



DEFENSE  
HEALTH AGENCY

**MB&RS**

**OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE  
HEALTH AFFAIRS  
16401 EAST CENTRETECH PARKWAY  
AURORA, CO 80011-9066**

**CHANGE 71  
32 CFR 199  
MAY 6, 2016**

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

**FINAL RULE**

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

**CHANGE TITLE: TRICARE PROGRAM; CLARIFICATION OF BENEFIT COVERAGE OF DURABLE EQUIPMENT AND ORDERING OR PRESCRIBING DURABLE EQUIPMENT; CLARIFICATION OF BENEFIT COVERAGE OF ASSISTIVE TECHNOLOGY DEVICES UNDER THE EXTENDED CARE HEALTH OPTION PROGRAM**

**FEDERAL REGISTER: Vol 81, No 88 (Pages 27328 - 27329)**

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

**ATTACHMENT(S): 11 PAGES  
DISTRIBUTION: 32 CFR 199**

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

**CHANGE 71  
32 CFR 199  
MAY 6, 2016**

**REMOVE PAGE(S)**

**CHAPTER 4**

Chapter pages 29 through 34 and 79

**CHAPTER 5**

Chapter pages 3, 4, 11, and 12

**INSERT PAGE(S)**

Chapter pages 29 through 34 and 79

Chapter pages 3, 4, 11, and 12

services or direct supervision of care provided by a physician in training. In order to be considered an attending physician, the teaching physician must:

- (i) Review the patient's history and the record of examinations and tests in the institution, and make frequent reviews of the patient's progress; and
- (ii) Personally examine the patient; and
- (iii) Confirm or revise the diagnosis and determine the course of treatment to be followed; and
- (iv) Either perform the physician's services required by the patient or supervise the treatment so as to assure that appropriate services are provided by physicians in training and that the care meets a proper quality level; and
- (v) Be present and ready to perform any service performed by an attending physician in a nonteaching setting when a major surgical procedure or a complex or dangerous medical procedure is performed; and
- (vi) Be personally responsible for the patient's care, at least throughout the period of hospitalization.

(2) Direct supervision by an attending physician of care provided by physicians in training. Payment on the basis of allowable charges may be made for the professional services rendered to a beneficiary by his/her attending physician when the attending physician provides personal and identifiable direction to physicians in training who are participating in the care of the patient. It is not necessary that the attending physician be personally present for all services, but the attending physician must be on the provider's premises and available to provide immediate personal assistance and direction if needed.

(3) Individual, personal services. A teaching physician may be reimbursed on an allowable charge basis for any individual, identifiable service rendered to a CHAMPUS beneficiary, so long as the service is a covered service and is normally reimbursed separately, and so long as the patient records substantiate the service.

(4) Who may bill. The services of a teaching physician must be billed by the institutional provider when the physician is employed by the provider or a related entity or under a contract which provides for payment to the physician by the provider or a related entity. Where the teaching physician has no relationship with the provider (except for standard physician privileges to admit patients) and generally treats patients on a fee-for-service basis in the private sector, the teaching physician may submit claims under his/her own provider number.

(B) Physicians in training. Physicians in training in an approved teaching program are considered to be "students" and may not be reimbursed directly by CHAMPUS for services rendered to a beneficiary when their services are provided as part of their employment (either salaried or contractual) by a hospital or other institutional provider. Services of physicians in training may be reimbursed on an allowable charge basis only if:

DHA Version - April 2005

- (1) The physician in training is fully licensed to practice medicine by the state in which the services are performed, and
- (2) The services are rendered outside the scope and requirements of the approved training program to which the physician in training is assigned.

**(d) Other benefits--**(1) General. Benefits may be extended for the allowable charge of those other covered services and supplies described in paragraph (d) of this section, which are provided in accordance with good medical practice and established standards of quality by those other authorized providers described in Sec. 199.6. Such benefits are subject to all applicable definitions, conditions, limitations, or exclusions as otherwise may be set forth in this or other chapters of this Regulation. To be considered for benefits under paragraph (d) of this section, the described services or supplies must be prescribed and ordered by a physician. Other authorized individual professional providers acting within their scope of licensure may also prescribe and order these services and supplies unless otherwise specified in paragraph (d) of this section.

