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CIVILIAN HEALTH AND MEDICAL PROGRAM
OF THE UNIFORMED SERVICES (CHAMPUS)

Change 9.

The Assistant Secretary of Defense for Health Affairs has authorized the following page changes to DoD 6010.8-R, "Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)," July 1991 (Reprint).

PAGE CHANGE

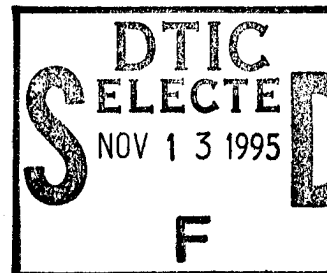
Remove: Pages 4-i through 4-67, 6-i through 6-36, 13-i through 13-37, and 14-i through 14-34

Insert: Attached replacement pages and new pages 4-68 through 4-81, 6-37 through 6-57, 13-38 through 13-44, and 14-35 through 14-38

EFFECTIVE DATES

The above changes are effective on or after:

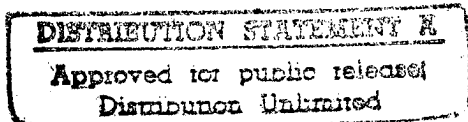
1. Dental Benefit Plan retroactively back to April 1, 1993
2. Authorized Provider and Provider Reimbursement Methods, April 6, 1995
3. Basic Program Benefits, October 1, 1995



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B.C. Whitehead
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Director
Correspondence and Directives

Attachments
237 pages



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WHEN PRESCRIBED ACTION HAS BEEN TAKEN, THIS TRANSMITTAL SHOULD BE FILED WITH THE BASIC DOCUMENT

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CHAPTER 4
BASIC PROGRAM BENEFITS

A. GENERAL

The CHAMPUS Basic Program is essentially a supplemental program to the Uniformed Services direct medical care system. The Basic Program is similar to private medical insurance programs, and is designed to provide financial assistance to CHAMPUS beneficiaries for certain prescribed medical care obtained from civilian sources.

1. Scope of benefits. Subject to all applicable definitions, conditions, limitations, or exclusions specified in this Regulation, the CHAMPUS Basic Program will pay for medically necessary services and supplies required in the diagnosis and treatment of illness or injury, including maternity care and well-baby care. Benefits include specified medical services and supplies provided to eligible beneficiaries from authorized civilian sources such as hospitals, other authorized institutional providers, physicians, other authorized individual professional providers, and professional ambulance service, prescription drugs, authorized medical supplies, and rental or purchase of durable medical equipment.
2. Persons eligible for Basic Program benefits. Persons eligible to receive the Basic Program benefits are set forth in Chapter 3 of this Regulation. Any person determined to be an eligible CHAMPUS beneficiary is eligible for Basic Program benefits.
3. Authority to act for CHAMPUS. The authority to make benefit determinations and authorize the disbursement of funds under CHAMPUS is restricted to the Director, OCHAMPUS; designated OCHAMPUS staff; Director, OCHAMPUSEUR; or CHAMPUS fiscal intermediaries. No other persons or agents (such as physicians, staff members of hospitals, or CHAMPUS health benefits advisors) have such authority.
4. Status of patient controlling for purposes of cost-sharing. Benefits for covered services and supplies described in this chapter will be extended either on an inpatient or outpatient cost-sharing basis in accordance with the status of the patient at the time the covered services and supplies were provided, unless otherwise specifically designated (such as for ambulance service or maternity care). For cost-sharing provisions, refer to section F. of this chapter.
5. Right to information. As a condition precedent to the provision of benefits hereunder, OCHAMPUS or its CHAMPUS fiscal intermediaries shall be entitled to receive information from a physician or hospital or other person, institution, or organization (including a local, state, or U.S. Government agency) providing services or supplies to the beneficiary for which claims or requests for approval for benefits are submitted. Such information and records may relate to the attendance, testing, monitoring, or examination or diagnosis of, or treatment rendered, or services and supplies furnished to a beneficiary, and shall be necessary for the accurate and efficient administration of CHAMPUS benefits. Before a determination will be made on a request for preauthorization or claim of benefits, a beneficiary or sponsor must provide particular additional information relevant to the requested determina-

tion, when necessary. The recipient of such information shall in every case hold such records confidential except when (a) disclosure of such information is authorized specifically by the beneficiary; (b) disclosure is necessary to permit authorized governmental officials to investigate and prosecute criminal actions, or (c) disclosure is authorized or required specifically under the terms of the Privacy Act or Freedom of Information Act (references (i) through (k)) (refer to section M. of chapter 1 of this Regulation). For the purposes of determining the applicability of and implementing the provisions of chapters 8, 11 and 12, or any provision of similar purpose of any other medical benefits coverage or entitlement, OCHAMPUS or CHAMPUS fiscal intermediaries may release, without consent or notice to any beneficiary or sponsor, to any person, organization, government agency, provider, or other entity any information with respect to any beneficiary when such release constitutes a routine use published in the Federal Register in accordance with DoD 5400.11-R (reference (k)). Before a person's claim of benefits will be adjudicated, the person must furnish to CHAMPUS information that reasonably may be expected to be in his or her possession and that is necessary to make the benefit determination. Failure to provide the requested information may result in denial of the claim.

6. Physical examinations. The Director, OCHAMPUS, or a designee, may require a beneficiary to submit to one or more medical (including psychiatric) examinations to determine the beneficiary's entitlement to benefits for which application has been made or for otherwise authorized medically necessary services and supplies required in the diagnosis or treatment of an illness or injury (including maternity and well-baby care). When a medical examination has been requested, CHAMPUS will withhold payment of any pending claims or preauthorization requests on that particular beneficiary. If the beneficiary refuses to agree to the requested medical examination, or unless prevented by a medical reason acceptable to OCHAMPUS, the examination is not performed within 90 days of initial request, all pending claims for services and supplies will be denied. A denial of payments for services or supplies provided before (and related to) the request for a physical examination is not subject to reconsideration. The medical examination and required beneficiary travel related to performing the requested medical examination will be at the expense of CHAMPUS. The medical examination may be performed by a physician in a Uniformed Services medical facility or by an appropriate civilian physician, as determined and selected by the Director, OCHAMPUS, or a designee who is responsible for making such arrangements as are necessary, including necessary travel arrangements.

7. Claims filing deadline. For all services provided on or after January 1, 1993, to be considered for benefits, all claims submitted for benefits, must, except as provided in Chapter 7, of this regulation, be filed with the appropriate CHAMPUS contractor no later than one year after the services are provided. Unless the requirement is waived, failure to file a claim within the deadline waives all rights to benefits for such services or supplies.

8. Double coverage and third party recoveries. CHAMPUS claims involving double coverage or the possibility that the United States can recover all or a part of its expenses from a third party, are specifically subject to the provisions of Chapter 8 or Chapter 12 of this Regulation as appropriate.

9. Nonavailability Statements within a 40-mile catchment area. In some geographic locations (or under certain special circumstances), it is necessary for a CHAMPUS beneficiary to determine whether the required medical care can be provided through a Uniformed Service facility. If the required medical care cannot be provided, the hospital commander, or a designee, will issue a Nonavailability Statement (DD Form 1251). Except for emergencies, a Nonavailability Statement should be issued before medical care is obtained from a civilian source. Failure to secure such a statement may waive the beneficiary's rights to benefits under CHAMPUS.

a. Rules applicable to issuance of Nonavailability Statement (DD Form 1251).

(1) The ASD(HA) is responsible for issuing rules and regulations regarding Nonavailability Statements.

(2) A Nonavailability Statement (NAS) is required for services in connection with nonemergency inpatient hospital care if such services are available at a facility of the Uniformed Services located within a 40-mile radius of the residence of the beneficiary, except that a NAS is not required for services otherwise available at a facility of the Uniformed Services located within a 40-mile radius of the beneficiary's residence when another insurance plan or program provides the beneficiary primary coverage for the services.

(3) An NAS is also required for selected outpatient procedures if such services are not available at a Uniformed Service facility (excluding facilities which are exclusively outpatient clinics) located within a 40-mile radius (catchment area) of the residence of the beneficiary. This does not apply to emergency services or for services for which another insurance plan or program provides the beneficiary primary coverage. Any changes to the selected outpatient procedures will be published in the Federal Register at least 30 days before the effective date of the change by the ASD(HA) and will be limited to the following categories: outpatient surgery and other selected outpatient procedures which have high unit costs and for which care may be available in military treatment facilities generally. The selected outpatient procedures will be uniform for all CHAMPUS beneficiaries.

(4) In addition to NAS requirements set forth in paragraph A.9, of this chapter, additional NAS requirements are established pursuant to paragraph A.10, of this chapter in connection with highly specialized care in national or 200 mile catchment areas of military or civilian Specialized Treatment Services Facilities.

b. Beneficiary responsibility. The beneficiary is responsible for securing information whether or not he or she resides in a geographic area that requires obtaining a Nonavailability Statement. Information concerning current rules and regulations may be obtained from the Offices of the Army, Navy, and Air Force Surgeon Generals; or a CHAMPUS health benefits advisor; or the Director, OCHAMPUS, or a designee; or from the appropriate CHAMPUS fiscal intermediary.

c. Rules in effect at time civilian medical care is provided apply. The applicable rules and regulations regarding Nonavailability Statements in effect at the time the civilian care is rendered apply in determining whether a Nonavailability Statement is required.

d. Nonavailability Statement (DD Form 1251) must be filed with applicable claim. When a claim is submitted for CHAMPUS benefits that includes services for which a Nonavailability Statement was issued, a valid Nonavailability Statement authorization must be on DEERS.

e. Nonavailability Statement (NAS) and claims adjudication.

(1) A NAS is valid for the adjudication of CHAMPUS claims for all related care otherwise authorized by this Regulation which is received from a civilian source while the beneficiary resided within the Uniformed Service facility catchment area which issued the NAS.

(2) A requirement for a NAS for inpatient hospital maternity care must be met for CHAMPUS cost-share of any related outpatient maternity care.

10. Nonavailability Statements in national or 200-mile catchment areas for highly specialized care available in selected military or civilian Specialized Treatment Service Facilities.

a. Specialized Treatment Service Facilities. STS Facilities may be designated for certain high cost, high technology procedures. The purpose of such designations is to concentrate patient referrals for certain highly specialized procedures which are of relatively low incidence and/or relatively high per case cost and which require patient concentration to permit resource investment and enhance the effectiveness of quality assurance efforts.

b. Designation. Selected military treatment facilities and civilian facilities will be designated by the Assistant Secretary of Defense for Health Affairs as STS Facilities for certain procedures. These designations will be based on the highly specialized capabilities of these selected facilities. For each STS designation for which NASs in national or 200-mile catchment areas will be required, there shall be a determination that total government costs associated with providing the service under the Specialized Treatment Services program will in aggregate be less than the total government cost of that service under the normal operation of CHAMPUS. There shall also be a determination that the Specialized Treatment Services Facility meets a standard of excellence in quality comparable to that prevailing in other specialized medical centers in the nation or region that provide the services involved.

c. Organ transplants and similar procedures. For organ transplants and procedures of similar extraordinary specialization, military or civilian STS Facilities may be designated for a nationwide catchment area, covering all 50 states, the District of Columbia and Puerto Rico (or, alternatively, for any portion of such a nationwide area).

d. Other highly specialized procedures. For other highly specialized procedures, military or civilian STS Facilities will be designated for catchment areas of up to approximately 200 miles radius. The exact geographical area covered for each STS Facility will be identified by reference to State and local

governmental jurisdictions, zip code groups or other method to describe an area within an approximate radius of 200 miles from the facility. In paragraph A.10 of this chapter, this catchment area is referred to as a "200-mile catchment area".

e. NAS requirement. For procedures subject to a nationwide catchment area NAS requirement under paragraph A.10.c of this chapter or a 200-mile catchment area NAS requirement under paragraph A.10.d of this chapter CHAMPUS cost sharing is not allowed unless the services are obtained from a designated civilian Specialized Treatment Services program (as authorized) or an NAS has been issued. This rule is subject to the exception set forth in paragraph A.10.f of this chapter. This NAS requirement is a general requirement of the CHAMPUS program.

f. Exceptions. Nationwide catchment area NASs and 200-mile catchment area NASs are not required in any of the following circumstances:

(1) An emergency.

(2) When another insurance plan or program provides the beneficiary primary coverage for the services.

