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**CHANGE 109
6010.57-M
MARCH 31, 2014**

**PUBLICATIONS SYSTEM CHANGE TRANSMITTAL
FOR
TRICARE POLICY MANUAL (TPM), FEBRUARY 2008**

The TRICARE Management Activity has authorized the following addition(s)/revision(s).

CHANGE TITLE: CENTERS FOR MEDICARE AND MEDICAID SERVICES 1500 UPDATE

CONREQ: 16801

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): This change will replace all instances of CMS 1500 (08/2005) with CMS 1500 Claim Form, in the TRICARE manuals.

EFFECTIVE DATE: January 6, 2014.

IMPLEMENTATION DATE: Upon direction of the Contracting Officer.

This change is made in conjunction with Feb 2008 TOM, Change No. 123 and Feb 2008 TRM, Change No. 94.

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**ATTACHMENT(S): 10 PAGE(S)
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WHEN PRESCRIBED ACTION HAS BEEN TAKEN, FILE THIS TRANSMITTAL WITH BASIC DOCUMENT.

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REMOVE PAGE(S)

CHAPTER 7

Section 3.18, pages 1 and 2

CHAPTER 9

Section 15.1, pages 19 through 22

CHAPTER 11

Section 12.1, pages 3 and 4

Addendum E, pages 7 and 8

INSERT PAGE(S)

Section 3.18, pages 1 and 2

Section 15.1, pages 19 through 22

Section 12.1, pages 3 and 4

Addendum E, pages 7 and 8

Applied Behavior Analysis (ABA)

Issue Date: August 10, 2012

Authority: 10 USC 1079(a), and 32 CFR 199.4(c)

1.0 CPT¹ PROCEDURE CODES

90887, 99080

2.0 HCPCS CODE

S5108

3.0 DESCRIPTION

Applied Behavior Analysis (ABA) is covered under the TRICARE Basic Program as an interim benefit.

4.0 POLICY

4.1 TRICARE covers ABA services for all eligible beneficiaries, including retirees and their dependent family members, with a diagnosis of Autism Spectrum Disorder (ASD). ABA reinforcement is covered separately for Active Duty Family Members (ADFM) under the Autism Demonstration and for Non-Active Duty Family Members (NADFM) under the ABA Pilot.

4.2 Autism Spectrum Disorder (ASD)

4.2.1 The covered ASD diagnoses are described under the Neurodevelopmental Disorders category of the most current edition of the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V). The DSM-V was released in May 2013. The DSM-V diagnostic code for ASD (299.00) is equivalent to the corresponding codes for Autistic Disorder (299.0) in the currently used edition of the International Classification of Diseases, Clinical Modification manual (currently ICD-9-CM) used for claims processing under TRICARE for services provided on or before September 30, 2014.

4.2.2 For services provided on or before September 30, 2014, as the Military Health System (MHS) and mental health provider community transitions to use of the DSM-V, a covered diagnosis for ASD also includes those found under the Pervasive Developmental Disorders (PDD) section of the DSM, Fourth Edition, Text Revision, (DSM-IV-TR). The covered DSM-IV-TR ASD diagnoses are: Autistic Disorder (299.00), Rett's Disorder (299.80), Childhood Disintegrative Disorder (CDD) (299.10), Asperger's Disorder (299.80), and Pervasive Development Disorder Not Otherwise

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Applied Behavior Analysis (ABA)

Specified (PDD-NOS) (including Atypical Autism) (299.80). The corresponding ICD-9-CM codes for the five DSM-IV-TR ASD diagnoses are: Autistic Disorder (299.0), Rett's Syndrome (330.8) (found under "Other Specific Cerebral Degenerations"), CDD (299.1), Asperger's Disorder (299.8), and PDD-NOS (to include Atypical Autism) (299.9).

Note: The DSM-IV-TR and the ICD-9-CM use the same numeric diagnosis codes for three of the five ASD Diagnoses found in the DSM-IV-TR (Autistic Disorder (299.00 & 299.0), CDD (299.10 & 299.1), and Asperger's (299.80 & 299.8)). The DSM-IV-TR uses one code 299.80 to refer to Rett's Disorder, PDD, and Asperger's Disorder whereas the ICD-9-CM designates a unique code for each diagnosis.