(2) Billing practices. To be considered for benefits under paragraph (d) of this section, covered services and supplies must be provided and billed for by an authorized provider as set forth in Sec. 199.6 of this part. Such billing must be itemized fully and described sufficiently, even when CHAMPUS payment is determined under the CHAMPUS DRG-based payment system, so that CHAMPUS can determine whether benefits are authorized by this part. Except for claims subject to the CHAMPUS DRG-based payment system, whenever continuing charges are involved, claims should be submitted to the appropriate CHAMPUS fiscal intermediary at least every 30 days (monthly) either by the beneficiary or sponsor or directly by the provider. 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.

(3) Other covered services and supplies--(i) Blood. If whole blood or plasma (or its derivatives) are provided and billed for by an authorized institution in connection with covered treatment, benefits are extended as set forth in paragraph (b) of this section. If blood is billed for directly to a beneficiary, benefits may be extended under paragraph (d) in the same manner as a medical supply.

(ii) Durable equipment--(A) Scope of benefit. (1) Durable equipment, which is for the specific use of the beneficiary and is ordered by an authorized individual professional provider listed in Sec. 199.6(c)(3)(i), (ii) or (iii), acting within his or her scope of licensure shall be covered if the durable equipment meets the definition in Sec. 199.2 and--

- (i) Provides the medically appropriate level of performance and quality for the medical condition present and
  - (ii) Is not otherwise excluded by this part.
- (2) Items that may be provided to a beneficiary as durable equipment include:
- (i) Durable medical equipment as defined in Sec. 199.2;

(ii) Wheelchairs. A wheelchair, which is medically appropriate to provide basic mobility, including reasonable additional costs for medically appropriate modifications to accommodate a particular physiological or medical need, may be covered as durable equipment. An electric wheelchair, or TRICARE approved alternative to an electric wheelchair (e.g., scooter) may be provided in lieu of a manual wheelchair when it is medically indicated and appropriate to provide basic mobility. Luxury or deluxe wheelchairs, as described in paragraph (d)(3)(ii)(A)(3) of this section, include features beyond those required for basic mobility of a particular beneficiary are not authorized.

(iii) Iron lungs.

(iv) Hospital beds.

(v) Cardiorespiratory monitors under conditions specified in paragraph (d)(3)(ii)(B) of this section.

(3) Whether a prescribed item of durable equipment provides the medically appropriate level of performance and quality for the beneficiary's condition must be supported by adequate documentation. Luxury, deluxe, immaterial, or non-essential features, which increase the cost of the item relative to a similar item without those features, based on industry standards for a particular item at the time the equipment is prescribed or replaced for a beneficiary, are not authorized. Only the "base" or "basic" model of equipment (or more cost-effective alternative equipment) shall be covered, unless customization of the equipment, or any accessory or item of supply for any durable medical equipment, is essential, as determined by the Director (or designee), for--

(i) Achieving therapeutic benefit for the patient;

(ii) Making the equipment serviceable; or

(iii) Otherwise assuring the proper functioning of the equipment.

(B) Cardiorespiratory monitor exception. (1) When prescribed by a physician who is otherwise eligible as a CHAMPUS individual professional provider, or who is on active duty with a United States Uniformed Service, an electronic cardiorespiratory monitor, including technical support necessary for the proper use of the monitor, may be cost-shared as durable medical equipment when supervised by the prescribing physician for in-home use by:

(i) An infant beneficiary who has had an apparent life-threatening event, as defined in guidelines issued by the Director, OCHAMPUS, or a designee, or

(ii) An infant beneficiary who is a subsequent or multiple birth biological sibling of a victim of sudden infant death syndrome (SIDS), or

(iii) An infant beneficiary whose birth weight was 1,500 grams or less, or

(iv) An infant beneficiary who is a pre-term infant with pathologic apnea, as defined in guidelines issued by the Director, OCHAMPUS, or a designee, or

(v) Any beneficiary who has a condition or suspected condition designated in guidelines

issued by the Director, OCHAMPUS, or a designee, for which the in-home use of the cardiorespiratory monitor otherwise meets Basic Program requirements.