(3) A case-by-case waiver is granted based on a medical judgment made by the commander of the STS Facility (or other person designated for this purpose) that, although the care is available at the facility, it would be medically inappropriate because of a delay in the treatment or other special reason to require that the STS Facility be used; or

(4) A case-by-case waiver is granted by the commander of the STS Facility (or other person designated for this purpose) that, although the care is available at the facility, use of the facility would impose exceptional hardship on the beneficiary or the beneficiary's family.

g. Waiver process. A process shall be established for beneficiaries to request a case-by-case waiver under paragraphs A.10.f.(3)(4) of this chapter. This process shall include:

(1) An opportunity for the beneficiary (and/or the beneficiary's physician) to submit information the beneficiary believes justifies a waiver.

(2) A written decision from a person designated for the purpose on the request for a waiver, including a statement of the reasons for the decision.

(3) An opportunity for the beneficiary to appeal an unfavorable decision to a designated appeal authority not involved in the initial decision; and

(4) A written decision on the appeal, including a statement of the reasons for the decision.

h. Notice. The Assistant Secretary of Defense for Health Affairs will annually publish in the Federal Register a notice of all military and civilian STS Facilities, including a listing of the several procedures subject to nationwide catchment area NASs and the highly specialized procedures subject to 200-mile catchment area NASs.

i. Specialized procedures. Highly specialized procedures that may be established as subject to 200-mile catchment area NASs are limited to:

(1) Medical and surgical diagnoses requiring inpatient hospital treatment of an unusually intensive nature, documented by a DRG-based payment system weight (pursuant to Chapter 14, paragraph A.1) for a single DRG or an aggregated DRG weight for a category of DRGs of at least 2.0 (i.e., treatment is at least two times as intensive as the average CHAMPUS inpatient case).

(2) Diagnostic or therapeutic services, including outpatient services, related to such inpatient categories of treatment.

(3) Other procedures which require highly specialized equipment the cost of which exceeds \$1,000,000 (e.g., lithotripter, positron emission tomography equipment) and such equipment is underutilized in the area; and

(4) Other comparable highly specialized procedures as determined by the Assistant Secretary of Defense for Health Affairs.

j. Quality standards. Any facility designated as a military or civilian STS Facility under paragraph A.10 of this chapter shall be required to meet quality standards established by the Assistant Secretary of Defense for Health Affairs. In the development of such standards, the Assistant Secretary shall consult with relevant medical speciality societies and other appropriate parties. To the extent feasible, quality standards shall be based on nationally recognized standards.

k. NAS procedures. The provisions of paragraphs A.9.b through A.9.e of this chapter regarding procedures applicable to NASs shall apply to expanded catchment area NASs required by paragraph A.10 of this chapter.

l. Travel and lodging expenses. In accordance with guidelines issued by the Assistant Secretary of Defense for Health Affairs, certain travel and lodging expenses associated with services under the Specialized Treatment Services program may be fully or partially reimbursed.

m. Preference for military facility use. In any case in which services subject to an NAS requirement under paragraph A.10 of this chapter are available in both a military STS Facility and from a civilian STS Facility, the military Facility must be used unless use of the civilian Facility is specifically authorized.

11. Quality and Utilization Review Peer Review Organization program. All benefits under the CHAMPUS program are subject to review under the CHAMPUS Quality and Utilization Review Peer Review Organization program pursuant to Chapter 15. Utilization and quality review of mental health services are also part of the Peer Review Organization program, and are addressed in paragraph A.12 of this chapter.)

12. Utilization review, quality assurance and preauthorization for inpatient mental health services.

a. In general. The Director, OCHAMPUS shall provide, either directly or through contract, a program of utilization and quality review for all mental health care services. Among other things, this program shall include mandatory

preadmission authorization before nonemergency inpatient mental health services may be provided and mandatory approval of continuation of inpatient services within 72 hours of emergency admissions. This program shall also include requirements for other pretreatment authorization procedures, concurrent review of continuing inpatient and partial hospitalization care, retrospective review, and other such procedures as determined appropriate by the Director, OCHAMPUS. The provisions of paragraph H of this chapter and paragraph F, Chapter 15, shall apply to this program. The Director, OCHAMPUS, shall establish, pursuant to paragraph F., Chapter 15, procedures substantially comparable to requirements of paragraph H of this chapter and Chapter 15. If the utilization and quality review program for mental health care services is provided by contract, the contractor(s) need not be the same contractor(s) as are engaged under Chapter 15 in connection with the review of other services.

b. Preadmission authorization.

(1) This section generally requires preadmission authorization for all nonemergency inpatient mental health services and prompt continued stay authorization after emergency admissions. It also requires preadmission authorization for all admissions to a partial hospitalization program, without exception, as the concept of an emergency admission does not pertain to a partial hospitalization level of care. Institutional services for which payment would otherwise be authorized, but which were provided without compliance with preadmission authorization requirements, do not qualify for the same payment that would be provided if the preadmission requirements had been met.

(2) In cases of noncompliance with preauthorization requirements, a payment reduction shall be made in accordance with Chapter 15, paragraph B.4.c.

(3) For purposes of paragraph A.12.b.(2) of this chapter, a day of services without the appropriate preauthorization is any day of services provided prior to:

(a) the receipt of an authorization; or

(b) the effective date of an authorization subsequently received.

(4) Services for which payment is disallowed under paragraph A.12.b.(2) of this chapter may not be billed to the patient (or the patient's family).

13. Implementing instructions. The Director, OCHAMPUS, shall issue policies, procedures, instructions, guidelines, standards, and/or criteria to implement this chapter.

B. INSTITUTIONAL BENEFITS

1. General. Services and supplies provided by an institutional provider authorized as set forth in Chapter 6 of this Regulation may be cost-shared only when such services or supplies (i) are otherwise authorized by this Regulation; (ii) are medically necessary; (iii) are ordered, directed, prescribed, or delivered by an

OCHAMPUS-authorized individual professional provider as set forth in Chapter 6 of this Regulation or by an employee of the authorized institutional provider who is otherwise eligible to be a CHAMPUS authorized individual professional provider; (iv) are delivered in accordance with generally accepted norms for clinical practice in the United States; (v) meet established quality standards; and (vi) comply with applicable definitions, conditions, limitations, exceptions, or exclusions as otherwise set forth in this Regulation.

a. Billing practices. To be considered for benefits under this section B., covered services and supplies must be provided and billed for by a hospital or other authorized institutional provider. Such billings must be fully itemized and sufficiently descriptive to permit CHAMPUS to determine whether benefits are authorized by this Regulation. Depending on the individual circumstances, teaching physician services may be considered an institutional benefit in accordance with this Section or a professional benefit under Section C. See paragraph C.3.m. of the Chapter for the CHAMPUS requirements regarding teaching physicians. In the case of continuous care, claims shall be submitted to the appropriate CHAMPUS fiscal intermediary at least every 30 days either by the beneficiary or sponsor or, on a participating basis, directly by the facility on behalf of the beneficiary (refer to Chapter 7).

b. Successive inpatient admissions. Successive inpatient admissions shall be deemed one inpatient confinement for the purpose of computing the active duty dependent's share of the inpatient institutional charges, provided not more than 60 days have elapsed between the successive admissions, except that successive inpatient admissions related to a single maternity episode shall be considered one confinement, regardless of the number of days between admissions. For the purpose of applying benefits, successive admissions will be determined separately for maternity admissions and admissions related to an accidental injury (refer to section F. of this chapter).

c. Related services and supplies. Covered services and supplies must be rendered in connection with and related directly to a covered diagnosis or definitive set of symptoms requiring otherwise authorized medically necessary treatment.

d. Inpatient, appropriate level required. For purposes of inpatient care, the level of institutional care for which Basic Program benefits may be extended must be at the appropriate level required to provide the medically necessary treatment except for patients requiring skilled nursing facility care. For patients for whom skilled nursing facility care is adequate, but is not available in the general locality, benefits may be continued in the higher level care facility. General locality means an area that includes all the skilled nursing facilities within 50 miles of the higher level facility, unless the higher level facility can demonstrate that the skilled nursing facilities are inaccessible to its patients. The decision as to whether a skilled nursing facility is within the higher level facility's general locality, or the skilled nursing facility is inaccessible to the higher level facility's patients shall be a CHAMPUS contractor initial determination for the purposes of appeal under chapter 10 of this regulation. CHAMPUS institutional benefit payments shall be limited to the

allowable cost that would have been incurred in the skilled nursing facility, as determined by the Director, OCHAMPUS, or a designee. If it is determined that the institutional care can be provided reasonably in the home setting, no CHAMPUS institutional benefits are payable.

e. General or special education not covered. Services and supplies related to the provision of either regular or special education generally are not covered. Such exclusion applies whether a separate charge is made for education or whether it is included as a part of an overall combined daily charge of an institution. In the latter instance, that portion of the overall combined daily charge related to education must be determined, based on the allowable costs of the educational component, and deleted from the institution's charges before CHAMPUS benefits can be extended. The only exception is when appropriate education is not available from or not payable by the cognizant public entity. Each case must be referred to the Director, OCHAMPUS, or a designee, for review and a determination of the applicability of CHAMPUS benefits.

2. Covered hospital services and supplies

a. Room and board. Includes special diets, laundry services, and other general housekeeping support services (inpatient only).

b. General staff nursing services.

c. ICU. Includes specialized units, such as for respiratory conditions, cardiac surgery, coronary care, burn care, or neurosurgery (inpatient only).

d. Operating room, recovery room. Operating room and recovery room, including other special treatment rooms and equipment, and hyperbaric chamber.

e. Drugs and medicines. Includes sera, biologicals, and pharmaceutical preparations (including insulin) that are listed in the official formularies of the institution or facility at the time of use. (To be considered as an inpatient supply, drugs and medicines must be consumed during the specific period the beneficiary is a registered inpatient. Drugs and medicines prescribed for use outside the hospital, even though prescribed and obtained while still a registered inpatient, will be considered outpatient supplies and the provisions of section D. of this chapter will apply.)

f. Durable medical equipment, medical supplies, and dressings. Includes durable medical equipment, medical supplies essential to a surgical procedure (such as artificial heart valve and artificial ball and socket joint), sterile trays, casts, and orthopedic hardware. Use of durable medical equipment is restricted to an inpatient basis.

NOTE: If durable medical equipment is to be used on an outpatient basis or continued in outpatient status after use as an inpatient, benefits will be provided as set forth in section D. of this chapter and cost-sharing will be on an outpatient basis (refer to subsection A.4. of this chapter).

g. Diagnostic services. Includes clinical laboratory examinations, x-ray examinations, pathological examinations, and machine tests that produce hard-copy results. Also includes CT scanning under certain limited conditions.

h. Anesthesia. Includes both the anesthetic agent and its administration.

i. Blood. Includes blood, plasma and its derivatives, including equipment and supplies, and its administration.

j. Radiation therapy. Includes radioisotopes.

k. Physical therapy.

l. Oxygen. Includes equipment for its administration.

m. Intravenous injections. Includes solution.

n. Shock therapy.

o. Chemotherapy.

p. Renal and peritoneal dialysis.

q. Psychological evaluation tests. When required by the diagnosis.

r. Other medical services. Includes such other medical services as may be authorized by the Director, OCHAMPUS, or a designee, provided they are related directly to the diagnosis or definitive set of symptoms and rendered by a member of the institution's medical or professional staff (either salaried or contractual) and billed for by the hospital.

3. Covered services and supplies provided by special medical treatment institutions or facilities, other than hospitals or RTCs

a. Room and board. Includes special diets, laundry services, and other general housekeeping support services (inpatient only).

b. General staff nursing services.

c. Drugs and medicines. Includes sera, biologicals, and pharmaceutical preparations (including insulin) that are listed in the official formularies of the institution or facility at the time of use. (To be considered as an inpatient supply, drugs and medicines must be consumed during the specific period the beneficiary is a registered inpatient. Drugs and medicines prescribed for use outside the authorized institutional provider, even though prescribed and obtained while still a registered inpatient, will be considered outpatient supplies and the provisions of section D. of this chapter will apply.)

d. Durable medical equipment, medical supplies, and dressings. Includes durable medical equipment, sterile trays, casts, orthopedic hardware and dressings. Use of durable medical equipment is restricted to an inpatient basis.

NOTE: If the durable medical equipment is to be used on an outpatient basis or continued in outpatient status after use as an inpatient, benefits will be provided as set forth in section D. of this chapter, and cost-sharing will be on an outpatient basis (refer to subsection A.4. of this chapter).

e. Diagnostic services. Includes clinical laboratory examinations, x-ray examinations, pathological examinations, and machine tests that produce hard-copy results.

f. Blood. Includes blood, plasma and its derivatives, including equipment and supplies, and its administration.

g. Physical therapy.

h. Oxygen. Includes equipment for its administration.

i. Intravenous injections. Includes solution.

j. Shock therapy.

k. Chemotherapy.

l. Psychological evaluation tests. When required by the diagnosis.

m. Renal and peritoneal dialysis.

n. Other medical services. Other medical services may be authorized by the Director, OCHAMPUS, or a designee, provided they are related directly to the diagnosis or definitive set of symptoms and rendered by a member of the institution's medical or professional staff (either salaried or contractual) and billed for by the authorized institutional provider of care.