4.2.3 The DoD and the rest of the United States transition to the ICD-10 on October 1, 2014. For those diagnosed with one of the five ASD diagnoses under the DSM-IV-TR on or before September 30, 2014 and those diagnosed with ASD under the DSM-V; on or after October 1, 2014, the corresponding International Classification of Diseases, Clinical Modification, 10th Revision, (ICD-10-CM) codes become: Autistic Disorder (F84.0), Rett's Syndrome (F84.2) (found under "Other Specific Cerebral Degenerations"), CDD (F84.3), Asperger's Disorder (F84.5), and PDDNOS (to include Atypical Autism) (F84.9).

4.3 Payable services include:

4.3.1 An initial beneficiary assessment;

4.3.2 Development of a treatment plan;

4.3.3 One-on-one ABA interventions with an eligible beneficiary, training of immediate family members to provide services in accordance with the treatment plan; and

4.3.4 Monitoring of the beneficiary's progress toward treatment goals.

4.4 ABA services will be provided only for those beneficiaries with an ASD diagnosis rendered by a TRICARE-authorized Primary Care Provider (PCP) or by a specialized ASD provider defined as:

4.4.1 Physician board-certified or board-eligible in behavioral developmental pediatrics, neurodevelopmental pediatrics, pediatric neurology or child psychiatry; or

4.4.2 Ph.D. or Psy.D. clinical psychologist working primarily with children.

5.0 REIMBURSEMENT

5.1 Claims for ABA services will be submitted by an authorized provider on Centers for Medicare and Medicaid Services (CMS) 1500 **Claim Form** as follows:

5.1.1 Functional Behavioral Assessment and Analysis.

5.1.1.1 The Functional Behavioral Assessment and Analysis and initial treatment plan will be billed using Healthcare Common Procedure Coding System (HCPCS) code S5108, "Home care training to home care client, per 15 minutes".

6.5.5.4 Items that generally serve a routine hygienic purpose, for example soaps and shampoos, and items that generally serve as skin conditioners such as baby lotion, baby oil, skin softeners, powders, and other skin care lotions, are not considered medical supplies unless the particular item is recognized as serving a specific purpose in the physician's prescribed management of the beneficiary's qualifying condition.

6.5.5.5 Limited amounts of medical supplies may be left in the home between visits where repeated applications are required and rendered by the beneficiary or other caregiver. These items must be part of the POC in which the home health staff are actively involved. For example, in the case of a beneficiary who requires a nutritional therapy enteral or parenteral feeding when HHA personnel are not present, it would be appropriate for the agency to leave reasonable quantities of the nutritional therapy product in the beneficiary's home for administration by other caregivers. Items such as needles, syringes, and catheters that require administration by a nurse should not be left in the home between visits.

6.5.6 Durable Equipment. As defined in [32 CFR 199.2](#), durable equipment is a device or apparatus that does not qualify as DME under the Basic Program but which is essential to the efficient arrest or reduction of functional loss resulting from, or the disabling effects of, the beneficiary's qualifying condition as discussed in [Sections 2.2](#) through [2.4](#). Examples of durable equipment are special computer peripheral devices (keyboard, mouse, etc.) or software that makes a computer functional to an ECHO beneficiary with a qualifying condition that would otherwise limit or prohibit the beneficiary's ability to use the computer; or a electrical/mechanical lifting device that raises an ECHO beneficiary in a wheelchair from ground level to first floor level of the beneficiary's residence.

6.5.7 DME. DME, although included in the POC and provided by a HHA, is not part of the EHC benefit; it will be cost-shared only through the TRICARE Basic Program.

6.6 Authorized Providers

6.6.1 All EHC and respite care services will be provided only by TRICARE-authorized HHAs who have in effect at the time of services a valid agreement to participate in the TRICARE program;

6.6.1.1 In order to receive payment for HHC services provided in accordance with this issuance, HHAs must be Medicare or Medicaid certified and meet all applicable Medicare or Medicaid conditions of participation.

6.6.1.2 HHAs for which Medicare or Medicaid certification is not available due to the specialized categories of individuals they serve, for example, individuals that are under the age of 18 or who are receiving maternity care, must meet the qualifying conditions for corporate services provider status as specified in [Chapter 11, Section 12.1](#).

6.6.2 HHAs, whether or not they are Medicare or Medicaid certified, will be responsible for assuring that all individuals rendering EHC services and respite care services meet all applicable qualification standards. The MCSCs are not responsible for certification of individuals employed by or contracted with a HHA.

