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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; MENTAL HEALTH AND SUBSTANCE USE DISORDER TREATMENT

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determines are necessary to implement the basic standards.

(ii) To be approved as a TRICARE authorized provider, the SUDRF is required to be licensed and operate in substantial compliance with state and federal regulations.

(iii) The SUDRF is currently accredited by an accrediting organization approved by the Director. Each SUDRF must be accredited to provide the level of required treatment by an accreditation body approved by the Director.

(iv) The SUDRF has a written participation agreement with OCHAMPUS. The SUDRF is not considered a TRICARE authorized provider, and CHAMPUS benefits are not paid for services provided until the date upon which a participation agreement is signed by the Director.

(B) Participation agreement requirements. In addition to other requirements set forth in this paragraph (b)(4)(xiv), in order for the services of an inpatient rehabilitation center for the treatment of substance use disorders to be authorized, the center shall have entered into a Participation Agreement with OCHAMPUS. A single consolidated participation agreement is acceptable for all units of the TRICARE authorized facility. The period of a Participation Agreement shall be specified in the agreement, and will generally be for not more than five years. The SUDRF shall not be considered to be a CHAMPUS authorized provider and CHAMPUS payments shall not be made for services provided by the SUDRF until the date the participation agreement is signed by the Director. In addition to review of the SUDRF's application and supporting documentation, an on-site visit by OCHAMPUS representatives may be part of the authorization process. The Participation Agreement shall include at least the following requirements:

(1) Render applicable services to eligible CHAMPUS beneficiaries in need of such services, in accordance with the participation agreement and CHAMPUS regulation;

(2) Accept payment for its services based upon the methodology provided in Sec. 199.14, or such other method as determined by the Director;

(3) Accept the CHAMPUS-determined rate as payment in full and collect from the CHAMPUS beneficiary or the family of the CHAMPUS beneficiary only those amounts that represent the beneficiary's liability, as defined in Sec. 199.4, and charges for services and supplies that are not a benefit of CHAMPUS;

(4) Make all reasonable efforts acceptable to the Director to collect those amounts which represent the beneficiary's liability, as defined in Sec. 199.4;

(5) Comply with the provisions of Sec. 199.8, and submit claims first to all health insurance coverage to which the beneficiary is entitled that is primary to CHAMPUS;

(6) Furnish OCHAMPUS with cost data, as requested by OCHAMPUS, certified to by an independent accounting firm or other agency as authorized by the Director;

(7) Certify that:

(i) It is and will remain in compliance with the provisions of paragraph (b)(4)(xiv) of the

section establishing standards for substance use disorder rehabilitation facilities; and

(ii) It has conducted a self-assessment of the facility's compliance with the CHAMPUS Standards for Substance Use Disorder Rehabilitation Facilities, as issued by the Director and notified the Director of any matter regarding which the facility is not in compliance with such standards; and

(iii) It will maintain compliance with the CHAMPUS Standards for Substance Use Disorder Rehabilitation Facilities, as issued by the Director, except for any such standards regarding which the facility notifies the Director that it is not in compliance.

(8) Designate an individual who will act as liaison for CHAMPUS inquiries. The SUDRF shall inform OCHAMPUS in writing of the designated individual;

(9) Furnish OCHAMPUS, as requested by OCHAMPUS, with cost data certified by an independent accounting firm or other agency as authorized by the Director;

(10) Comply with all requirements of this section applicable to institutional providers generally concerning accreditation requirements, preauthorization, concurrent care review, claims processing, beneficiary liability, double coverage, utilization and quality review, and other matters;

(11) Grant the Director, or designee, the right to conduct quality assurance audits or accounting audits with full access to patients and records (including records relating to patients who are not CHAMPUS beneficiaries) to determine the quality and cost effectiveness of care rendered. The audits may be conducted on a scheduled or unscheduled (unannounced) basis. This right to audit/review included, but is not limited to:

(i) Examination of fiscal and all other records of the center which would confirm compliance with the participation agreement and designation as an authorized TRICARE provider;

(ii) Conducting such audits of center records including clinical, financial, and census records, as may be necessary to determine the nature of the services being provided, and the basis for charges and claims against the United States for services provided CHAMPUS beneficiaries;

(iii) Examining reports of evaluations and inspection conducted by federal, state and local government, and private agencies and organizations;

(iv) Conducting on-site inspections of the facilities of the SUDRF and interviewing employees, members of the staff, contractors, board members, volunteers, and patients, as required.

(v) Audits conducted by the United States Government Accountability Office.

(C) Other requirements applicable to substance use disorder rehabilitation facilities.