(2) The following types of services and items may be cost-shared when provided in conjunction with an otherwise authorized cardiorespiratory monitor:

(i) Trend-event recorder, including technical support necessary for the proper use of the recorder.

(ii) Analysis of recorded physiological data associated with monitor alarms.

(iii) Professional visits for services otherwise authorized by this part, and for family training on how to respond to an apparent life threatening event.

(iv) Diagnostic testing otherwise authorized by this part.

(C) Exclusions. Durable equipment, which is otherwise qualified as a benefit is excluded from coverage under the following circumstances:

(1) Durable equipment for a beneficiary who is a patient in a type of facility that ordinarily provides the same type of durable equipment item to its patients at no additional charge in the usual course of providing its services.

(2) Durable equipment, which is available to the beneficiary from a Uniformed Services Medical Treatment Facility.

(D) Basis for reimbursement. (1) Durable equipment may be provided on a rental or purchase basis. Coverage of durable equipment will be based on the price most advantageous to the government taking into consideration the anticipated duration of the medically necessary need for the equipment and current price information for the type of item. The cost analysis must include a comparison of the total price of the item as a monthly rental charge, a lease-purchase price, and a lump-sum purchase price and a provision for the time value of money at the rate determined by the U.S. Department of Treasury. If a beneficiary wishes to obtain an item of durable equipment with deluxe, luxury, immaterial or non-essential features, the beneficiary may agree to accept TRICARE coverage limited to the allowable amount that would have otherwise been authorized for a similar item without those features. In that case, the TRICARE coverage is based upon the allowable amount for the kind of durable equipment normally used to meet the intended purpose (i.e., the standard item least costly). The provider shall not hold the beneficiary liable for deluxe, luxury, immaterial, or non-essential features that cannot be considered in determining the TRICARE allowable costs. However, the beneficiary shall be held liable if the provider has a specific agreement in writing from the beneficiary (or his or her representative) accepting liability for the itemized difference in costs of the durable equipment with deluxe, luxury, or immaterial features and the TRICARE allowable costs for an otherwise authorized item without such features.

(2) In general, repairs of beneficiary owned durable equipment are covered when necessary to make the equipment serviceable and replacement of durable equipment is allowed when the durable equipment is not serviceable because of normal wear, accidental damage or when necessitated by a change in the beneficiary's condition. However, repairs of

DHA Version - April 2005

durable equipment damaged while using the equipment in a manner inconsistent with its common use, and replacement of lost or stolen rental durable equipment are excluded from coverage. In addition, repairs of deluxe, luxury, or immaterial features of durable equipment are excluded from coverage.

(iii) Medical supplies and dressings (consumables). Medical supplies and dressings (consumables) are those that do not withstand prolonged, repeated use. Such items must be related directly to an appropriate and verified covered medical condition of the specific beneficiary for whom the item was purchased and obtained from a medical supply company, a pharmacy, or authorized institutional provider. Examples of covered medical supplies and dressings are disposable syringes for a known diabetic, colostomy sets, irrigation sets, and elastic bandages. An external surgical garment specifically designed for use following a mastectomy is considered a medical supply item.

NOTE: Generally, the allowable charge of a medical supply item will be under \$100. Any item over this amount must be reviewed to determine whether it would not qualify as a DME item. If it is, in fact, a medical supply item and does not represent an excessive charge, it can be considered for benefits under paragraph (d)(3)(iii) of this section.

(iv) Oxygen. Oxygen and equipment for its administration are covered. Benefits are limited to providing a tank unit at one location with oxygen limited to a 30-day supply at any one time. Repair and adjustment of CHAMPUS-purchased oxygen equipment also is covered.