4. Services and supplies provided by RTCs

a. Room and board. Includes use of residential facilities such as food service (including special diets), laundry services, supervised reasonable recreational and social activity services, and other general services as considered appropriate by the Director, OCHAMPUS, or a designee.

b. Patient assessment. Includes the assessment of each child or adolescent accepted by the RTC, including clinical consideration of each of his or her fundamental needs, that is, physical, psychological, chronological age, developmental level, family, educational, social, environmental, and recreational.

c. Diagnostic services. Includes clinical laboratory examinations, x-ray examinations, pathological examinations, and machine tests that produce hard-copy results.

d. Psychological evaluation tests.

e. Treatment of mental disorders. Services and supplies that are medically or psychologically necessary to diagnose and treat the mental disorder for which the patient was admitted to the RTC. Covered services and requirements for qualifications of providers are as listed in paragraph C.3.i. of this chapter.

f. Other necessary medical care. Emergency medical services or other authorized medical care may be rendered by the RTC provided it is professionally capable of rendering such services and meets standards required by the Director, OCHAMPUS. It is intended, however, that CHAMPUS payments to an RTC should primarily cover those services and supplies directly related to the treatment of mental disorders that require residential care.

g. Criteria for determining medical or psychological necessity. In determining the medical or psychological necessity of services and supplies provided by RTCs, the evaluation conducted by the Director, OCHAMPUS (or designee) shall consider the appropriate level of care for the patient, the intensity of services required by the patient, and the availability of that care. In addition to the criteria set forth in this paragraph B.4. of this chapter, additional evaluation standards, consistent with such criteria, may be adopted by the Director, OCHAMPUS (or designee). RTC services and supplies shall not be considered medically or psychologically necessary unless, at a minimum, all the following criteria are clinically determined in the evaluation to be fully met:

(1) Patient has a diagnosable psychiatric disorder.

(2) Patient exhibits patterns of disruptive behavior with evidence of disturbances in family functioning or social relationships and persistent psychological and/or emotional disturbances.

(3) RTC services involve active clinical treatment under an individualized treatment plan that provides for:

(a) Specific level of care, and measurable goals/objectives relevant to each of the problems identified;

(b) Skilled interventions by qualified mental health professionals to assist the patient and/or family;

(c) Time frames for achieving proposed outcomes; and

(d) Evaluation of treatment progress to include timely reviews and updates as appropriate of the patient's treatment plan that reflects alterations in the treatment regimen, the measurable goals/objectives, and the level of care required for each of the patient's problems, and explanations of any failure to achieve the treatment goals/objectives.

(4) Unless therapeutically contraindicated, the family and/or guardian must actively participate in the continuing care of the patient either through direct involvement at the facility or geographically distant family therapy. (In the latter case, the treatment center must document that there has been collaboration with the family and/or guardian in all reviews.)

h. Preauthorization requirement.

(1) All admissions to RTC care are elective and must be certified as medically/psychologically necessary prior to admission. The criteria for preauthorization shall be those set forth in paragraph B.4.g. of this chapter. In applying those criteria in the context of preadmission authorization review, special emphasis is placed on the development of a specific diagnosis/treatment plan, consistent with those criteria and reasonably expected to be effective, for that individual patient.

(2) The timetable for development of the individualized treatment plan shall be as follows:

(a) The plan must be under development at the time of the admission.

(b) A preliminary treatment plan must be established within 24 hours of the admission.

(c) A master treatment plan must be established within ten calendar days of the admission.

(3) The elements of the individualized treatment plan must include:

(a) The diagnostic evaluation that establishes the necessity for the admission;

(b) An assessment regarding the inappropriateness of services at a less intensive level of care;

(c) A comprehensive, biopsychosocial assessment and diagnostic formulation;

(d) A specific individualized treatment plan that integrates measurable goals/objectives and their required level of care for each of the patient's problems that are a focus of treatment;

(e) A specific plan for involvement of family members, unless therapeutically contraindicated; and

(f) A discharge plan, including an objective of referring the patient to further services, if needed, at less intensive levels of care within the benefit limit period.

(4) Preauthorization requests should be made not fewer than two business days prior to the planned admission. In general, the decision regarding preauthorization shall be made within one business day of receipt of a request for preauthorization, and shall be followed with written confirmation. Preauthorizations are valid for the period of time, appropriate to the type of care involved, stated when the preauthorization is issued. In general, preauthorizations are valid for 30 days.

i. Concurrent review. Concurrent review of the necessity for continued stay will be conducted no less frequently than every 30 days. The criteria for concurrent review shall be those set forth in paragraph B.4.g. of this chapter. In applying those criteria in the context of concurrent review, special emphasis is placed on evaluating the progress being made in the active individualized clinical treatment being provided and on developing appropriate discharge plans.

5. Extent of institutional benefits

a. Inpatient room accommodations

(1) Semiprivate. The allowable costs for room and board furnished an individual patient are payable for semiprivate accommodations in a hospital or other authorized institution, subject to appropriate cost-sharing provisions (refer to section F. of this chapter). A semiprivate accommodation is a room containing at least two beds. Therefore, if a room publicly is designated by the institution as a semiprivate accommodation and contains multiple beds, it qualifies as semiprivate for the purpose of CHAMPUS.

(2) Private. A room with one bed that is designated as a private room by the hospital or other authorized institutional provider. The allowable cost of a private room accommodation is covered only under the following conditions:

(a) When its use is required medically and when the attending physician certifies that a private room is necessary medically for the proper care and treatment of a patient; or

(b) When a patient's medical condition requires isolation;
or

(c) When a patient (in need of immediate inpatient care but not requiring a private room) is admitted to a hospital or other authorized institution that has semiprivate accommodations, but at the time of admission, such accommodations are occupied; or

(d) When a patient is admitted to an acute care hospital (general or special) without semiprivate rooms.

(3) Duration of private room stay. The allowable cost of private accommodations is covered under the circumstances described in subparagraph B.5.a.(2) of this chapter until the patient's condition no longer requires the private room for medical reasons or medical isolation; or, in the case

of the patient not requiring a private room, when a semiprivate accommodation becomes available; or, in the case of an acute care hospital (general or special) which does not have semiprivate rooms, for the duration of an otherwise covered inpatient stay.

(4) Hospital (except an acute care hospital, general or special) or other authorized institutional provider without semiprivate accommodations. When a beneficiary is admitted to a hospital (except an acute care hospital, general or special) or other institution that has no semiprivate accommodations, for any inpatient day when the patient qualifies for use of a private room (as set forth in subparagraphs B.5.a.(2)(a) and (b), above), the allowable cost of private accommodations is covered. For any inpatient day in such a hospital or other authorized institution when the patient does not require medically the private room, the allowable cost of semiprivate accommodations is covered, such allowable costs to be determined by the Director, OCHAMPUS, or a designee.

b. General staff nursing services. General staff nursing services cover all nursing care (other than that provided by private duty nurses) including, but not limited to, general duty nursing, emergency room nursing, recovery room nursing, intensive nursing care, and group nursing arrangements. Only nursing services provided by nursing personnel on the payroll of the hospital or other authorized institution are eligible under this section B. If a nurse who is not on the payroll of the hospital or other authorized institution is called in specifically to care for a single patient (individual nursing) or more than one patient (group nursing), whether the patient is billed for the nursing services directly or through the hospital or other institution, such services constitute private duty (special) nursing services and are not eligible for benefits under this paragraph (the provisions of paragraph C.2.o. of this chapter would apply).

c. ICU. An ICU is a special segregated unit of a hospital in which patients are concentrated, by reason of serious illness, usually without regard to diagnosis. Special lifesaving techniques and equipment are available regularly and immediately within the unit, and patients are under continuous observation by a nursing staff specially trained and selected for the care of this type of patient. The unit is maintained on a continuing, rather than an intermittent or temporary, basis. It is not a postoperative recovery room or a postanesthesia room. In some large or highly specialized hospitals, the ICUs may be refined further for special purposes, such as for respiratory conditions, cardiac surgery, coronary care, burn care, or neurosurgery. For purposes of CHAMPUS, these specialized units would be considered ICUs if they otherwise conformed to the definition of an ICU.

d. Treatment rooms. Standard treatment rooms include emergency rooms, operating rooms, recovery rooms, special treatment rooms, and hyperbaric chambers and all related necessary medical staff and equipment. To be recognized for purposes of CHAMPUS, treatment rooms must be so designated and maintained by the hospital or other authorized institution on a continuing basis. A treatment room set up on an intermittent or temporary basis would not be so recognized.

e. Drugs and medicines. Drugs and medicines are included as a supply of a hospital or other authorized institution only under the following conditions:

- (1) They represent a cost to the facility rendering treatment;
- (2) They are furnished to a patient receiving treatment, and are related directly to that treatment; and
- (3) They are ordinarily furnished by the facility for the care and treatment of inpatients.

f. Durable medical equipment, medical supplies, and dressings. Durable medical equipment, medical supplies, and dressings are included as a supply of a hospital or other authorized institution only under the following conditions:

- (1) If ordinarily furnished by the facility for the care and treatment of patients; and
- (2) If specifically related to, and in connection with, the condition for which the patient is being treated; and
- (3) If ordinarily furnished to a patient for use in the hospital or other authorized institution (except in the case of a temporary or disposable item); and
- (4) Use of durable medical equipment is limited to those items provided while the patient is an inpatient. If such equipment is provided for use on an outpatient basis, the provisions of section D. of this chapter apply.

g. Transitional use items. Under certain circumstances, a temporary or disposable item may be provided for use beyond an inpatient stay, when such item is necessary medically to permit or facilitate the patient's departure from the hospital or other authorized institution, or which may be required until such time as the patient can obtain a continuing supply; or it would be unreasonable or impossible from a medical standpoint to discontinue the patient's use of the item at the time of termination of his or her stay as an inpatient.

h. Anesthetics and oxygen. Anesthetics and oxygen and their administration are considered a service or supply if furnished by the hospital or other authorized institution, or by others under arrangements made by the facility under which the billing for such services is made through the facility.

6. Inpatient mental health services. Inpatient mental health services are those services furnished by institutional and professional providers for treatment of a nervous or mental disorder (as defined in Chapter 2) to a

patient admitted to a CHAMPUS-authorized acute care general hospital; a psychiatric hospital; or, unless otherwise exempted, a special institutional provider.

a. Criteria for determining medical or psychological necessity. In determining the medical or psychological necessity of acute inpatient mental health services, the evaluation conducted by the Director, OCHAMPUS (or designee) shall consider the appropriate level of care for the patient, the intensity of services required by the patient, and the availability of that care. The purpose of such acute inpatient care is to stabilize a life-threatening or severely disabling condition within the context of a brief, intensive model of inpatient care in order to permit management of the patient's condition at a less intensive level of care. Such care is appropriate only if the patient requires services of an intensity and nature that are generally recognized as being effectively and safely provided only in an acute inpatient hospital setting. In addition to the criteria set forth in this paragraph B.6. of this chapter, additional evaluation standards, consistent with such criteria, may be adopted by the Director, OCHAMPUS (or designee). Acute inpatient care shall not be considered necessary unless the patient needs to be observed and assessed on a 24-hour basis by skilled nursing staff, and/or requires continued intervention by a multidisciplinary treatment team; and in addition, at least one of the following criteria is determined to be met:

- (1) Patient poses a serious risk of harm to self and/or others.
- (2) Patient is in need of high dosage, intensive medication or somatic and/or psychological treatment, with potentially serious side effects.
- (3) Patient has acute disturbances of mood, behavior, or thinking.

b. Emergency admissions. Admission to an acute inpatient hospital setting may be on an emergency or on a non-emergency basis. In order for an admission to qualify as an emergency, the following criteria, in addition to those in paragraph B.6.a. of this chapter, must be met:

- (1) the patient must be at immediate risk of serious harm to self and or others based on a psychiatric evaluation performed by a physician (or other qualified mental health professional with hospital admission authority); and
- (2) the patient requires immediate continuous skilled observation and treatment at the acute psychiatric level of care.

c. Preauthorization requirements.