6.6.3 Reimbursement for all EHC services provided by Medicare or Medicaid certified and non-Medicare or non-Medicaid certified HHAs will be as discussed in [paragraph 6.7](#) and [6.8](#).

6.7 Claims

6.7.1 Billing. HHAs will use itemized billing for EHC services, including those items that will be cost-shared under the TRICARE Basic Program, that are identified on the beneficiary's POC

6.7.2 Primary Agency. When necessary, multiple HHAs may be involved in providing the services indicated in the beneficiary's POC. When such is the case, the MCSC will designate one such agency as the Primary Agency. In addition to being responsible for providing the services in the plan, the primary agency is also responsible for:

6.7.2.1 Negotiating the reimbursement rate with the MCSC having jurisdiction where the beneficiary lives;

6.7.2.2 Arranging for the services to be provided by other HHAs;

6.7.2.3 Insuring the qualifications of the other HHAs;

6.7.2.4 Insuring that services provided by other HHAs are in accordance with the POC; and

6.7.2.5 Reimbursing the other HHAs that provide services.

6.7.3 The MCSCs will deny claims from other than the primary agency for services and items provided as described herein.

6.7.4 The EHC and respite care benefits will not use the "Requests for Anticipated Payment."

6.7.5 All claims for EHC services or items will be submitted only after such services or items are provided.

6.7.6 EHC and respite care services will be coded using the appropriate procedure codes shown in [paragraph 1.0](#).

6.7.7 The EHC and respite care benefits will operate on the platform of existing TRICARE claims processing systems.

6.7.8 Hours of services provided in accordance with the beneficiary's POC will become the unit of reimbursement and tracking in the claims processing systems. The EHC and respite care benefits require that services be recorded in 1 hour increments.

6.7.9 HHAs providing EHC services will submit claims using the CMS 1500 [Claim Form](#), either in paper form or electronic version.

6.7.9.1 Frequency of submitting claims is at the discretion of the MCSC, that is, the HHA may be required by the MCSC to submit claims weekly, monthly, or at such other intervals as the MCSC determines is appropriate.

6.7.9.2 The monthly (or other billing period as specified by the MCSC) claim will indicate the total hours for each type of service, that is, skilled services, skilled therapy services, home health aide services, and medical social services, will be grouped according to the professional level of the

individuals providing such services. The totals will be entered on separate lines of the CMS 1500 Claim Form.

6.7.10 The following, although required to be included in the POC and when provided by the HHA, will be itemized billed separately from the allowed HHC services and will be cost-shared through the TRICARE Basic Program or the ECHO as appropriate. The amount reimbursed for these items do not accrue to the EHC fiscal year benefit cap established under [paragraph 6.8](#).

- Rental or purchase of durable equipment and durable medical equipment;
- FDA-approved injectable drugs for osteoporosis;
- Pneumococcal pneumonia, influenza virus and hepatitis B vaccines;
- Oral cancer drugs and antiemetics;
- Orthotics and prosthetics;
- Ambulance services operated by the HHA;
- Enteral and parenteral supplies and equipment; and
- Other drugs and biologicals administered by other than oral method.

6.8 Reimbursement

Reimbursement for the services described in this issuance will be made on the basis of allowable charges or negotiated rates between the MCSCs and the HHAs.

6.8.1 Benefit cap. Coverage for the EHC benefit is capped on a fiscal year basis.

6.8.2 Basis of the cap. The purpose of the EHC benefit is to assist eligible beneficiaries in remaining at their primary residence rather than being confined to institutional facilities, such as a SNF or other acute care facility. Therefore, TRICARE has determined that the appropriate EHC benefit cap is equivalent to what TRICARE would reimburse if the beneficiary was in a SNF.

6.8.2.1 Annually, the MCSCs will calculate the EHC cap for each beneficiary's area of primary residence as follows:

6.8.2.1.1 Obtain the annual notice, published in the **Federal Register**, of the CMS PPS and Consolidated Billing for SNFs--Update for the upcoming fiscal year. (From time to time the update notice may be known by another name but will contain the same information.)

Note: Although CMS periodically publishes updates to the SNF rates during any given fiscal year, those will not be used to calculate the EHC cap. Only the SNF reimbursement rates in effect on October 1 of each year will be used to calculate the EHC cap for the fiscal year beginning on that date.