(v) Ambulance. Civilian ambulance service is covered when medically necessary in connection with otherwise covered services and supplies and a covered medical condition. For the purpose of TRICARE payment, ambulance service is an outpatient service (including in connection with maternity care) with the exception of otherwise covered transfers between hospitals which are cost-shared on an inpatient basis. Ambulance transfers from a hospital based emergency room to another hospital more capable of providing the required care will also be cost-shared on an inpatient basis.

NOTE: The inpatient cost-sharing provisions for ambulance transfers only apply to otherwise covered transfers between hospitals, i.e., acute care, general, and special hospitals; psychiatric hospitals; and long-term hospitals.

(A) Ambulance service cannot be used instead of taxi service and is not payable when the patient's condition would have permitted use of regular private transportation; nor is it payable when transport or transfer of a patient is primarily for the purpose of having the patient nearer to home, family, friends, or personal physician. Except as described in paragraph (d)(3)(v)(C)(1) of this section transport must be to the closest appropriate facility by the least costly means.

(B) Vehicles such as medicabs or ambicabs function primarily as public passenger conveyances transporting patients to and from their medical appointments. No actual medical care is provided to the patients in transit. These types of vehicles do not qualify for benefits for the purpose of CHAMPUS payment.

(C) Except as described in paragraph (d)(3)(v)(C)(1)(i) of this section, ambulance services by other than land vehicles (such as a boat or airplane) may be considered only when the

pickup point is inaccessible by a land vehicle, or when great distance or other obstacles are involved in transporting the patient to the nearest hospital with appropriate facilities and the patient's medical condition warrants speedy admission or is such that transfer by other means is contraindicated.

(1) Advanced life support air ambulance and certified advanced life support attendant are covered services for solid organ and stem cell transplant candidates.

(2) Advanced life support air ambulance and certified advanced life support attendant shall be reimbursed subject to standard reimbursement methodologies.

(vi) Drugs and medicines. Drugs and medicines that by United States law require a prescription are also referred to as "legend drugs." Legend drugs are covered when prescribed by a physician or other authorized individual professional provider acting within the scope of the provider's license and ordered or prescribed in connection with an otherwise covered condition or treatment, and not otherwise excluded by TRICARE. This includes Rh immune globulin.

(A) Drugs administered by a physician or other authorized individual professional provider as an integral part of a procedure covered under paragraph (b) or (c) of this section (such as chemotherapy) are not covered under this subparagraph inasmuch as the benefit for the institutional services or the professional services in connection with the procedure itself also includes the drug used.

(B) CHAMPUS benefits may not be extended for drugs not approved by the U.S. Food and Drug Administration for commercial marketing. Drugs grandfathered by the Federal Food, Drug and Cosmetic Act of 1938 may be covered under CHAMPUS as if FDA approved.

(C) Over-the-counter (OTC) drugs (drugs that by United States law do not require a prescription), in general, are not covered. However, insulin is covered for a known diabetic even in states that do not require a prescription for its purchase. In addition, OTC drugs used for smoking cessation are covered when all requirements under the TRICARE smoking cessation program are met as provided in paragraph (e)(30) of this section.

(vii) Prosthetics, prosthetic devices, and prosthetic supplies, as determined by the Secretary of Defense to be necessary because of significant conditions resulting from trauma, congenital anomalies, or disease. Additionally, the following are covered:

(A) Any accessory or item of supply that is used in conjunction with the device for the purpose of achieving therapeutic benefit and proper functioning;

(B) Services necessary to train the recipient of the device in the use of the device;

(C) Repair of the device for normal wear and tear or damage;

(D) Replacement of the device if the device is lost or irreparably damaged or the cost of repair would exceed 60 percent of the cost of replacement.

(viii) Orthopedic braces and appliances. The purchase of leg braces (including attached shoes), arm braces, back braces, and neck braces is covered, orthopedic shoes, arch supports,

DHA Version - April 2005

(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; 79 FR 78707, Dec 31, 2014; 79 FR 78712, Dec 31, 2014; **81 FR 27328, May 6, 2016**]

**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.

DHA Version - April 2005



environment, as appropriate. An AT device may be covered only if it is recommended in a beneficiary's Individual Educational Program (IEP) or, if the beneficiary is not eligible for an IEP, the AT device is an item or educational learning device normally included in an IEP and is preauthorized under ECHO as an integral component of the beneficiary's individual comprehensive health care services plan (including rehabilitation) as prescribed by a TRICARE authorized provider.