(1) All non-emergency admissions to an acute inpatient hospital level of care must be authorized prior to the admission. The criteria for preauthorization shall be those set forth in paragraph B.6.a. of this chapter. In applying those criteria in the context of preauthorization review, special emphasis is placed on the development of a specific individualized treatment plan, consistent with those criteria and reasonably expected to be effective, for that individual patient.

(2) The timetable for development of the individualized treatment plan shall be as follows:

(a) The development of the plan must begin immediately upon admission.

(b) A preliminary treatment plan must be established within 24 hours of the admission.

(c) A master treatment plan must be established within five calendar days of the admission.

(3) The elements of the individualized treatment plan must include:

(a) The diagnostic evaluation that establishes the necessity for the admission;

(b) An assessment regarding the inappropriateness of services at a less intensive level of care;

(c) A comprehensive biopsychosocial assessment and diagnostic formulation;

(d) A specific individualized treatment plan that integrates measurable goals/objectives and their required level of care for each of the patient's problems that are a focus of treatment;

(e) A specific plan for involvement of family members, unless therapeutically contraindicated; and

(f) A discharge plan, including an objective of referring the patient to further services, if needed, at less intensive levels of care within the benefit limit period.

(4) The request for preauthorization must be received by the reviewer designated by the Director, OCHAMPUS prior to the planned admission. In general, the decision regarding preauthorization shall be made within one business day of receipt of a request for preauthorization, and shall be followed with written confirmation. In the case of an authorization issued after an admission resulting from approval of a request made prior to the admission, the effective date of the certification shall be the date of the receipt of the request. However, if the request on which the approved authorization is based was made after the admission (and the case was not an emergency admission), the effective date of the authorization shall be the date of approval.

(5) Authorization prior to admission is not required in the case of a psychiatric emergency requiring an inpatient acute level of care, but authorization for a continuation of services must be obtained promptly. Admissions resulting from a bona fide psychiatric emergency should be reported within 24 hours of the admission or the next business day after the admission, but must be reported to

the Director, OCHAMPUS or a designee, within 72 hours of the admission. In the case of an emergency admission authorization resulting from approval of a request made within 72 hours of the admission, the effective date of the authorization shall be the date of the admission. However, if it is determined that the case was not a bona fide psychiatric emergency admission (but the admission can be authorized as medically or psychologically necessary), the effective date of the authorization shall be the date of the receipt of the request.

d. Concurrent review. Concurrent review of the necessity for continued stay will be conducted. The criteria for concurrent review shall be those set forth in paragraph B.6.a. of this chapter. In applying those criteria in the context of concurrent review, special emphasis is placed on evaluating the progress being made in the active clinical treatment being provided and on developing/refining appropriate discharge plans. In general, the decision regarding concurrent review shall be made within one business day of the review, and shall be followed with written confirmation.

7. Emergency inpatient hospital services. In the case of a medical emergency, benefits can be extended for medically necessary inpatient services and supplies provided to a beneficiary by a hospital, including hospitals that do not meet CHAMPUS standards or comply with the provisions of title VI of the Civil Rights Act (reference (z)), or satisfy other conditions herein set forth. In a medical emergency, medically necessary inpatient services and supplies are those that are necessary to prevent the death or serious impairment of the health of the patient, and that, because of the threat to the life or health of the patient, necessitate, the use of the most accessible hospital available and equipped to furnish such services. The availability of benefits depends upon the following three separate findings and continues only as long as the emergency exists, as determined by medical review. If the case qualified as an emergency at the time of admission to an unauthorized institutional provider and the emergency subsequently is determined no longer to exist, benefits will be extended up through the date of notice to the beneficiary and provider that CHAMPUS benefits no longer are payable in that hospital.

a. Existence of medical emergency. A determination that a medical emergency existed with regard to the patient's condition;

b. Immediate admission required. A determination that the condition causing the medical emergency required immediate admission to a hospital to provide the emergency care; and

c. Closest hospital utilized. A determination that diagnosis or treatment was received at the most accessible (closest) hospital available and equipped to furnish the medically necessary care.

8. RTC day limit.

a. With respect to mental health services provided on or after October 1, 1991, benefits for residential treatment are generally limited to 150 days in a fiscal year or 150 days in an admission (not including days of care prior to October 1, 1991). The RTC benefit limit is separate from the benefit limit for acute inpatient mental health care.

b. Waiver of the RTC day limit.

(1) There is a statutory presumption against the appropriateness of residential treatment services in excess of the 150 day limit. However, the Director, OCHAMPUS, (or designee) may in special cases, after considering the opinion of the peer review designated by the Director (involving a health professional who is not a federal employee) confirming that applicable criteria have been met, waive the RTC benefit limit in paragraph B.8.a. of this chapter and authorize payment for care beyond that limit.

(2) The criteria for waiver shall be those set forth in paragraph B.4.g. of this chapter. In applying those criteria to the context of waiver request reviews, special emphasis is placed on assuring that the record documents that:

(a) Active treatment has taken place for the past 150 days and substantial progress has been made according to the plan of treatment.

(b) The progress made is insufficient, due to the complexity of the illness, for the patient to be discharged to a less intensive level of care.

(c) Specific evidence is presented to explain the factors which interfered with treatment progress during the 150 days of RTC care.

(d) The waiver request includes specific time frames and a specific plan of treatment which will lead to discharge.

(3) Where family or social issues complicate transfer to a lower level of intensity, the RTC is responsible for determining and arranging the supportive and adjunctive resources required to permit appropriate transfer. If the RTC fails adequately to meet this responsibility, the existence of such family or social issues shall be an inadequate basis for a waiver of the benefit limit.

(4) It is the responsibility of the patient's attending clinician to establish, through actual documentation from the medical record and other sources, that the conditions for waiver exist.

c. RTC day limits do not apply to services provided under the Program for the Handicapped (Chapter 5 of this Regulation) or services provided as partial hospitalization care.

9. Acute care day limits.

a. With respect to mental health care services provided on or after October 1, 1991, payment for inpatient acute hospital care is, in general, statutorily limited as follows:

(1) Adults, aged 19 and over - 30 days in a fiscal year or 30 days in an admission (excluding days provided prior to October 1, 1991).

(2) Children and adolescents, aged 18 and under - 45 days in a fiscal year or 45 days in an admission (excluding days provided prior to October 1, 1991).

b. It is the patient's age at the time of admission that determines the number of days available.

c. Waiver of the acute care day limits.

(1) There is a statutory presumption against the appropriateness of inpatient acute services in excess of the day limits set forth in paragraph B.9.a. of this chapter. However, the Director, OCHAMPUS (or designee) may in special cases, after considering the opinion of the peer review designated by the Director (involving a health professional who is not a federal employee) confirming that applicable criteria have been met, waive the acute inpatient limits described in paragraph B.9.a. of this chapter and authorize payment for care beyond those limits.

(2) The criteria for waiver of the acute inpatient limit shall be those set forth in paragraph B.6.a. of this chapter. In applying those criteria in the context of waiver request review, special emphasis is placed on determining whether additional days of acute inpatient mental health care are medically/psychologically necessary to complete necessary elements of the treatment plan prior to implementing appropriate discharge planning. A waiver may also be granted in cases in which a patient exhibits well-documented new symptoms, maladaptive behavior, or medical complications which have appeared in the inpatient setting requiring a significant revision to the treatment plan.

(3) The clinician responsible for the patient's care is responsible for documenting that a waiver criterion has been met and must establish an estimated length of stay beyond the date of the inpatient limit. There must be evidence of a coherent and specific plan for assessment, intervention and reassessment that reasonably can be accomplished within the time frame of the additional days of coverage requested under the waiver provision.

(4) For patients in care at the time the inpatient limit is reached, a waiver must be requested prior to the limit. For patients being readmitted after having received 30 or 45 days in the fiscal year, the waiver review will be conducted at the time of the preadmission authorization.

d. Acute care day limits do not apply to services provided under the Program for the Handicapped (Chapter 5 of this Regulation) or services provided as partial hospitalization care.

10. Psychiatric partial hospitalization services.

a. In general. Partial hospitalization services are those services furnished by a CHAMPUS-authorized partial hospitalization program and authorized mental health providers for the active treatment of a mental disorder. All services must follow a medical model and vest patient care under the general direction of a licensed psychiatrist employed by the partial hospitalization center to ensure medication and physical needs of all the patients are considered. The primary or attending provider must be a CHAMPUS authorized mental health provider, operating within the scope of his/her license. These categories include physicians, clinical psychologists, certified psychiatric nurse specialists, clinical social workers,

marriage and family counselors, pastoral counselors and mental health counselors. Partial hospitalization services are covered as a basic program benefit only if they are provided in accordance with this paragraph B.10. of this chapter.

b. Criteria for determining medical or psychological necessity of psychiatric partial hospitalization services. Psychiatric partial hospitalization services will be considered necessary only if all of the following conditions are present:

(1) The patient is suffering significant impairment from a mental disorder (as defined in Chapter 2) which interferes with age appropriate functioning.

(2) The patient is unable to maintain himself or herself in the community, with appropriate support, at a sufficient level of functioning to permit an adequate course of therapy exclusively on an outpatient basis (but is able, with appropriate support, to maintain a basic level of functioning to permit partial hospitalization services and presents no substantial imminent risk of harm to self or others).

(3) The patient is in need of crisis stabilization, treatment of partially stabilized mental health disorders, or services as a transition from an inpatient program.

(4) The admission into the partial hospitalization program is based on the development of an individualized diagnosis and treatment plan expected to be effective for that patient and permit treatment at a less intensive level.

c. Preauthorization and concurrent review requirements. All preadmission authorization and concurrent review requirements and procedures applicable to acute mental health inpatient hospital care in paragraphs A.12. and B. of this chapter are applicable to the partial hospitalization program, except that the criteria for considering medical or psychological necessity shall be those set forth in paragraph B.10.b. of this chapter, and no emergency admissions will be recognized.

d. Institutional benefits limited to 60 days. Benefits for institutional services for partial hospitalization are limited to 60 treatment days (whether a full day or partial day program) in a fiscal year or in an admission. This limit may be extended by waiver.

e. Waiver of the 60-day partial hospitalization program limit. The Director, OCHAMPUS (or designee) may, in special cases, waive the 60-day partial hospitalization benefit and authorize payment for care beyond the 60-day limit.

(1) The criteria for waiver are set forth in paragraph B.10.b. of this chapter. In applying these criteria in the context of waiver request review, special emphasis is placed on determining whether additional days of partial hospitalization are medically/psychologically necessary to complete essential elements of the treatment plan prior to discharge. Consideration is also given in cases in which a patient exhibits well-documented new symptoms or maladaptive behaviors which have appeared in the partial hospitalization setting requiring significant revisions to the treatment plan.

(2) The clinician responsible for the patient's care is responsible for documenting the need for additional days and must establish an estimated length of stay beyond the date of the 60-day limit. There must be evidence of a coherent and specific plan for assessment, intervention and reassessment that reasonably can be accomplished within the time frame of the additional days of coverage requested under the waiver provisions.

(3) For patients in care at the time the partial hospitalization program limit is reached, a waiver must be requested prior to the limit. For patients being readmitted after having received 60 days in the fiscal year, the waiver review will be conducted at the time of the preadmission authorization.

f. Services and supplies. The following services and supplies are included in the per diem rate approved for an authorized partial hospitalization program:

(1) Board. Includes use of the partial hospital facilities such as food service, supervised therapeutically constructed recreational and social activities, and other general services as considered appropriate by the Director, OCHAMPUS, or a designee.

(2) Patient assessment. Includes the assessment of each individual accepted by the facility, and must, at a minimum, consist of a physical examination; psychiatric examination; psychological assessment; assessment of physiological, biological and cognitive processes; developmental assessment; family history and assessment; social history and assessment; educational or vocational history and assessment; environmental assessment; and recreational/activities assessment. Assessments conducted within 30 days prior to admission to a partial program may be used if approved and deemed adequate to permit treatment planning by the partial hospital program.

(3) Psychological testing.