6.8.2.1.2 From the "RUG-IV Case-Mix Adjusted Federal Rates for Urban SNFs by Labor and Non-Labor Component", determine the highest cost RUG-IV category;

6.8.2.1.3 Multiply the labor component obtained in [paragraph 6.8.2.1.2](#) by the "FY 2014 Wage Index for Urban Areas Based on CBSA Labor Market Areas" value corresponding to the beneficiary's location;

6.8.2.1.4 Sum the non-labor component from [paragraph 6.8.2.1.2](#) and the adjusted labor component from [paragraph 6.8.2.1.3](#); the result is the beneficiary's EHC per diem in that location;

6.8.2.1.5 Multiply the per diem obtained in [paragraph 6.8.2.1.4](#) by 365 (366 in leap year); the result is the beneficiary's fiscal year cap for EHC in that location.

6.8.2.1.6 For beneficiary's residing in areas not listed in Table A, use "RUG-IV Case-Mix Adjusted Federal Rates for Rural SNFs by Labor and Non-Labor Component" and "FY 2014 Wage Index Based on CBSA Labor Market Areas for Rural Areas" and adjust similarly to [paragraphs 6.8.2.1.3](#) through [6.8.2.1.5](#) to determine the EHC cap for beneficiaries residing in rural areas.

6.8.2.2 Beneficiaries who seek EHC at any time during the fiscal year will have their cap calculated as above and prorated by month for the remaining portion of that fiscal year.

6.8.2.3 The maximum amount reimbursed in any month for EHC services is the amount authorized in accordance with the approved POC and based on the actual number of hours of HHC provided and billed at the allowable charge or the negotiated rate. In no case will the amount reimbursed for any month of EHC exceed one-twelfth (1/12) of the annual fiscal year cap established under [paragraph 6.8.2.1](#) and as adjusted for the actual number of days in the month during which the services were provided.

6.8.2.4 Beneficiaries who move will have their cap recalculated to reflect the wage index for their new location. The maximum amount reimbursed in the remaining months of that fiscal year for EHC services will reflect the re-calculated EHC cap.

6.8.2.5 The cost for EHC services does not accrue to the maximum monthly or fiscal year Government cost-shares indicated in [Section 16.1](#).

6.8.3 The sponsor's cost-share for EHC services will be as indicated in [Section 16.1](#).

7.0 EXCLUSIONS

7.1 Basic program and the ECHO Respite Care benefit (see [Section 12.1](#)).

7.2 EHC services will not be provided outside the beneficiary's primary residence.

7.3 EHC services and EHC respite care services are not available for the purpose of covering primary caregiver(s) absences due to deployment, employment, seeking employment, or to pursue education. Except for those excluded activities, this exclusion does not otherwise restrict or prohibit the primary caregiver(s) from engaging in other activities they choose, including those outside the beneficiary's primary residence.

7.4 EHC services and supplies can be provided only to the eligible beneficiary, that is, such services will not be provided to or on behalf of other members of the beneficiary's family nor other individuals who reside in or are visiting in the beneficiary's primary residence.

7.5 EHC services and supplies are excluded from those who are being provided continuing coverage of HHC as participants of the former Individual Case Management Program for Persons with Extraordinary Conditions (ICMP-PEC) or previous case management demonstrations.

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Chapter 11, Section 12.1

Corporate Services Provider Class

2.2.2.3 The following minimal requirements should be adhered to in the establishment of alternative reimbursement methodologies for in-system/network corporate services providers in order to ensure quality of care and fiscal accountability:

2.2.2.3.1 Alternative reimbursement methodologies may include and/or be a combination of fee schedules, discounts from usual and customary fees or CMAC, flat fee arrangements (negotiated all inclusive rates), capitation arrangements, discounts off of DRGs, per diems; or such other method as is mutually agreed upon, provided such alternative payments do not exceed what would have otherwise been allowed under Standard TRICARE payment methodologies in another setting (e.g., comparable services rendered in a hospital inpatient or outpatient setting).

2.2.2.3.2 Payments in full (e.g., negotiated flat fees, all-inclusive global fees, capitation arrangements, discounts off of DRGs and per diems) are prospective reimbursement systems which may include items related or incidental to the treatment of the patient but for which coverage is not normally extended under TRICARE. These incidental services are to be included in the negotiated prospective payment rate; i.e., they can neither be billed to the beneficiary or deducted from the negotiated global rate.