(1) Even though a SUDRF may qualify as a TRICARE authorized provider and may have entered into a participation agreement with CHAMPUS, payment by CHAMPUS for particular services provided is contingent upon the SUDRF also meeting all conditions set

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forth in Sec. 199.4.

(2) The center shall provide inpatient services to CHAMPUS beneficiaries in the same manner it provides services to all other patients. The center may not discriminate against CHAMPUS beneficiaries in any manner, including admission practices, placement in special or separate wings or rooms, or provisions of special or limited treatment.

(3) The substance use disorder facility shall assure that all certifications and information provided to the Director, incident to the process of obtaining and retaining authorized provider status, is accurate and that it has no material errors or omissions. In the case of any misrepresentations, whether by inaccurate information being provided or material facts withheld, authorized provider status will be denied or terminated, and the facility will be ineligible for consideration for authorized provider status for a two year period.

(xv) Home health agencies (HHAs). HHAs must be Medicare approved and meet all Medicare conditions of participation under sections 1861(o) and 1891 of the Social Security Act (42 U.S.C. 1395x(o) and 1395bbb) and 42 CFR part 484 in relation to TRICARE beneficiaries in order to receive payment under the TRICARE program. An HHA may be found to be out of compliance with a particular Medicare condition of participation and still participate in the TRICARE program as long as the HHA is allowed continued participation in Medicare while the condition of noncompliance is being corrected. An HHA is a public or private organization, or a subdivision of such an agency or organization, that meets the following requirements:

(A) Engaged in providing skilled nursing services and other therapeutic services, such as physical therapy, speech-language pathology services, or occupational therapy, medical services, and home health aide services.

(1) Makes available part-time or intermittent skilled nursing services and at least one other therapeutic service on a visiting basis in place of residence used as a patient's home.

(2) Furnishes at least one of the qualifying services directly through agency employees, but may furnish the second qualifying service and additional services under arrangement with another HHA or organization.

(B) Policies established by a professional group associated with the agency or organization (including at least one physician and one registered nurse) to govern the services and provides for supervision of such services by a physician or a registered nurse.

(C) Maintains clinical records for all patients.

(D) Licensed in accordance with State and local law or is approved by the State or local licensing agency as meeting the licensing standards, where applicable.

(E) Enters into an agreement with TRICARE in order to participate and to be eligible for payment under the program. In this agreement the HHA and TRICARE agree that the HHA will:

(1) Not charge the beneficiary or any other person for items or services for which the beneficiary is entitled to have payment under the TRICARE HHA prospective payment

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system.

(2) Be allowed to charge the beneficiary for items or services requested by the beneficiary in addition to those that are covered under the TRICARE HHA prospective payment system.

(F) Abide by the following consolidated billing requirements:

(1) The HHA must submit all TRICARE claims for all home health services, excluding durable medical equipment (DME), while the beneficiary is under the home health plan without regard to whether or not the item or service was furnished by the HHA, by others under arrangement with the HHA, or under any other contracting or consulting arrangement.

(2) Separate payment will be made for DME items and services provided under the home health benefit which are under the DME fee schedule. DME is excluded from the consolidated billing requirements.

(3) Home health services included in consolidated billing are:

(i) Part-time or intermittent skilled nursing;

(ii) Part-time or intermittent home health aide services;

(iii) Physical therapy, occupational therapy and speech-language pathology;

(iv) Medical social services;

(v) Routine and non-routine medical supplies;

(vi) A covered osteoporosis drug (not paid under PPS rate) but excluding other drugs and biologicals;

(vii) Medical services provided by an intern or resident-in-training of a hospital, under an approved teaching program of the hospital in the case of an HHA that is affiliated or under common control of a hospital;

(viii) Services at hospitals, SNFs or rehabilitation centers when they involve equipment too cumbersome to bring home.

(G) Meet such other requirements as the Secretary of Health and Human Services and/or Secretary of Defense may find necessary in the interest of the health and safety of the individuals who are provided care and services by such agency or organization.

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

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payment system for rehabilitation hospitals or rehabilitation units as specified in 42 CFR 412(a)(3).

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

(xviii) Intensive outpatient programs. This paragraph (b)(4)(xviii) establishes standards and requirements for intensive outpatient treatment programs for psychiatric and substance use disorder.

(A) Organization and administration--(1) Definition. Intensive outpatient treatment (IOP) programs are defined in Sec. 199.2. IOP services consist of a comprehensive and complimentary schedule of recognized treatment approaches that may include day, evening, night, and weekend services consisting of individual and group counseling or therapy, and family counseling or therapy as clinically indicated for children and adolescents, or adults aged 18 and over, and may include case management to link patients and their families with community based support systems.