(4) Treatment services. All services, supplies, equipment and space necessary to fulfill the requirements of each patient's individualized diagnosis and treatment plan (with the exception of the five psychotherapy sessions per week which may be allowed separately for individual or family psychotherapy based upon the provisions of B.10.g. of this chapter.) All mental health services must be provided by a CHAMPUS authorized individual professional provider of mental health services. [Exception: PHPs that employ individuals with master's or doctoral level degrees in a mental health discipline who do not meet the licensure, certification and experience requirements for a qualified mental health provider but are actively working toward licensure or certification, may provide services within the all-inclusive per diem rate but the individual must work under the clinical supervision of a fully qualified mental health provider employed by the PHP.]

g. Social services required. The facility must provide an active social services component which assures the patient appropriate living arrangements after treatment hours, transportation to and from the facility, arrangement of community based support services, referral of suspected child abuse to the appropriate state agencies, and effective after care arrangements, at a minimum.

h. Educational services required. Programs treating children and adolescents must ensure the provision of a state certified educational component which assures that patients do not fall behind in educational placement while receiving partial hospital treatment. CHAMPUS will not fund the cost of educational services separately from the per diem rate. The hours devoted to education do not count toward the therapeutic half or full day program.

i. Family therapy required. The facility must ensure the provision of an active family therapy treatment component which assures that each patient and family participate at least weekly in family therapy provided by the institution and rendered by a CHAMPUS authorized individual professional provider of mental health services. There is no acceptable substitute for family therapy. An exception to this requirement may be granted on a case-by-case basis by the Director, OCHAMPUS, or designee, only if family therapy is clinically contraindicated.

j. Professional mental health benefits limited. Professional mental health benefits are limited to a maximum of one session (60 minutes individual, 90 minutes family) per authorized treatment day not to exceed five sessions in any calendar week. These may be billed separately from the partial hospitalization per diem rate only when rendered by an attending, CHAMPUS-authorized mental health professional who is not an employee of, or under contract with, the partial hospitalization program for purposes of providing clinical patient care.

k. Non-mental health related medical services. Separate billing will be allowed for otherwise covered, non-mental health related medical services.

C. PROFESSIONAL SERVICES BENEFIT

1. General. Benefits may be extended for those covered services described in this section C., that are provided in accordance with good medical practice and established standards of quality by physicians or other authorized individual professional providers, as set forth in Chapter 6 of this Regulation. Such benefits are subject to all applicable definitions, conditions, exceptions, limitations, or exclusion as may be otherwise set forth in this or other chapters of this Regulation. Except as otherwise specifically authorized, to be considered for benefits under this section C., the described services must be rendered by a physician, or prescribed, ordered, and referred medically by a physician to other authorized individual professional providers. Further, except under specifically defined circumstances, there should be an attending physician in any episode of care. (For example, certain services of a clinical psychologist are exempt from this requirement. For these exceptions, refer to Chapter 6.)

a. Billing practices. To be considered for benefits under this section C., covered professional services must be performed personally by the physician or other authorized individual professional provider, who is other than a salaried or contractual staff member of a hospital or other authorized institution, and who ordinarily and customarily bills on a fee-for-service basis for professional services rendered. Such billings must be itemized fully and sufficiently descriptive to permit CHAMPUS to determine

whether benefits are authorized by this Regulation. See paragraph C.3.m. of this Chapter for the requirements regarding the special circumstances for teaching physicians. For continuing professional care, claims should be submitted to the appropriate CHAMPUS fiscal intermediary at least every 30 days either by the beneficiary or sponsor, or directly by the physician or other authorized individual professional provider on behalf of a beneficiary (refer to Chapter 7 of this Regulation).

b. Services must be related. Covered professional services must be rendered in connection with and directly related to a covered diagnosis or definitive set of symptoms requiring medically necessary treatment.

2. Covered services of physicians and other authorized individual professional providers

a. Surgery. Surgery means operative procedures, including related preoperative and postoperative care; reduction of fractures and dislocations; injection and needling procedures of the joints; laser surgery of the eye; and the following procedures:

- Bronchoscopy
- Laryngoscopy
- Thoracoscopy
- Catheterization of the heart
- Arteriograph thoracic lumbar
- Esophagoscopy
- Gastroscope
- Proctoscopy
- Sigmoidoscopy
- Peritoneoscopy
- Cystoscopy
- Colonoscopy
- Upper G.I. panendoscopy
- Encephalograph
- Myelography
- Discography
- Visualization of intracranial aneurysm by intracarotid injection of dye, with exposure of carotid artery, unilateral
- Ventriculography
- Insufflation of uterus and fallopian tubes for determination of tubal patency (Rubin's test of injection of radiopaque medium or for dilation)
- Introduction of opaque media into the cranial arterial system, preliminary to cerebral arteriography, or into vertebral and subclavian systems
- Intraspinal introduction of air preliminary to pneumoencephalography
- Intraspinal introduction of opaque media preliminary to myelography
- Intraventricular introduction of air preliminary to ventriculography

NOTE: The Director, OCHAMPUS, or a designee, shall determine such additional procedures that may fall within the intent of this definition of "surgery."

- b. Surgical assistance.
- c. Inpatient medical services.
- d. Outpatient medical services.
- e. Psychiatric services.
- f. Consultation services.
- g. Anesthesia services.
- h. Radiation therapy services.
- i. X-ray services.
- j. Laboratory and pathological services.
- k. Physical medicine services or physiatry services.
- l. Maternity care.
- m. Well-baby care.
- n. Other medical care. Other medical care includes, but is not limited to, hemodialysis, inhalation therapy, shock therapy, and chemotherapy. The Director, OCHAMPUS, or a designee, shall determine those additional medical services for which benefits may be extended under this paragraph.

NOTE: A separate professional charge for the oral administration of approved antineoplastic drugs is not covered.

- o. Private duty (special) nursing services.
- p. Routine eye examinations. Coverage for routine eye examinations is limited to dependents of active duty members, to one examination per calendar year per person, and to services rendered on or after October 1, 1984.

3. Extent of professional benefits

a. Multiple surgery. In cases of multiple surgical procedures performed during the same operative session, benefits shall be extended as follows:

(1) One hundred (100) percent of the CHAMPUS-determined allowable charge for the major surgical procedure (the procedure for which the greatest amount is payable under the applicable reimbursement method); and

(2) Fifty (50) percent of the CHAMPUS-determined allowable charge for each of the other surgical procedures.

(3) Except that:

(a) If the multiple surgical procedures involve the fingers or toes, benefits for the first surgical procedure shall be at one hundred (100) percent of the CHAMPUS-determined allowable charge; the second procedure at fifty (50) percent; and the third and subsequent procedures at twenty-five (25) percent.

(b) If the multiple surgical procedures include an incidental procedure, no benefits shall be allowed for the incidental procedure.

(c) If the multiple surgical procedures involve specific procedures identified by the Director, OCHAMPUS, benefits shall be limited as set forth in CHAMPUS instructions.

b. Different types of inpatient care, concurrent. If a beneficiary receives inpatient medical care during the same admission in which he or she also receives surgical care or maternity care, the beneficiary shall be entitled to the greater of the CHAMPUS-determined allowable charge for either the inpatient medical care or surgical or maternity care received, as the case may be, but not both; except that the provisions of this paragraph C.3.b. shall not apply if such inpatient medical care is for a diagnosed condition requiring inpatient medical care not related to the condition for which surgical care or maternity care is received, and is received from a physician other than the one rendering the surgical care or maternity care.

NOTE: This provision is not meant to imply that when extra time and special effort are required due to postsurgical or postdelivery complications, the attending physician may not request special consideration for a higher than usual charge.

c. Need for surgical assistance. Surgical assistance is payable only when the complexity of the procedure warrants a surgical assistant (other than the surgical nurse or other such operating room personnel), subject to utilization review. In order for benefits to be extended for surgical assistance service, the primary surgeon may be required to certify in writing to the nonavailability of a qualified intern, resident, or other house physician. When a claim is received for a surgical assistant involving the following circumstances, special review is required to ascertain whether the surgical assistance service meets the medical necessity and other requirements of this section C.

(1) If the surgical assistance occurred in a hospital that has a residency program in a specialty appropriate to the surgery;

(2) If the surgery was performed by a team of surgeons;

(3) If there were multiple surgical assistants; or

(4) If the surgical assistant was a partner of or from the same group of practicing surgeons as the attending surgeon.

d. Aftercare following surgery. Except for those diagnostic procedures classified as surgery in this section C., and injection and needling procedures involving the joints, the benefit payments made for surgery (regardless of the setting in which it is rendered) include normal aftercare, whether the aftercare is billed for by the physician or other authorized individual professional provider on a global, all-inclusive basis, or billed for separately.

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

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

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

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

i. Treatment of mental disorders. CHAMPUS benefits for the treatment of mental disorders are payable for beneficiaries who are outpatients or inpatients of CHAMPUS-authorized general or psychiatric hospitals, RTCs, or specialized treatment facilities, as authorized by the Director, OCHAMPUS, or a designee. All such

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

(1) Covered diagnostic and therapeutic services. Subject to the requirements and limitations stated, CHAMPUS benefits are payable for the following services when rendered in the diagnosis or treatment of a covered mental disorder by a CHAMPUS-authorized, qualified mental health provider practicing within the scope of his or her license. Qualified mental health providers are: psychiatrists or other physicians; clinical psychologists, certified psychiatric nurse specialists or clinical social workers; and certified marriage and family therapists, pastoral, and mental health counselors, under a physician's supervision. No payment will be made for any service listed in this subparagraph C.3.i.(1) rendered by an individual who does not meet the criteria of Chapter 6 of this Regulation for his or her respective profession, regardless of whether the provider is an independent professional provider or an employee of an authorized professional or institutional provider.

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

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

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

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

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

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

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

(h) Collateral visits. Covered collateral visits are those that are medically or psychologically necessary for the treatment of the patient and, as such, are considered as a psychotherapy session for purposes of subparagraph C.3.i.(2) of this chapter.

(2) Limitations and review requirements

(a) Outpatient psychotherapy. Outpatient psychotherapy generally is limited to a maximum of two psychotherapy sessions per week, in any combination of individual, family, conjoint, collateral, or group sessions. Before benefits can be extended for more than two outpatient psychotherapy sessions per week, professional review of the medical or psychological necessity for and appropriateness of the more intensive therapy is required.

(b) Inpatient psychotherapy. Coverage of inpatient psychotherapy is based on the medical or psychological necessity for the services identified in the patient's treatment plan. As a general rule, up to five psychotherapy sessions per week are considered appropriate. Additional sessions per week or more than one type of psychotherapy session performed on the same day (for example, an individual psychotherapy session and a family psychotherapy session on the same day) could be considered for coverage, depending on the medical or psychological necessity for the services. Benefits for inpatient psychotherapy will end automatically when authorization has been granted for the maximum number of inpatient mental health days in accordance with the limits as described in this Chapter 4, unless additional coverage is granted by the Director, OCHAMPUS or a designee.

(3) Covered ancillary therapies. Includes art, music, dance, occupational, and other ancillary therapies, when included by the attending provider in an approved inpatient, residential treatment plan and under the clinical supervision of a licensed doctoral level mental health professional. These ancillary therapies are not separately reimbursed professional services but are included within the institutional reimbursement.

(4) Review of claims for treatment of mental disorder. The Director, OCHAMPUS, shall establish and maintain procedures for review, including professional review, of the services provided for the treatment of mental disorders.

j. Physical and occupational therapy

(1) Physical therapy. To be covered, physical therapy must be related to a covered medical condition. If performed by other than a physician, a physician (or other authorized individual professional provider acting within the scope of their license) shall refer the patient for treatment and supervise the physical therapy. Generally, coverage of outpatient physical therapy is limited to a 60-day period, at up to two physical therapy sessions per week. Physical therapy beyond this length or frequency requires documentation of the medical necessity for the therapy and the anticipated results of the therapy. General exercise programs are not covered, even if recommended by a physician and conducted by qualified personnel. Passive exercises and range of motion exercises are not covered except when prescribed as an integral part of a comprehensive program of physical therapy.

(2) Occupational therapy. To be covered, occupational therapy must be related to a covered medical condition and must be directed to assisting the patient to overcome or compensate for disability resulting from illness, injury, or the effects of treatment of a covered condition. If performed by other than a physician, a physician shall prescribe the treatment and a physician shall supervise the occupational therapy. The occupational therapist providing the therapy shall be an employee of a CHAMPUS-authorized institutional provider and the services must be rendered in connection with CHAMPUS authorized care. Only those occupational therapy services that are rendered as part of an organized inpatient or outpatient rehabilitation program are covered. Occupational therapists are not considered CHAMPUS-authorized providers in their own right and may not submit bills on a fee-for-service basis. The employing institutional provider shall bill for the services of the occupational therapist.

k. Well-baby care. Benefits routinely are payable for well-baby care from birth up to the child's second birthday.

(1) The following services are payable when rendered as a part of a specific well-baby care program and when rendered by the attending pediatrician, family physician, or a pediatric nurse practitioner:

- (a) Newborn examination, PKU tests, and newborn circumcision.
- (b) History, physical examination, discussion, and counseling.
- (c) Vision, hearing, and dental screening.
- (d) Developmental appraisal.
- (e) Immunization (that is, DPT, polio, measles, mumps, and rubella).
- (f) Tuberculin test, hematocrit or Hgb., and urinalysis.