(i) An AT device may be covered under ECHO only if it is not otherwise covered by TRICARE as durable equipment, a prosthetic, augmentation communication device, or other benefits under Sec. 199.4.

(ii) An AT device may include an educational learning device directly related to the beneficiary's qualifying condition when recommended by an IEP and not otherwise provided by State or local government programs. If an individual is not eligible for an IEP, an educational learning device normally included in the IEP may be authorized as if directly related to the beneficiary's qualifying condition and prescribed by a TRICARE authorized provider as part of the beneficiary's individual comprehensive health care services plan.

(iii) Electronic learning devices may include the hardware and software as appropriate. The Director, DHA, shall determine the types and (or) platforms of electronic devices and the replacement lifecycle of the hardware and its supporting software. All upgrades or replacements shall require a recommendation from the individual's IEP or the individual's comprehensive health care services plan.

(iv) Duplicative or redundant hardware platforms are not authorized.

Note to paragraph (c)(2)(iv): When one or more electronic platforms such as a desktop computer, laptop, notebook or tablet can perform the same functions in relation to the teaching or educational objective directly related to the qualifying condition, it is the intent of this provision to allow only one electronic platform that may be chosen by the beneficiary. Duplicative or redundant platforms are not allowed; however, a second platform may be obtained, if the individual's IEP recommends one platform such as a computer for the majority of the learning objectives, but there exists another objective, which cannot be performed on that platform. In these limited circumstances, the beneficiary may submit a request with the above justification to the Director, TMA, who may authorize a second device.

(v) **AT devices damaged through improper use of the device may not be replaced until the device would next be eligible for a lifecycle replacement.**

(vi) AT devices do not include equipment or devices whose primary purpose is to assist the individual to engage in sports or recreational activities.

(3) Training that teaches the use of assistive technology devices or to acquire skills that are necessary for the management of the qualifying condition. Such training is also authorized for the beneficiary's immediate family. Vocational training, in the beneficiary's home or a facility providing such, is also allowed.

(4) Special education as provided by the Individuals with Disabilities Education Act and defined at 34 CFR 300.26 and that is specifically designed to accommodate the disabling

effects of the qualifying condition.

(5) Institutional care within a state, as defined in Sec. 199.2, in private nonprofit, public, and state institutions and facilities, when the severity of the qualifying condition requires protective custody or training in a residential environment. For the purpose of this section protective custody means residential care that is necessary when the severity of the qualifying condition is such that the safety and well-being of the beneficiary or those who come into contact with the beneficiary may be in jeopardy without such care.

(6) Transportation of an ECHO beneficiary receiving benefits under paragraph (c)(5), and a medical attendant when necessary to assure the beneficiary's safety, to or from a facility or institution to receive authorized ECHO services or items.

(7) Respite care. ECHO beneficiaries are eligible for 16 hours of respite care per month in any month during which the beneficiary otherwise receives an ECHO benefit(s). Respite care is defined in Sec. 199.2. Respite care services will be provided by a TRICARE-authorized home health agency and will be designed to provide health care services for the covered beneficiary, and not baby-sitting or child-care services for other members of the family. The benefit will not be cumulative, that is, any respite care hours not used in one month will not be carried over or banked for use on another occasion.

(i) TRICARE-authorized home health agencies must provide and bill for all authorized ECHO respite care services through established TRICARE claims' mechanisms. No special billing arrangements will be authorized in conjunction with coverage that may be provided by Medicaid or other federal, state, community or private programs.

(ii) For authorized ECHO respite care, TRICARE will reimburse the allowable charges or negotiated rates.

(iii) The Government's cost-share incurred for these services accrues to the fiscal year benefit limit of \$36,000.

(8) Other services. (i) Assistive services. Services of qualified personal assistants, such as an interpreter or translator for ECHO beneficiaries who are deaf or mute and readers for ECHO beneficiaries who are blind, when such services are necessary in order for the ECHO beneficiary to receive authorized ECHO benefits.

