances, the beneficiary or sponsor is responsible to the provider for any amounts billed.

(2) Benefit payments made to participating provider. When the authorized provider elects to participate by signing a CHAMPUS claim form, indicating participation in the appropriate space on the claim form, and submitting a specific claim on behalf of the beneficiary to the appropriate CHAMPUS fiscal intermediary, any CHAMPUS benefit payments due as a result of that claim submission will be made in the name of and mailed to the participating provider. Thus, by signing the claim form, the authorized provider agrees to abide by the CHAMPUS-determined allowable charge or cost, whether or not lower than the

amount billed. Therefore, the beneficiary or sponsor is responsible only for any required deductible amount and any cost-sharing portion of the CHAMPUS-determined allowable charge or cost as may be required under the terms and conditions set forth in Secs. 199.4 and 199.5 of this part.

(3) CEOB.(i) When a CHAMPUS claim is adjudicated, a CEOB is sent to the beneficiary or sponsor. A copy of the CEOB also is sent to the provider if the claim was submitted on a participating basis. The CEOB form provides, at a minimum, the following information: (i) Name and address of beneficiary.

(ii) Name and address of provider.

(iii) Services or supplies covered by claim for which CEOB applies.

(iv) Dates services or supplies provided.

(v) Amount billed; CHAMPUS-determined allowable charge or cost; and amount of CHAMPUS payment.

(vi) To whom payment, if any, was made.

(vii) Reasons for any denial.

(viii) Recourse available to beneficiary for review of claim decision (refer to Sec. 199.10 of this part).

NOTE: The Director, OCHAMPUS, or a designee, may authorize a CHAMPUS fiscal intermediary to waive a CEOB to protect the privacy of a CHAMPUS beneficiary.

(4) Benefit under \$1. If the CHAMPUS benefit is determined to be under \$1, payment is waived.

(i) Extension of the Active Duty Dependents Dental Plan to areas outside the United States. The Assistant Secretary of Defense (Health Affairs) (ASD(HA)) may, under the authority of 10 U.S.C. 1076a(h), extend the Active Duty Dependents Dental Plan to areas other than those areas specified in paragraph (a)(2)(i) of this section for the eligible beneficiaries of members of the Uniformed Services. In extending the program outside the Continental United States, the ASD(HA), or designee, is authorized to establish program elements, methods of administration and payment rates and procedures to providers that are different from those in effect under this section in the Continental United States to the extent the ASD(HA), or designee, determines necessary for the effective and efficient operation of the plan outside the Continental United States. This includes provisions for preauthorization of care if the needed services are not available in a Uniformed Service overseas dental treatment facility and payment by the Department of certain cost-shares and other portions of a provider's billed charges. Other differences may occur based on limitations in the availability and capabilities of the Uniformed Services overseas dental treatment facility and a particular nation's civilian sector providers in certain areas. Otherwise, rules pertaining to services covered under the plan and quality of care standards for providers shall be comparable to those in effect under this section in the Continental United States and

available military guidelines. In addition, all provisions of 10 U.S.C. 1076a shall remain in effect.

(j) **General assignment of benefits not recognized.** CHAMPUS does not recognize any general assignment of CHAMPUS benefits to another person. All CHAMPUS benefits are payable as described in this and other Sections of this part.

[51 FR 24008, Jul 1, 1986, as amended at 52 FR 33007, Sep 1, 1987; 53 FR 5373, Feb 24, 1988; 54 FR 25246, Jun 14, 1989; 56 FR 28487, Jun 21, 1991; 56 FR 59878, Nov 26, 1991; 58 FR 35408, Jul 1, 1993; 58 FR 51238, Oct 1, 1993; 58 FR 58961, Nov 5, 1993; 62 FR 35097, Jun 30, 1997; 63 FR 48446, Sep 10, 1998; 64 FR 38576, Jul 19, 1999; 67 FR 42721, Jun 25, 2002; 68 FR 44881, Jul 31, 2003; 69 FR 44952, Jul 28, 2004; 69 FR 51569, Aug 20, 2004; 70 FR 19265, Apr 13, 2005; 79 FR 41642, Jul 17, 2014]

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