(2) Additional services or visits required because of specific findings or because of the particular circumstance of the individual case are covered if medically necessary and otherwise authorized for benefits under CHAMPUS.

1. Private duty (special) nursing. Benefits are available for the skilled nursing services rendered by a private duty (special) nurse to a beneficiary requiring intensive skilled nursing care that can only be provided with the technical proficiency and scientific skills of an R.N. The specific skilled nursing services being rendered are controlling, not the condition of the patient or the professional status of the private duty (special) nurse rendering the services.

(1) Inpatient private duty (special) nursing services are limited to those rendered to an inpatient in a hospital that does not have an ICU. In addition, under specified circumstances, private duty (special) nursing in the home setting also is covered.

(2) The private duty (special) nursing care must be ordered and certified to be medically necessary by the attending physician.

(3) The skilled nursing care must be rendered by a private duty (special) nurse who is neither a member of the immediate family nor is a member of the beneficiary's household.

(4) Private duty (special) nursing care does not, except incidentally, include providing services that provide or support primarily the essentials of daily living or acting as a companion or sitter.

(5) If the private duty (special) nursing care services being performed are primarily those that could be rendered by the average adult with minimal instruction or supervision, the services would not qualify as covered private duty (special) nursing services, regardless of whether performed by an R.N., regardless of whether or not ordered and certified to by the attending physician, and regardless of the condition of the patient.

(6) In order for such services to be considered for benefits, a private duty (special) nurse is required to maintain detailed daily nursing notes, whether the case involves inpatient nursing service or nursing services rendered in the home setting.

(7) Claims for continuing private duty (special) nursing care shall be submitted at least every 30 days. Each claim will be reviewed and the nursing care evaluated whether it continues to be appropriate and eligible for benefits.

(8) In most situations involving private duty (special) nursing care rendered in the home setting, benefits will be available only for a portion of the care, that is, providing benefits only for that time actually required to perform medically necessary skilled nursing services. If full-time private duty (special) nursing services are engaged, usually for convenience or to provide personal services to the patient, CHAMPUS benefits are payable only for that portion of the day during which skilled nursing services are rendered, but in no event is less than 1 hour of nursing care payable in any 24-hour period during which skilled nursing services are determined to have been rendered. Such situations often are

better accommodated through the use of visiting nurses. This allows the personal services that are not coverable by CHAMPUS to be obtained at lesser cost from other than an R.N. Skilled nursing services provided by visiting nurses are covered under CHAMPUS.

NOTE: When the services of an R.N. are not available, benefits may be extended for the otherwise covered services of a L.P.N. or L.V.N.

m. Physicians in a teaching setting.

(1) Teaching Physicians.

(a) General. The services of teaching physicians may be reimbursed on an allowable charge basis only when the teaching physician has established an attending physician relationship between the teaching physician and the services (e.g., services rendered as a consultant, assistant surgeon, etc.). Attending physician services may include both direct patient care services or direct supervision of care provided by a physician in training. In order to be considered an attending physician, the teaching physician must:

1 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

2 Personally examine the patient; and

3 Confirm or revise the diagnosis and determine the course of treatment to be followed; and

4 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

5 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

6 Be personally responsible for the patient's care, at least throughout the period of hospitalization.

(b) 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.

(c) 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.

(d) 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.

(2) 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:

(a) The physician in training is fully licensed to practice medicine by the state in which the services are performed, and

(b) 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 this section D., which are provided in accordance with good medical practice and established standards of quality by those other authorized providers described in Chapter 6 of this Regulation. 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 this section D., 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 this section D. For example, durable medical equipment and cardiorespiratory monitors can only be ordered by a physician.

2. Billing practices. To be considered for benefits under this Section D., covered services and supplies must be provided and billed for by an authorized provider as set forth in Chapter 6 of this Regulation. 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 Regulation. 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

a. 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 section B. of this chapter. If blood is billed for directly to a beneficiary, benefits may be extended under this section D. in the same manner as a medical supply.

b. Durable medical equipment

(1) Scope of benefit. Subject to the exceptions in paragraphs (2) and (3) below, only durable medical equipment (DME) which is ordered by a physician for the specific use of the beneficiary, and which complies with the definition of "Durable Medical Equipment" in Chapter 2 of this Regulation, and which is not otherwise excluded by this Regulation qualifies as a Basic Program benefit.

(2) Cardiorespiratory monitor exception.

(a) 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:

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

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

3 An infant beneficiary whose birth weight was 1,500 grams or less, or,

4 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,

5 Any beneficiary who has a condition or suspected condition designated in guidelines issued by the Director, OCHAMPUS, or designee, for which the in-home use of the cardiorespiratory monitor otherwise meets Basic Program requirements.

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

1 Trend-event recorder, including technical support necessary for the proper use of the recorder.

2 Analysis of recorded physiological data associated with monitor alarms.

3 Professional visits for services otherwise authorized by this Regulation, and for family training on how to respond to an apparent life-threatening event.

4 Diagnostic testing otherwise authorized by this Regulation.

(3) Basic mobility equipment exception. A wheelchair, or a CHAMPUS-approved alternative, which is medically necessary to provide basic mobility, including reasonable additional cost for medically necessary modifications to accommodate a particular disability, may be cost-shared as durable medical equipment.

(4) Exclusions. DME which is otherwise qualified as a benefit is excluded as a benefit under the following circumstances:

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

(b) DME which is available to the beneficiary from a Uniformed Services Medical Treatment Facility.

(c) DME with deluxe, luxury, or immaterial features which increase the cost of the item to the government relative to similar item without those features.

(5) Basis for reimbursement. The cost of DME may be shared by the CHAMPUS based upon the price which is 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 the Treasury.

c. 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.c., above.

d. 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.

e. Ambulance. Civilian ambulance service to, from, and between hospitals is covered when medically necessary in connection with otherwise covered services and supplies and a covered medical condition. Ambulance service also is covered for transfers to a Uniformed Service Medical Treatment Facility (USMTF). For the purpose of CHAMPUS 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.

(1) Ambulance service is covered for emergency transfers from a beneficiary's place of residence, accident scene, or other location to a USMTF, and for transfer to a USMTF after treatment at, or admission to, a civilian hospital, if ordered by other than a representative of the USMTF.

(2) 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 subparagraph D.3.e.(1), above, transport must be to closest appropriate facility by the least costly means.

(3) 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.

(4) 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.

f. Prescription drugs and medicines. Prescription drugs and medicines that by United States law require a physician's or other authorized individual professional provider's prescription (acting within the scope of their license) and that are ordered or prescribed by a physician or other authorized individual professional provider (except that insulin is covered for a known diabetic, even though a prescription may not be required for its purchase) in connection with an otherwise covered condition or treatment, including Rh immune globulin.

(1) Drugs administered by a physician or other authorized individual professional provider as an integral part of a procedure covered under sections B. or C. of this chapter (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.

(2) 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.

g. Prosthetic devices. The purchase of prosthetic devices is limited to artificial limbs and eyes, except those items that are inserted surgically into the body as an essential and integral part of an otherwise covered surgical procedure are not excluded.

NOTE: In order for CHAMPUS benefits to be extended, any surgical implant must be approved for use in humans by the U.S. Food and Drug Administration. Devices that are approved only for investigational use in humans are not payable.

h. 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, shoe inserts, and other supportive devices for the feet, including special-ordered, custom-made built-up shoes or regular shoes subsequently built up, are not covered.

E. SPECIAL BENEFIT INFORMATION

1. General. There are certain circumstances, conditions, or limitations that impact the extension of benefits and that require special emphasis and explanation. This section E. sets forth those benefits and limitations recognized to be in this category. The benefits and limitations herein described also are subject to all applicable definitions, conditions, limitations, exceptions, and exclusions as set forth in this or other chapters of this Regulation, except as otherwise may be provided specifically in this section E.

2. Abortion. The statute under which CHAMPUS operates prohibits payment for abortions with one single exception--where the life of the woman would be endangered if the fetus were carried to term. Covered abortion services are limited to medical services and supplies only. Physician certification is required attesting that the abortion was performed because the mother's life would have been endangered if the fetus were carried to term. Abortions performed for suspected or confirmed fetal abnormality (e.g., anencephalic) or for mental health reasons (e.g., threatened suicide) do not fall within the exceptions permitted within the language of the statute and are not authorized for payment under CHAMPUS.

NOTE: Covered abortion services are limited to medical services or supplies only for the single circumstance outlined above and do not include abortion counseling or referral fees. Payment is not allowed for any services involving preparation for, or normal followup to, a noncovered abortion. The Director, OCHAMPUS, or a designee, shall issue guidelines describing the policy on abortion.

3. Family planning. The scope of the CHAMPUS family planning benefit is as follows:

a. Birth control (such as contraception)

(1) Benefits provided. Benefits are available for services and supplies related to preventing conception, including the following:

(a) Surgical insertion, removal, or replacement of intrauterine devices.

(b) Measurement for, and purchase of, contraceptive diaphragms (and later remeasurement and replacement).

(c) Prescription oral contraceptives.

(d) Surgical sterilization (either male or female).

(2) Exclusions. The family planning benefit does not include the following:

(a) Prophylactics (condoms).

(b) Spermicidal foams, jellies, and sprays not requiring a prescription.

(c) Services and supplies related to noncoital reproductive technologies, including but not limited to artificial insemination (including any costs related to donors or semen banks), in-vitro fertilization and gamete intrafallopian transfer.

(d) Reversal of a surgical sterilization procedure (male or female).

b. Genetic testing. Genetic testing essentially is preventive rather than related to active medical treatment of an illness or injury. However, under the family planning benefit, genetic testing is covered when performed in certain high risk situations. For the purpose of CHAMPUS, genetic testing includes tests to detect developmental abnormalities as well as purely genetic defects.

(1) Benefits provided. Benefits may be extended for genetic testing performed on a pregnant beneficiary under the following prescribed circumstances. The tests must be appropriate to the specific risk situation and must meet one of the following criteria:

(a) The mother-to-be is 35 years old or older; or

(b) The mother- or father-to-be has had a previous child born with a congenital abnormality; or

(c) Either the mother- or father-to-be has a family history of congenital abnormalities; or

(d) The mother-to-be contracted rubella during the first trimester of the pregnancy; or

(e) Such other specific situations as may be determined by the Director, OCHAMPUS, or a designee, to fall within the intent of this paragraph E.3.b.

(2) Exclusions. It is emphasized that routine or demand genetic testing is not covered. Further, genetic testing does not include the following:

(a) Tests performed to establish paternity of a child.

(b) Tests to determine the sex of an unborn child.

4. Treatment of substance use disorders. Emergency and inpatient hospital care for complications of alcohol and drug abuse or dependency and detoxification are covered as for any other medical condition. Specific coverage for the treatment of substance use disorders includes detoxification, rehabilitation, and outpatient care provided in authorized substance use disorder rehabilitation facilities.

a. Emergency and inpatient hospital services. Emergency and inpatient hospital services are covered when medically necessary for the active medical treatment of the acute phases of substance abuse withdrawal (detoxification), for stabilization, and for treatment of medical complications of substance use disorders. Emergency and inpatient hospital services are considered medically necessary only when the patient's condition is such that the personnel and facilities of a hospital are required. Stays provided for substance use disorder rehabilitation in a hospital-based rehabilitation facility are covered, subject to the provisions of paragraph E.4.b. of this chapter. Inpatient hospital services also are subject to the provisions regarding the limit on inpatient mental health services.

b. Authorized substance use disorder treatment. Only those services provided by CHAMPUS-authorized institutional providers are covered. Such a provider must be either an authorized hospital, or an organized substance use disorder treatment program in an authorized free-standing or hospital-based substance use disorder rehabilitation facility. Covered services consist of any or all of the services listed below. A qualified mental health provider (physicians, clinical psychologists, clinical social workers, psychiatric nurse specialists) (see paragraph C.3.i. of this chapter) shall prescribe the particular level of treatment. Each CHAMPUS beneficiary is entitled to three substance use disorder treatment benefit periods in his or her lifetime, unless this limit is waived pursuant to paragraph E.4.e. of this chapter. (A benefit period begins with the first date of covered treatment and ends 365 days later, regardless of the total services actually used within the benefit period. Unused benefits cannot be carried over to subsequent benefit periods. Emergency and inpatient hospital services (as described in paragraph E.4.a. of this chapter) do not constitute substance abuse treatment for purposes of establishing the beginning of a benefit period.)