2.2.3 All billing for Corporate Services Providers should be submitted on a Centers for Medicare and Medicaid Services (CMS) 1500 **Claim Form**. TRICARE Management Activity (TMA) will assign pricing rate codes (e.g., assigning a pricing rate code "GP" for non-institutional per diem rates) to accommodate approved alternative reimbursement systems. The contractor should designate the coding that it wants to use as part of the alternative reimbursement request submitted to the Deputy Director, TMA or designee for review and approval.

2.2.4 The contractor will determine the appropriate procedural category of a qualified organization and may change the category based upon the provider's TRICARE claim characteristics. The category determination is conclusive and may not be appealed.

2.2.5 The corporate entity will not be allowed additional facility charges that are not already incorporated into the professional services fee structure (i.e., facility charges that are not already included in the overhead and malpractice cost indices used in establishing locally-adjusted CMAC rates).

2.2.6 While the expanded provider category will allow coverage of professional services for corporate entities qualifying for provider authorization status under the provisions of this policy, it will at the same time restrict coverage of professional services for those corporate entities which cannot meet the criteria for corporate services provider status under TRICARE.

2.3 Conditions for Coverage/Authorization

2.3.1 Be a corporation or a foundation, but not a professional corporation or professional association;

2.3.2 Be institution-affiliated or freestanding;

2.3.3 Provide services and related supplies of a type rendered by TRICARE individual professional providers employed directly or contractually by a corporation, or diagnostic technical services and related supplies of a type which requires direct patient contact and a technologist

who is licensed by the state in which the procedure is rendered or who is certified by a Qualified Accreditation Organization;

2.3.4 Provide the level of care that does not necessitate that the beneficiary be provided with on-site sleeping accommodations and food in conjunction with the delivery of the services except for sleep disorder diagnostic centers in which on-site sleeping accommodations are an integral part of the diagnostic evaluation process.

2.3.5 Render services for which direct or indirect payment is expected to be made by TRICARE only after obtaining written authorization (i.e., comply with applicable TRICARE authorization requirements before rendering designated services or items for which TRICARE cost-share/copayment may be expected);

2.3.6 Comply with all applicable organizational and individual licensing or certification requirements that exist in the state, county, municipality, or other political jurisdiction in which the corporate entity provides services;

2.3.7 Maintain Medicare approval for payment when the contractor determines that a category, or type, of provider is substantially comparable to a provider or supplier for which Medicare has regulatory conditions of participation or conditions of coverage, or when Medicare approved status is not required, be accredited by a qualified accreditation organization, as defined in [Section 12.2](#); and

2.3.8 Has entered into a negotiated provider contract with a network provider or a participation agreement with a non-network provider which at least complies with the minimum participation agreement requirements set forth in [Section 12.3](#). The participation agreement will accompany the application form (Application for TRICARE-Provider Status: CORPORATE SERVICES PROVIDER) sent out as part of the initial authorization process for non-network providers as described below.

2.4 Application Process

2.4.1 The information collected on the "Application for TRICARE-Provider Status: CORPORATE SERVICES PROVIDERS" (i.e., the information collection form for which the provider is seeking TRICARE authorization status) will be used by the contractor in determining whether the provider meets the criteria for authorization as a corporate services provider under the TRICARE program (refer to [Addendum D](#) for a copy of the corporate services provider application form).

2.4.2 The application will be sent out and information collected when a:

2.4.2.1 Provider requests permission to become a TRICARE provider;

2.4.2.2 Claim is filed for care received from a provider who is not listed on the contractor's provider file; or

2.4.2.3 Formerly TRICARE authorized provider requests reinstatement.

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Chapter 11, Addendum E

Participation Agreement For Substance Use Disorder Rehabilitation Facility (SUDRF)
Services For TRICARE Beneficiaries

(l) Prior to initiation of this agreement, and annually thereafter, conduct a self assessment of its compliance with the **TRICARE/CHAMPUS Standards for Inpatient Rehabilitation and Partial Hospitalization for the Treatment of Substance Use Disorders** as issued by the Deputy Director, TMA, and notify the Deputy Director, TMA of any matter regarding which the facility is not in compliance with such standards.