(ii) Equipment adaptation. The allowable equipment and an AT device purchase shall include such services and modifications to the equipment as necessary to make the equipment usable for a particular ECHO beneficiary.

(iii) Equipment maintenance. Reasonable repairs and maintenance of the beneficiary owned or rented DE or AT devices provided by this section shall be allowed while a beneficiary is registered in the ECHO Program. Repairs of DE and/or AT devices damaged while using the item in a manner inconsistent with its common use, and replacement of lost or stolen rental DE are not authorized coverage as an ECHO benefit. In addition, repairs and maintenance of deluxe, luxury, or immaterial features of DE or AT devices are not authorized coverage as an ECHO benefit.

DHA Version - April 2005

facilities. The maximum Government cost-share for services that require demonstration of public facility non-availability or inadequacy is limited to \$36,000 per fiscal year per beneficiary. State-administered plans for medical assistance under Title XIX of the Social Security Act (Medicaid) are not considered available and adequate facilities for the purpose of this section.

(B) The domicile of the beneficiary shall be the basis for the determination of public facility availability when the sponsor and beneficiary are separately domiciled due to the sponsor's move to a new permanent duty station or due to legal custody requirements.

(C) Written certification, in accordance with information requirements, formats, and procedures established by the Director, TRICARE Management Activity or designee that requested ECHO services or items cannot be obtained from public facilities because the services or items are not available and adequate, is a prerequisite for ECHO benefit payment for training, rehabilitation, special education, assistive technology, and institutional care in private nonprofit, public, and state institutions and facilities, and if appropriate, transportation to and from such institutions and facilities.

(1) An administrator or designee of a public facility may make such certification for a beneficiary residing within the service area of that public facility.

(2) The Director, TRICARE Management Activity or designee may determine, on a case-by-case basis, that apparent public facility availability or adequacy for a requested type of service or item cannot be substantiated for a specific beneficiary's request for ECHO benefits and therefore is not available.

(i) A case-specific determination shall be based upon a written statement by the beneficiary (or sponsor or guardian acting on behalf of the beneficiary) which details the circumstances wherein a specific individual representing a specific public facility refused to provide a public facility use certification, and such other information as the Director, TRICARE Management Activity or designee determines to be material to the determination.

(ii) A case-specific determination of public facility availability by the Director, TRICARE Management Activity or designee is conclusive and is not appealable under Sec. 199.10.

**(4) Repair or maintenance of DE owned by the beneficiary or an AT device is exempt from the public facility-use certification requirements.**

(5) The requirements of this paragraph (h)(3)(v)(A) notwithstanding, no public facility use certification is required for services and items that are provided under Part C of the Individuals with Disabilities Education Act in accordance with the Individualized Family Services Plan and that are otherwise allowable under the ECHO.

**(i) Implementing instructions.** The Director, TRICARE Management Activity or designee shall issue TRICARE policies, instructions, procedures, guidelines, standards, and criteria as may be necessary to implement the intent of this section.

**(j) Effective date.** All changes to this section are effective as of October 14, 2008, and claims for ECHO benefits provided on or after that date will be reprocessed retroactively to that date as necessary.

DHA Version - April 2005

CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES (CHAMPUS)  
PART 199.5 TRICARE EXTENDED CARE HEALTH OPTION (ECHO)

---

[62 FR 35093, Jun. 30, 1997, as amended at 62 FR 42904, Aug. 11, 1997; 66 FR 9655, Feb. 9, 2001; 67 FR 18827, Apr. 17, 2002; 69 FR 44947, Jul. 28, 2004; 69 FR 51564, Aug. 20, 2004; 71 FR 47092, Aug. 16, 2006; 72 FR 2447, Jan. 19, 2007; 73 FR 30478, May 28, 2008; 75 FR 47711, Aug. 9, 2010; 79 FR 78713, Dec. 31, 2014; 81 FR 27329, May 6, 2016]

DHA Version - April 2005