(1) Rehabilitative care. Rehabilitative care in an authorized hospital or substance use disorder rehabilitative facility, whether free-standing or hospital-based, is covered on either a residential or partial care (day or night program) basis. Coverage during a single benefit period is limited to no more than one inpatient stay (exclusive of stays classified in DRG 433) in hospitals subject to CHAMPUS DRG-based payment system or 21 days in a DRG-exempt facility for rehabilitation care, unless the limit is waived pursuant to paragraph E.4.e. of this chapter. If the patient is medically in need of chemical detoxification, but does not require the personnel or facilities of a general hospital setting, detoxification services are covered in addition to the rehabilitative care, but in a DRG-exempt facility detoxification services are limited to 7 days, unless the limit is waived pursuant to paragraph E.4.e. of this chapter. The medical necessity for the detoxification must be documented. Any detoxification services provided by the substance use disorder rehabilitation facility must be under general medical supervision.

(2) Outpatient care. Outpatient treatment provided by an approved substance use disorder rehabilitation facility, whether free-standing or hospital-based, is covered for up to 60 visits in a benefit period, unless the limit is waived pursuant to paragraph E.4.e. of this chapter.

(3) Family therapy. Family therapy provided by an approved substance use disorder rehabilitation facility, whether free-standing or hospital-based, is covered for up to 15 visits in a benefit period, unless the limit is waived pursuant to paragraph E.4.e. of this chapter.

c. Exclusions

(1) Aversion therapy. The programmed use of physical measures, such as electric shock, alcohol, or other drugs as negative reinforcement (aversion therapy) is not covered, even if recommended by a physician.

(2) Domiciliary settings. Domiciliary facilities, generally referred to as halfway or quarterway houses, are not authorized providers and charges for services provided by these facilities are not covered.

d. Confidentiality. Release of any patient identifying information, including that required to adjudicate a claim, must comply with the provisions of section 544 of the Public Health Service Act, as amended, (42 U.S.C. 290dd-3), which governs the release of medical and other information from the records of patients undergoing treatment of substance abuse. If the patient refuses to authorize the release of medical records which are, in the opinion of the Director, OCHAMPUS, or a designee, necessary to determine benefits on a claim for treatment of substance abuse the claim will be denied.

e. Waiver of benefit limits. The specific benefit limits set forth in paragraphs E.4.b. of this chapter may be waived by the Director, OCHAMPUS in special cases based on a determination that all of the following criteria are met:

(1) Active treatment has taken place during the period of the benefit limit and substantial progress has been made according to the plan of treatment.

(2) Further progress has been delayed due to the complexity of the illness.

(3) Specific evidence has been presented to explain the factors that interfered with further treatment progress during the period of the benefit limit.

(4) The waiver request includes specific time frames and a specific plan of treatment which will complete the course of treatment.

5. Organ transplants. Basic Program benefits are available for otherwise covered services or supplies in connection with an organ transplant procedure, provided such transplant procedure generally is in accordance with accepted professional medical standards and is not considered to be experimental or investigational.

a. Recipient costs. CHAMPUS benefits are payable for recipient costs when the recipient of the transplant is a beneficiary, whether or not the donor is a beneficiary.

b. Donor costs

- (1) Donor costs are payable when both the donor and recipient are CHAMPUS beneficiaries.
- (2) Donor costs are payable when the donor is a CHAMPUS beneficiary but the recipient is not.
- (3) Donor costs are payable when the donor is the sponsor and the recipient is a beneficiary. (In such an event, donor costs are paid as a part of the beneficiary and recipient costs.)
- (4) Donor costs also are payable when the donor is neither a CHAMPUS beneficiary nor a sponsor, if the recipient is a CHAMPUS beneficiary. (Again, in such an event, donor costs are paid as a part of the beneficiary and recipient costs.)

c. General limitations

- (1) If the donor is not a beneficiary, CHAMPUS benefits for donor costs are limited to those directly related to the transplant procedure itself and do not include any medical care costs related to other treatment of the donor, including complications.
- (2) In most instances, for costs related to kidney transplants, Medicare (not CHAMPUS) benefits will be applicable. If a CHAMPUS beneficiary participates as a kidney donor for a Medicare beneficiary, Medicare will pay for expenses in connection with the kidney transplant to include all reasonable preparatory, operation and postoperation recovery expenses associated with the donation (postoperative recovery expenses are limited to the actual period of recovery). (Refer to paragraph E.3.f. of Chapter 3 of this Regulation.)
- (3) Donor transportation costs are excluded whether or not the donor is a beneficiary.
- (4) When the organ transplant is performed under a study, grant, or research program, no CHAMPUS benefits are payable for either recipient or donor cost.

d. Kidney acquisition. With specific reference to acquisition costs for kidneys, each hospital that performs kidney transplants is required for Medicare purposes to develop for each year separate standard acquisition costs for kidneys obtained from live donors and kidneys obtained from cadavers. The standard acquisition cost for cadaver kidneys is compiled by dividing the total cost of cadaver kidneys acquired by the number of transplants using cadaver kidneys. The standard acquisition cost for kidneys from live donors is compiled similarly using the total acquisition cost of kidneys from live donors and the number of transplants using kidneys from live donors. All recipients of cadaver kidneys are charged the same standard cadaver kidney acquisition cost and all recipients of kidneys from live donors are charged the same standard live donor acquisition cost. The appropriate hospital standard kidney acquisition costs (live donor or cadaver) required for Medicare in every instance must be used as the acquisition cost for purposes of providing CHAMPUS benefits.

e. Liver transplants. Effective July 1, 1983, CHAMPUS benefits are payable for services and supplies related to liver transplantation under the following circumstances only:

(1) Medical indications for liver transplantation. CHAMPUS shall provide benefits for services and supplies related to liver transplantation performed for beneficiaries suffering from irreversible liver injury who have exhausted alternative medical and surgical treatments, who are approaching the terminal phase of their illness, and who are considered appropriate for liver transplantation according to guidelines adopted by the Director, OCHAMPUS.

(2) Contraindications. CHAMPUS shall not provide coverage if any of the following contraindications exist:

(a) Active alcohol or other substance abuse;

(b) Malignancies metastasized to or extending beyond the margins of the liver; or

(c) Viral-induced liver disease when viremia is still present.

(3) Specific covered services. CHAMPUS shall provide coverage for the following services related to liver transplantation:

(a) Medically necessary services to evaluate a potential candidate's suitability for liver transplantation, whether or not the patient is ultimately accepted as a candidate for transplantation;

(b) Medically necessary pre- and post-transplant inpatient hospital and outpatient services;

(c) Surgical services and related pre- and post-operative services of the transplant team;

(d) Services provided by a donor organ acquisition team, including the costs of transportation to the location of the donor organ and transportation of the team and the donated organ to the location of the transplantation center;

(e) Medically necessary services required to maintain the viability of the donor organ following a formal declaration of brain death and after all existing legal requirements for excision of the donor organ have been met;

(f) Blood and blood products;

(g) Services and drugs required for immunosuppression, provided the drugs are approved by the United States Food and Drug Administration;

(h) Services and supplies, including inpatient care, which are medically necessary to treat complications of the transplant procedure, including management of infection and rejection episodes; and

(i) Services and supplies which are medically necessary for the periodic evaluation and assessment of the successfully transplanted patient.

(4) Specific noncovered services. CHAMPUS benefits will not be paid for the following:

(a) Services and supplies for which the beneficiary has no legal obligation to pay. For example, CHAMPUS shall not reimburse expenses that are waived by the transplant center, or for which research funds are available; and

(b) Out-of-hospital living expenses and any other non-medical expenses, including transportation, of the liver transplant candidate or family members, whether pre- or post-transplant.

(5) Implementation guidelines. The Director, OCHAMPUS, shall issue such guidelines as are necessary to implement the provision of this paragraph.

f. Heart Transplantation. CHAMPUS benefits are payable for services and supplies related to heart transplantation under the following circumstances:

(1) Medical indications for heart transplantation. CHAMPUS shall provide benefits for services and supplies related to heart transplantation performed for beneficiaries with end-stage cardiac disease who have exhausted alternative medical and surgical treatments, who have a very poor prognosis as a result of poor cardiac functional status, for whom plans for long-term adherence to a disciplined medical regimen are feasible, and who are considered appropriate for heart transplantation according to guidelines adopted by the Director, OCHAMPUS. However, benefits for heart transplantation are available only if the procedure is performed in a CHAMPUS-approved heart transplantation center or meets other certification or accreditation standards recognized by the Director, OCHAMPUS. See Chapter 6, paragraph B.4.c. of this Regulation.

(2) Specific covered services. CHAMPUS shall provide coverage for the following services related to heart transplantation:

(a) Medically necessary services to evaluate a potential candidate's suitability for heart transplantation, whether or not the patient is ultimately accepted as a candidate for transplantation;

(b) Medically necessary pre- and post-transplant inpatient hospital and outpatient services;

(c) Surgical services and related pre- and post-operative services of the transplant team;

(d) Services provided by the donor acquisition team, including the costs of transportation to the location of the donor organ and transportation of the team and the donated organ to the location of the transplantation center;

(e) Medically necessary services required to maintain the viability of the donor organ following a formal declaration of brain death and after all existing legal requirements for excision of the donor organ have been met;

(f) Blood and blood products;

(g) Services and drugs required for immunosuppression, provided the drugs are approved by the United States Food and Drug Administration;

(h) Services and supplies, including inpatient care, which are medically necessary to treat complications of the transplant procedure, including management of infection and rejection episodes; and

(i) Services and supplies which are medically necessary for the periodic evaluation and assessment of the successfully transplanted patient.

(3) Noncovered services. CHAMPUS benefits will not be paid for the following:

(a) Services and supplies for which the beneficiary has no legal obligation to pay; and

(b) Out-of-hospital living expenses and any other non-medical expenses, including transportation of the heart transplant candidate or family members, whether pre- or post-transplant.

(4) Implementation guidelines. The Director, OCHAMPUS, shall issue such guidelines as are necessary to implement the provisions of this paragraph.

6. Eyeglasses, spectacles, contact lenses, or other optical devices. Eyeglasses, spectacles, contact lenses, or other optical devices are excluded under the Basic Program except under very limited and specific circumstances.

a. Exception to general exclusion. Benefits for glasses and lenses may be extended only in connection with the following specified eye conditions and circumstances:

(1) Eyeglasses or lenses that perform the function of the human lens, lost as the result of intraocular surgery or ocular injury or congenital absence.

NOTE: Notwithstanding the general requirement for U.S. Food and Drug Administration approval of any surgical implant set forth in paragraph D.3.g. of this chapter, intraocular lenses are authorized under CHAMPUS if they are either approved for marketing by the FDA or are subject to an investigational device exemption.

(2) "Pinhole" glasses prescribed for use after surgery for detached retina.

(3) Lenses prescribed as "treatment" instead of surgery for the following conditions:

(a) Contact lenses used for treatment of infantile glaucoma.

(b) Corneal or scleral lenses prescribed in connection with treatment of keratoconus.

(c) Scleral lenses prescribed to retain moisture when normal tearing is not present or is inadequate.

(d) Corneal or scleral lenses prescribed to reduce a corneal irregularity other than astigmatism.

b. Limitations. The specified benefits are limited further to one set of lenses related to one of the qualifying eye conditions set forth in paragraph E.6.a., above. If there is a prescription change requiring a new set of lenses (but still related to the qualifying eye condition), benefits may be extended for a second set of lenses, subject to specific medical review.

7. Transsexualism or such other conditions as gender dysphoria. All services and supplies directly or indirectly related to transsexualism or such other conditions as gender dysphoria are excluded under CHAMPUS. This exclusion includes, but is not limited to, psychotherapy, prescription drugs, and intersex surgery that may be provided in connection with transsexualism or such other conditions as gender dysphoria. There is only one very limited exception to this general exclusion, that is, notwithstanding the definition of congenital anomaly, CHAMPUS benefits may be extended for surgery and related medically necessary services performed to correct sex gender confusion (that is, ambiguous genitalia) which has been documented to be present at birth.

8. Cosmetic, reconstructive, or plastic surgery. For the purposes of CHAMPUS, cosmetic, reconstructive, or plastic surgery is surgery that can be expected primarily to improve physical appearance or that is performed primarily for psychological purposes or that restores form, but does not correct or improve materially a bodily function.

NOTE: If a surgical procedure primarily restores function, whether or not there is also a concomitant improvement in physical appearance, the surgical procedure does not fall within the provisions set forth in this subsection E.8.

a. Limited benefits under CHAMPUS. Benefits under the Basic Program generally are not available for cosmetic, reconstructive, or plastic surgery. However, under certain limited circumstances, benefits for otherwise covered services and supplies may be provided in connection with cosmetic, reconstructive, or plastic surgery as follows:

- (1) Correction of a congenital anomaly; or
- (2) Restoration of body form following an accidental injury; or
- (3) Revision of disfiguring and extensive scars resulting from neoplastic surgery.