3.4 QUALITY OF CARE

(a) The SUDRF shall assure that any and all eligible beneficiaries receive substance use treatment that complies with the standards in Article 3.3, above, and the **TRICARE/CHAMPUS Standards for Inpatient Rehabilitation and Partial Hospitalization for the Treatment of Substance Use Disorders**.

(b) The SUDRF shall provide substance use treatment in the same manner to TRICARE beneficiaries as it provides to all patients to whom it renders services.

(c) The SUDRF shall not discriminate against TRICARE beneficiaries in any manner including admission practices or provisions of special or limited treatment.

3.5 BILLING FORM

The SUDRF shall use the Centers for Medicare and Medicaid Services (CMS) 1450 UB-04 billing form (or subsequent editions) for inpatient services, and the CMS 1500 Claim Form for partial hospitalization or outpatient services. The SUDRF shall identify SUDRF care on the billing form in the remarks block by stating "SUDRF care".

3.6 COMPLIANCE WITH TMA UTILIZATION REVIEW ACTIVITIES

Under the terms of this agreement, the SUDRF shall:

(a) Appoint a single individual within the facility to serve as the point of contact for conducting utilization review activities with TMA or its designee. This individual must have a clinical background and be capable of directly responding to questions from professionally qualified reviewers. The SUDRF will inform TMA in writing of the designated individual and notify TMA within seven days of the identity and phone number of any successor individual who take over this position.

(b) Obtain precertification for all inpatient or partial hospitalization services to be rendered to TRICARE beneficiaries within the facility.

(c) Promptly provide medical records and other documentation required in support of the utilization review process upon request by TMA or its designee. Confidentiality considerations are not valid reasons for refusal to submit medical records on any TRICARE beneficiary. Failure to comply with documentation requirements will usually result in the denial of certification of care.

(d) Maintain medical records, including the clinical formulation, progress notes, and master treatment plan, in compliance with TRICARE standards and regulations.

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Chapter 11, Addendum E

Participation Agreement For Substance Use Disorder Rehabilitation Facility (SUDRF)
Services For TRICARE Beneficiaries

3.7 PROFESSIONAL STAFF ORGANIZATION

The SUDRF shall follow a medical model for all services and shall vest ultimate authority for planning, developing, implementing and monitoring all clinical activities in a psychiatrist or licensed doctoral level psychologist. The management of medical care will be vested in a physician. The course of treatment is prescribed and supervised by a qualified mental health professional who meets TRICARE requirements as an individual professional provider as specified in [32 CFR 199.6](#) and who operates within the scope of his or her license.

3.8 PROFESSIONAL STAFF QUALIFICATIONS

The SUDRF shall comply with requirements for professional staff qualifications stated in the **TRICARE/CHAMPUS Standards for Inpatient Rehabilitation and Partial Hospitalization for the Treatment of Substance Use Disorders**, and [32 CFR 199.6](#).

(a) The Chief Executive Officer (CEO) shall possess a master's degree in business administration, nursing, social work, or psychology, or shall meet similar educational requirements as prescribed by the Deputy Director of TMA and shall have five years' administrative experience in the field of mental health.

(b) Professional staff who perform assessments and/or treat patients have a background in chemical dependency and, when applicable, experience in treating adolescents with substance use disorders.

ARTICLE 4

PAYMENT PROVISIONS

4.1 RATE STRUCTURE: DETERMINATION OF RATE

As specified in [32 CFR 199.14\(a\)\(1\)\(ii\)\(F\)](#), effective for admissions on or after July 1, 1995, SUDRFs are subject to the Diagnosis-Related-Group-based (DRG-based) payment system for inpatient rehabilitation services. For partial hospitalization care, SUDRFs are subject to the per-diem payment amounts calculated as specified in [32 CFR 199.14\(a\)\(2\)\(ix\)\(C\)](#).

4.2 INPATIENT SUDRF SERVICES INCLUDED IN DRG PAYMENT

All normally covered inpatient services furnished to TRICARE beneficiaries by hospitals are subject to the TRICARE DRG-based payment system. For inpatient rehabilitation care, professional services are reimbursed separately according to [32 CFR 199.14\(a\)\(4\)](#).

4.3 PARTIAL HOSPITALIZATION SUDRF SERVICES INCLUDED IN PER DIEM PAYMENT

The per diem payment amount must be accepted as payment in full for all institutional services provided, including board, patient assessment, treatment services (with the exception of five psychotherapy sessions per week which may be allowed separately for individual or family