Part 199.14

Provider Reimbursement Methods

Revision:
Rule:

(a) Hospitals.
   (1) CHAMPUS Diagnosis Related Group (DRG)-based payment system.
      (i) General--
         (A) DRGs used.
         (B) Assignment of discharges to DRGs.
         (C) Basis of payment--
         (D) DRG system updates.
      (ii) Applicability of the DRG system.
         (A) Areas affected.
         (B) Services subject to the DRG-based payment system.
         (C) Services exempt from the DRG-based payment system.
         (D) Hospitals subject to the CHAMPUS DRG-based payment system.
         (E) Hospitals which do not participate in Medicare.
         (F) Substance Use Disorder Rehabilitation facilities.
      (iii) Determination of payment amounts.
         (A) Calculation of DRG weights.
         (B) Empty and low-volume DRGs.
         (C) Updating DRG weights.
         (D) Calculation of the adjusted standardized amounts.
         (E) Adjustments to the DRG-based payments amounts.
         (F) Updating the adjusted standardized amounts.
         (G) Annual cost pass-throughs.
   (2) CHAMPUS mental health per diem payment system.
      (i) Applicability of the mental health per diem payment system.
         (A) Hospitals and units covered.
         (B) Services covered.
      (ii) Hospital-specific per diems for higher volume hospitals and units.
         (A)
         (B) Cap--
         (C) Review of per diem.
      (iii) Regional per diems for lower volume hospitals and units.
         (A) Per diem amounts.
         (B) Review of per diem amount.
         (C) Adjustments to regional per diems.
         (D) Annual cost pass-through for direct medical education.
      (iv) Base period and update factors.
         (A) Base period.
         (B) Alternative hospital-specific data base.
         (C) Update factors--
(v) Higher volume hospitals.
   (A) In general.
   (B) Hospitals that subsequently become higher volume hospitals.
   (C) Special retrospective payment provision for new hospitals.
   (D) Review of classification.

(vi) Payment for hospital based professional services.

(vii) Leave days.

(viii) Exemptions from the CHAMPUS mental health per diem payment system.
   (A) Non-specialty providers.
   (B) DRG 424.
   (C) Non-mental health services.
   (D) Sole community hospitals (SCHs).
   (E) Hospitals outside the U.S.

(ix) Payment for psychiatric and substance use disorder rehabilitation partial hospitalization services, intensive outpatient psychiatric and substance use disorder services and opioid treatment services--
   (A) Per diem payments.
   (B) Services which may be billed separately.

(3) Reimbursement for inpatient services provided by a CAH.

(4) Billed charges and set rates.

(5) CHAMPUS discount rates.

(6) Hospital outpatient services.
   (i) Outpatient Services Not Subject to Hospital Outpatient Prospective Payment System (OPPS).
      (A) Laboratory services.
      (B) Rehabilitation therapy services.
      (C) Venipuncture.
      (D) Radiology services.
      (E) Diagnostic services.
      (F) Ambulance services.
      (G) Durable medical equipment (DME) and supplies.
      (H) Oxygen and related supplies.
      (I) Drugs administered other than oral method.
      (J) Professional provider services.
      (K) Facility charges.
      (L) Ambulatory surgery services.
   (ii) Outpatient Services Subject to OPPS.
   (iii) Outpatient Services Subject to CAH Reasonable Cost Method.
   (iv) CAH Ambulance Services.

(7) Reimbursement for inpatient services provided by an SCH.

(8) General temporary military contingency payment adjustment for SCHs and CAHs.

(b) Skilled nursing facilities (SNFs).
   (1) Use of Medicare prospective payment system and rates.
   (2) Payment in full.
   (3) Education costs.
   (4) Resident assessment data.

(c) Reimbursement for Other Than Hospitals and SNFs.
(d) Payment of institutional facility costs for ambulatory surgery.
   (1) In general.
   (2) Payment in full.
   (3) Calculation of standard payment rates.
      (i) Step 1: Calculate a median standardized cost for each procedure.
      (ii) Step 2: Grouping procedures.
      (iii) Step 3: Adjustments to groups.
      (iv) Step 4: Standard payment amount per group.
      (v) Step 5: Actual payments.
   (4) Multiple procedures.
   (5) Annual updates.
   (6) Recalculation of rates.

(e) Reimbursement of Birthing Centers.

(f) Reimbursement of Residential Treatment Centers.

(g) Reimbursement of hospice programs.
   (1) National hospice rates.
      (i) Routine home care.
      (ii) Continuous home care.
      (iii) Inpatient respite care.
      (iv) General inpatient care.
      (v) Date of discharge.
   (2) Use of Medicare rates.
   (3) Physician reimbursement.
      (i) Physicians employed by, or contracted with, the hospice.
      (ii) Independent attending physician.
      (iii) Voluntary physician services.
   (4) Unrelated medical treatment.
   (5) Cap amount.
   (6) Inpatient limitation.
   (7) Hospice reporting responsibilities.
   (8) Reconsideration of cap amount and inpatient limit.
   (9) Beneficiary cost-sharing.

(h) Reimbursement of Home Health Agencies (HHAs).
   (1) Split percentage payments.
   (2) Low-utilization payment.
   (3) Partial episode payment (PEP).
   (4) Significant change in condition (SCIC).
   (5) Outlier payment.
   (6) Services paid outside the HHA prospective payment system.
      (i) Durable medical equipment (DME).
      (ii) Osteoporosis drugs.
   (7) Accelerated payments.
      (i) Approval of payment.
      (ii) Amount of payment.
      (iii) Recovery of payment.
   (8) Assessment data.
(9) Administrative review.

(i) Changes in Federal Law affecting Medicare.

(j) Reimbursement of individual health care professionals and other non-institutional, non-professional providers.
   (1) Allowable charge method--
      (i) Introduction--
         (A) In general.
         (B) CHAMPUS Maximum Allowable Charge.
         (C) Limits on balance billing by nonparticipating providers.
         (D) Special rule for TRICARE Prime Enrollees.
         (E) Special rule for certain TRICARE Standard Beneficiaries.
      (ii) Prevailing charge level.
      (iii) Appropriate charge level.
         (A) Step 1: Procedures classified.
         (B) Step 2: Calculating appropriate charge levels.
         (C) Special rule for cases in which the CHAMPUS appropriate charge was prematurely reduced.
         (D) Special rule for cases in which the national CMAC is less than the Medicare rate.
      (iv) Calculating CHAMPUS Maximum Allowable Charge levels for localities.
         (A) In general.
         (B) Special locality-based phase-in provision.
         (C) Special locality-based waivers of reductions to assure adequate access to care.
         (D) Special locality-based exception to applicable CMACs to assure adequate beneficiary access to care.
         (E) Special locality-based exception to applicable CMACs to ensure an adequate TRICARE Prime preferred network.
      (vii) Adjustments and procedural rules.
      (viii) Clinical laboratory services.
   (2) Bonus payments in medically underserved areas.
   (3) All-inclusive rate.
   (4) Alternative method.

(k) Reimbursement of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS).

(l) Reimbursement Under the Military-Civilian Health Services Partnership Program.
   (1) Reimbursement of institutional health care providers.
   (2) Reimbursement of individual health-care professionals and other non-institutional health care providers.

(m) Accommodation of Discounts Under Provider Reimbursement Methods.
   (1) General rule.
   (2) Special applications.
   (3) Procedures.

(n) Outside the United States.
(o) Implementing Instructions.