(2) Eligibility. In order to qualify as a TRICARE authorized provider, every intensive outpatient program must meet the minimum basic standards set forth in paragraphs (b)(4)(xviii)(A) through (C) of this section, as well as additional elaborative criteria and standards as the Director determines are necessary to implement the basic standards. Each intensive outpatient program must be either a distinct part of an otherwise-authorized institutional provider or a free-standing psychiatric or substance use disorder intensive outpatient program. Approval of a hospital by TRICARE is sufficient for its IOP to be an authorized TRICARE provider. Such hospital-based intensive outpatient programs are not required to be separately authorized by TRICARE.

(i) To qualify as a TRICARE authorized provider, the IOP is required to be licensed and operate in substantial compliance with state and federal regulations.

(ii) The IOP is currently accredited by an accrediting organization approved by the Director. Each IOP authorized to treat substance use disorder must be accredited to provide the level of required treatment by an accreditation body approved by the Director.

(iii) The facility has a written participation agreement with TRICARE. The IOP is not considered a TRICARE authorized provider and TRICARE benefits are not paid for services provided until the date upon which a participation agreement is signed by the Director.

(B) Participation agreement requirements. In addition to other requirements set forth in paragraph (b)(4)(xii) of this section, in order for the services of an IOP to be authorized, the IOP shall have entered into a Participation Agreement with TRICARE. A single consolidated participation agreement is acceptable for all units of the TRICARE authorized facility granted that all programs meet the requirements of this part. The period of a Participation Agreement shall be specified in the agreement, and will generally be for not more than five years. In addition to review of a facility's application and supporting documentation, an on-site

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inspection by DHA authorized personnel may be required prior to signing a participation agreement. The Participation Agreement shall include at least the following requirements:

- (1) Render intensive outpatient program services to eligible TRICARE beneficiaries in need of such services, in accordance with the participation agreement and TRICARE regulation.
- (2) Accept payment for its services based upon the methodology provided in Sec. 199.14, or such other method as determined by the Director;
- (3) Collect from the TRICARE beneficiary or the family of the TRICARE beneficiary only those amounts that represent the beneficiary's liability, as defined in Sec. 199.4, and charges for services and supplies that are not a benefit of TRICARE;
- (4) Make all reasonable efforts acceptable to the Director to collect those amounts, which represent the beneficiary's liability, as defined in Sec. 199.4;
- (5) Comply with the provisions of Sec. 199.8, and submit claims first to all health insurance coverage to which the beneficiary is entitled that is primary to TRICARE;
- (6) Submit claims for services provided to TRICARE beneficiaries at least every 30 days (except to the extent a delay is necessitated by efforts to first collect from other health insurance). If claims are not submitted at least every 30 days, the IOP agrees not to bill the beneficiary or the beneficiary's family for any amounts disallowed by TRICARE;
- (7) Free-standing intensive outpatient programs shall certify that:
 - (i) It is and will remain in compliance with the provisions of paragraph (b)(4)(xii) of this section establishing standards for psychiatric and SUD IOPs;
 - (ii) It has conducted a self-assessment of the facility's compliance with the CHAMPUS Standards for Intensive Outpatient Programs, as issued by the Director, and notified the Director of any matter regarding which the facility is not in compliance with such standards; and
 - (iii) It will maintain compliance with the TRICARE standards for IOPs, as issued by the Director, except for any such standards regarding which the facility notifies the Director, or a designee that it is not in compliance.
- (8) Designate an individual who will act as liaison for TRICARE inquiries. The IOP shall inform TRICARE, or a designee in writing of the designated individual;
- (9) Furnish OCHAMPUS with cost data, as requested by OCHAMPUS, certified by an independent accounting firm or other agency as authorized by the Director.
- (10) Comply with all requirements of this section applicable to institutional providers generally concerning accreditation requirements, preauthorization, concurrent care review, claims processing, beneficiary liability, double coverage, utilization and quality review, and other matters;
- (11) Grant the Director, or designee, the right to conduct quality assurance audits or

accounting audits with full access to patients and records (including records relating to patients who are not CHAMPUS beneficiaries) to determine the quality and cost effectiveness of care rendered. The audits may be conducted on a scheduled or unscheduled (unannounced) basis. This right to audit/review included, but is not limited to:

(i) Examination of fiscal and all other records of the center which would confirm compliance with the participation agreement and designation as an authorized TRICARE provider;

(ii) Conducting such audits of center records including clinical, financial, and census records, as may be necessary to determine the nature of the services being provided, and the basis for charges and claims against the United States for services provided CHAMPUS beneficiaries;

(iii) Examining reports of evaluations and inspection conducted by federal, state and local government, and private agencies and organizations;

(iv) Conducting on-site inspections of the facilities of the IOP and interviewing employees, members of the staff, contractors, board members, volunteers, and patients, as required.

(v) Audits conducted by the United States Government Accountability Office.

(C) Other requirements applicable to Intensive Outpatient Programs (IOP). (1) Even though an IOP may qualify as a TRICARE authorized provider and may have entered into a participation agreement with CHAMPUS, payment by CHAMPUS for particular services provided is contingent upon the IOP also meeting all conditions set forth in Sec. 199.4.

(2) The IOP may not discriminate against CHAMPUS beneficiaries in any manner, including admission practices, placement in special or separate wings or rooms, or provisions of special or limited treatment.

(3) The IOP shall assure that all certifications and information provided to the Director incident to the process of obtaining and retaining authorized provider status is accurate and that it has no material errors or omissions. In the case of any misrepresentations, whether by inaccurate information being provided or material facts withheld, authorized provider status will be denied or terminated, and the IOP will be ineligible for consideration for authorized provider status for a two year period.

(xix) Opioid Treatment Programs (OTPs). This paragraph (b)(4)(xix) establishes standards and requirements for Opioid Treatment Programs.

(A) Organization and administration. (1) Definition. Opioid Treatment Programs (OTPs) are defined in Sec. 199.2. Opioid Treatment Programs (OTPs) are organized, ambulatory, addiction treatment services for patients with an opioid use disorder. OTPs have the capacity to provide daily direct administration of medications without the prescribing of medications. Medication supplies for patients to take outside of OTPs originate from within OTPs. OTPs offer medication assisted treatment, patient-centered, recovery-oriented individualized treatment through addiction counseling, mental health therapy, case management, and health education.

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(2) Eligibility. (i) Every free-standing Opioid Treatment Program must be accredited by an accrediting organization recognized by Director, under the current standards of an accrediting organization, as well as meet additional elaborative criteria and standards as the Director determines are necessary to implement the basic standards. OTPs adhere to requirements of the Department of Health and Human Services' 42 CFR part 8, the Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Treatment, and the Drug Enforcement Agency. OTPs must be either a distinct part of an otherwise authorized institutional provider or a free-standing program. Approval of hospitals by TRICARE is sufficient for their OTPs to be authorized TRICARE providers. Such hospital-based OTPs, if certified under 42 CFR 8, are not required to be separately authorized by TRICARE.

(ii) To qualify as a TRICARE authorized provider, OTPs are required to be licensed and operate in substantial compliance with state and federal regulations.

(iii) OTPs have a written participation agreement with OCHAMPUS. OTPs are not considered a TRICARE authorized provider, and CHAMPUS benefits are not paid for services provided until the date upon which a participation agreement is signed by the Director.

(B) Participation agreement requirements. In addition to other requirements set forth in this paragraph (b)(4)(xix), in order for the services of OTPs to be authorized, OTPs shall have entered into a Participation Agreement with TRICARE. A single consolidated participation agreement is acceptable for all units of a TRICARE authorized facility. The period of a Participation Agreement shall be specified in the agreement, and will generally be for not more than five years. In addition to review of a facility's application and supporting documentation, an on-site inspection by DHA authorized personnel may be required prior to signing a participation agreement. The Participation Agreement shall include at least the following requirements:

(1) Render services from OTPs to eligible TRICARE beneficiaries in need of such services, in accordance with the participation agreement and TRICARE regulation.

(2) Accept payment for its services based upon the methodology provided in Sec. 199.14, or such other method as determined by the Director;

(3) Collect from the TRICARE beneficiary or the family of the TRICARE beneficiary only those amounts that represent the beneficiary's liability, as defined in Sec. 199.4, and charges for services and supplies that are not a benefit of TRICARE;

(4) Make all reasonable efforts acceptable to the Director to collect those amounts, which represent the beneficiary's liability, as defined in Sec. 199.4;

(5) Comply with the provisions of Sec. 199.8, and submit claims first to all health insurance coverage to which the beneficiary is entitled that is primary to TRICARE;

(6) Submit claims for services provided to TRICARE beneficiaries at least every 30 days (except to the extent a delay is necessitated by efforts to first collect from other health insurance). If claims are not submitted at least every 30 days, OTPs agree not to bill the beneficiary or the beneficiary's family for any amounts disallowed by TRICARE;

- (7) Free-standing opioid treatment programs shall certify that:
- (i) It is and will remain in compliance with the provisions of paragraph (b)(4)(xii) of this section establishing standards for opioid treatment programs;
 - (ii) It will maintain compliance with the TRICARE standards for OTPs, as issued by the Director, except for any such standards regarding which the facility notifies the Director, or a designee, that it is not in compliance.
- (8) Designate an individual who will act as liaison for TRICARE inquiries. OTPs shall inform TRICARE, or a designee, in writing of the designated individual;
- (9) Furnish TRICARE, or a designee, with cost data, as requested by TRICARE, certified by an independent accounting firm or other agency as authorized by the Director;
- (10) Comply with all requirements of this section applicable to institutional providers generally concerning accreditation requirements, claims processing, beneficiary liability, double coverage, utilization and quality review, and other matters;
- (11) Grant the Director, or designee, the right to conduct quality assurance audits or accounting audits with full access to patients and records (including records relating to patients who are not TRICARE beneficiaries) to determine the quality and cost effectiveness of care rendered. The audits may be conducted on a scheduled or unscheduled (unannounced) basis. This right to audit/review includes, but is not limited to:
- (i) Examination of fiscal and all other records of OTPs which would confirm compliance with the participation agreement and designation as an authorized TRICARE provider;
 - (ii) Conducting such audits of OTPs' records including clinical, financial, and census records, as may be necessary to determine the nature of the services being provided, and the basis for charges and claims against the United States for services provided TRICARE beneficiaries;
 - (iii) Examining reports of evaluations and inspections conducted by federal, state and local government, and private agencies and organizations.
- (C) Other requirements applicable to OTPs. (1) Even though OTPs may qualify as a TRICARE authorized provider and may have entered into a participation agreement with CHAMPUS, payment by CHAMPUS for particular services provided is contingent upon OTPs also meeting all conditions set forth in Sec. 199.4.
- (2) OTPs may not discriminate against CHAMPUS beneficiaries in any manner, including admission practices or provisions of special or limited treatment.
- (3) OTPs shall assure that all certifications and information provided to the Director incident to the process of obtaining and retaining authorized provider status is accurate and that it has no material errors or omissions. In the case of any misrepresentations, whether by inaccurate information being provided or material facts withheld, authorized provider status will be denied or terminated, and OTPs will be ineligible for consideration for authorized provider status for a two year period.

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

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

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

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

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

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

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

(iii) Education, training and experience requirement. The Director, OCHAMPUS, or designee, may establish for each category or type of provider allowed by this paragraph (c)

specific education, training, and experience requirements as necessary to promote the delivery of services by fully qualified individuals.

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

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

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

(i) Physicians. (A) Doctors of Medicine (M.D.).

(B) Doctors of Osteopathy (D.O.).

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

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

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

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

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- (A) Clinical psychologist. For purposes of CHAMPUS, a clinical psychologist is an individual who is licensed or certified by the state for the independent practice of psychology and:
- (1) Possesses a doctoral degree in psychology from a regionally accredited university; and
 - (2) Has has 2 years of supervised clinical experience in psychological health services of which at least 1 year is post-doctoral and 1 year (may be the post-doctoral year) is in an organized psychological health service training program; or
 - (3) As an alternative to paragraphs (c)(3)(iii)(A)(1) and (2) of this section is listed in the National Register of Health Service Providers in Psychology.
- (B) Doctors of Optometry.
- (C) Doctors of Podiatry or Surgical Chiropody.
- (D) Certified nurse midwives. (1) A certified nurse midwife may provide covered care independent of physician referral and supervision, provided the nurse midwife is:
- (i) Licensed, when required, by the local licensing agency for the jurisdiction in which the care is provided; and
 - (ii) Certified by the American College of Nurse Midwives. To receive certification, a candidate must be a registered nurse who has completed successfully an educational program approved by the American College of Nurse Midwives, and passed the American College of Nurse Midwives National Certification Examination.
- (2) The services of a registered nurse who is not a certified nurse midwife may be authorized only when the patient has been referred for care by a licensed physician and a licensed physician provides continuing supervision of the course of care. A lay midwife who is neither a certified nurse midwife nor a registered nurse is not a CHAMPUS-authorized provider, regardless of whether the services rendered may otherwise be covered.
- (E) Certified nurse practitioner. Within the scope of applicable licensure or certification requirements, a certified nurse practitioner may provide covered care independent of physician referral and supervision, provided the nurse practitioner is:
- (1) A licensed, registered nurse; and
 - (2) Specifically licensed or certified as a nurse practitioner by the state in which the care was provided, if the state offers such specific licensure or certification; or
 - (3) Certified as a nurse practitioner (certified nurse) by a professional organization offering certification in the speciality of practice, if the state does not offer specific licensure or certification for nurse practitioners.