(4) Reconstructive breast surgery following a medically necessary mastectomy performed for the treatment of carcinoma, severe fibrocystic disease, other nonmalignant tumors or traumatic injuries.

(5) Penile implants and testicular prostheses for conditions resulting from organic origins (i.e., trauma, radical surgery, disease process, for correction of congenital anomaly, etc.). Also penile implants for organic impotency.

NOTE: Organic impotence is defined as that which can be reasonably expected to occur following certain diseases, surgical procedures, trauma, injury, or congenital malformation. Impotence does not become organic because of psychological or psychiatric reasons.

(6) Generally, benefits are limited to those cosmetic, reconstructive, or plastic surgery procedures performed no later than December 31 of the year following the year in which the related accidental injury or surgical trauma occurred, except for authorized postmastectomy breast reconstruction for which there is no time limitation between mastectomy and reconstruction. Also, special consideration for exception will be given to cases involving children who may require a growth period.

b. General exclusions

(1) For the purposes of CHAMPUS, dental congenital anomalies such as absent tooth buds or malocclusion specifically are excluded. Also excluded are any procedures related to transsexualism or such other conditions as gender dysphoria except as provided in subsection E.7., above.

(2) Cosmetic, reconstructive, or plastic surgery procedures performed primarily for psychological reasons or as a result of the aging process also are excluded.

(3) Procedures performed for elective correction of minor dermatological blemishes and marks or minor anatomical anomalies also are excluded.

(4) In addition, whether or not it would otherwise qualify for benefits under paragraph E.8.a., above, the breast augmentation mammoplasty is specifically excluded.

c. Noncovered surgery, all related services and supplies excluded. When it is determined that a cosmetic, reconstructive, or plastic surgery procedure does not qualify for CHAMPUS benefits, all related services and supplies are excluded, including any institutional costs.

d. Examples of noncovered cosmetic, reconstructive, or plastic surgery procedures. The following is a partial list of cosmetic, reconstructive, or plastic surgery procedures that do not qualify for benefits under CHAMPUS. This list is for example purposes only and is not to be construed as being all-inclusive.

- (1) Any procedure performed for personal reasons to improve the appearance of an obvious feature or part of the body that would be considered by an average observer to be normal and acceptable for the patient's age or ethnic or racial background.
- (2) Cosmetic, reconstructive, or plastic surgical procedures that are justified primarily on the basis of a psychological or psychiatric need.
- (3) Augmentation mammoplasties, except for those performed as a part of postmastectomy breast reconstruction as specifically authorized in subparagraph E.8.a.(4) of this chapter.
- (4) Face lifts and other procedures related to the aging process.
- (5) Reduction mammoplasties (unless there is medical documentation of intractable pain, not amenable to other forms of treatment, resulting from large, pendulous breasts).
- (6) Panniculectomy; body sculpture procedures.
- (7) Repair of sagging eyelids (without demonstrated and medically documented significant impairment of vision).
- (8) Rhinoplasties (without evidence of accidental injury occurring within the previous 6 months that resulted in significant obstruction of breathing).
- (9) Chemical peeling for facial wrinkles.
- (10) Dermabrasion of the face.
- (11) Elective correction of minor dermatological blemishes and marks or minor anatomical anomalies.
- (12) Revision of scars resulting from surgery or a disease process, except disfiguring and extensive scars resulting from neoplastic surgery.
- (13) Removal of tattoos.
- (14) Hair transplants.
- (15) Electrolysis.
- (16) Any procedures related to transsexualism or such other conditions as gender dysphoria except as provided in subsection E.7. of this chapter.
- (17) Penile implant procedure for psychological impotency, transsexualism or such other conditions as gender dysphoria.
- (18) Insertion of prosthetic testicles for transsexualism or such other conditions as gender dysphoria.

9. Complications (unfortunate sequelae) resulting from noncovered initial surgery or treatment. Benefits are available for otherwise covered services and supplies required in the treatment of complications resulting from a noncovered incident of treatment (such as nonadjunctive dental care, transsexual surgery, and cosmetic surgery) but only if the later complication represents a separate medical condition such as a systemic infection, cardiac arrest, and acute drug reaction. Benefits may not be extended for any later care or procedures related to the complication that essentially is similar to the initial noncovered care. Examples of complications similar to the initial episode of care (and thus not covered) would be repair of facial scarring resulting from dermabrasion for acne or repair of a prolapsed vagina in a biological male who had undergone transsexual surgery.

10. Dental. CHAMPUS does not include a dental benefit. Under very limited circumstances, benefits are available for dental services and supplies when the dental services are adjunctive to otherwise covered medical treatment.

a. Adjunctive dental care, limited. Adjunctive dental care is limited to those services and supplies provided under the following conditions:

(1) Dental care which is medically necessary in the treatment of an otherwise covered medical (not dental) condition, is an integral part of the treatment of such medical condition and is essential to the control of the primary medical condition. The following is a list of conditions for which CHAMPUS benefits are payable under this provision:

(a) Intraoral abscesses which extend beyond the dental alveolus.

(b) Extraoral abscesses.

(c) Cellulitis and osteitis which is clearly exacerbating and directly affecting a medical condition currently under treatment.

(d) Removal of teeth and tooth fragments in order to treat and repair facial trauma resulting from an accidental injury.

(e) Myofacial Pain Dysfunction Syndrome.

(f) Total or complete ankyloglossia.

(g) Adjunctive dental and orthodontic support for cleft palate.

(h) The prosthetic replacement of either the maxilla or the mandible due to the reduction of body tissues associated with traumatic injury (e.g., impact, gun shot wound), in addition to services related to treating neoplasms or iatrogenic dental trauma.

NOTE: The test of whether dental trauma is covered is whether the trauma is solely dental trauma. Dental trauma, in order to be covered, must be related to, and an integral part of medical trauma; or a result of medically necessary treatment of an injury or disease.

(2) Dental care required in preparation for medical treatment of a disease or disorder or required as the result of dental trauma caused by the medically necessary treatment of an injury or disease (iatrogenic).

(a) Necessary dental care including prophylaxis and extractions when performed in preparation for or as a result of in-line radiation therapy for oral or facial cancer.

(b) Treatment of gingival hyperplasia, with or without periodontal disease, as a direct result of prolonged therapy with Dilantin (diphenylhydantoin) or related compounds.

(c) Dental care is limited to the above and similar conditions specifically prescribed by the Director, OCHAMPUS, as meeting the requirements for coverage under the provisions of this section.

b. General exclusions.

(1) Dental care which is routine, preventative, restorative, prosthodontic, periodontic or emergency does not qualify as adjunctive dental care for the purposes of CHAMPUS except when performed in preparation for or as a result of dental trauma caused by medically necessary treatment of an injury or disease.

(2) The adding or modifying of bridgework and dentures.

(3) Orthodontia, except when directly related to and an integral part of the medical or surgical correction of a cleft palate or when required in preparation for, or as a result of, trauma to the teeth and supporting structures caused by medically necessary treatment of an injury or disease.

c. Preauthorization required. In order to be covered, adjunctive dental care requires preauthorization from the Director, OCHAMPUS, or a designee, in accordance with subsection A.11. of this chapter. When adjunctive dental care involves a medical (not dental) emergency (such as facial injuries resulting from an accident), the requirement for preauthorization is waived. Such waiver, however, is limited to the essential adjunctive dental care related to the medical condition requiring the immediate emergency treatment. A complete explanation, with supporting medical documentation, must be submitted with claims for emergency adjunctive dental care.

d. Covered oral surgery. Notwithstanding the above limitations on dental care, there are certain oral surgical procedures that are performed by both physicians and dentists, and that are essentially medical rather than dental care. For the purposes of CHAMPUS, the following procedures, whether performed by a physician or dentist, are considered to be in this category and benefits may be extended for otherwise covered services and supplies without preauthorization:

(1) Excision of tumors and cysts of the jaws, cheeks, lips, tongue, and roof and floor of the mouth, when such conditions require a pathological (histological) examination.

(2) Surgical procedures required to correct accidental injuries of the jaws, cheeks, lips, tongue, and roof and floor of the mouth.

(3) Treatment of oral or facial cancer.

(4) Treatment of fractures of facial bones.

(5) External (extra-oral) incision and drainage of cellulitis.

(6) Surgery of accessory sinuses, salivary glands, or ducts.

(7) Reduction of dislocations and the excision of the temporomandibular joints, when surgery is a necessary part of the reduction.

(8) Any oral surgical procedure that falls within the cosmetic, reconstructive, or plastic surgery definition is subject to the limitations and requirements set forth in subsection E.8. of this chapter.

NOTE: Extraction of unerupted or partially erupted, malposed or impacted teeth, with or without the attached follicular or development tissues, is not a covered oral surgery procedure except when the care is indicated in preparation for medical treatment of a disease or disorder or required as a result of dental trauma caused by the necessary medical treatment of an injury or illness. Surgical preparation of the mouth for dentures is not covered by CHAMPUS.

e. Inpatient hospital stay in connection with nonadjunctive, noncovered dental care. Institutional benefits specified in section B. of this chapter may be extended for inpatient hospital stays related to noncovered, nonadjunctive dental care when such inpatient stay is medically necessary to safeguard the life of the patient from the effects of dentistry because of the existence of a specific and serious nondental organic impairment currently under active treatment. (Hemophilia is an example of a condition that could be considered a serious nondental impairment.) Preauthorization by the Director, OCHAMPUS, or a designee, is required for such inpatient stays to be covered in the same manner as required for adjunctive dental care described in paragraph E.10.c. of this chapter. Regardless of whether or not the preauthorization request for the hospital admission is approved and thus qualifies for institutional benefits, the professional service related to the nonadjunctive dental care is not covered.

11. Drug abuse. Under the Basic Program, benefits may be extended for medically necessary prescription drugs required in the treatment of an illness or injury or in connection with maternity care (refer to section D. of this chapter). However, CHAMPUS benefits cannot be authorized to support or maintain an existing or potential drug abuse situation, whether or not the drugs (under other circumstances) are eligible for benefit consideration and whether or not obtained by legal means.

a. Limitations on who can prescribe drugs. CHAMPUS benefits are not available for any drugs prescribed by a member of the beneficiary's family or by a nonfamily member residing in the same household with the beneficiary or sponsor.

b. Drug maintenance programs excluded. Drug maintenance programs when one addictive drug is substituted for another on a maintenance basis (such as methadone substituted for heroin) are not covered. This exclusion applies even in areas outside the United States where addictive drugs are dispensed legally by physicians on a maintenance dosage level.

c. Kinds of prescription drugs that are monitored carefully by CHAMPUS for possible abuse situations.

(1) Narcotics. Examples are Morphine and Demerol.

(2) Nonnarcotic analgesics. Examples are Talwin and Darvon.

(3) Tranquilizers. Examples are Valium, Librium, and Meprobamate.

(4) Barbiturates. Examples are Seconal and Nembutal.

(5) Nonbarbiturate hypnotics. Examples are Doriden and Chloral Hydrate.

(6) Stimulants. Examples are amphetamines.

d. CHAMPUS fiscal intermediary responsibilities. CHAMPUS fiscal intermediaries are responsible for implementing utilization control and quality assurance procedures designed to identify possible drug abuse situations. The CHAMPUS fiscal intermediary is directed to screen all drug claims for potential overutilization and irrational prescribing of drugs, and to subject any such cases to extensive review to establish the necessity for the drugs and their appropriateness on the basis of diagnosis or definitive symptoms.

(1) When a possible drug abuse situation is identified, all claims for drugs for that specific beneficiary or provider will be suspended pending the results of a review.

(2) If the review determines that a drug abuse situation does in fact exist, all drug claims held in suspense will be denied.

(3) If the record indicates previously paid drug benefits, the prior claims for that beneficiary or provider will be reopened and the circumstances involved reviewed to determine whether or not drug abuse also existed at the time the earlier claims were adjudicated. If drug abuse is later ascertained, benefit payments made previously will be considered to have been extended in error and the amounts so paid recouped.

(4) Inpatient stays primarily for the purpose of obtaining drugs and any other services and supplies related to drug abuse also are excluded.

e. Unethical or illegal provider practices related to drugs. Any such investigation into a possible drug abuse that uncovers unethical or illegal drug dispensing practices on the part of an institution, a pharmacy, or physician will be referred to the professional or investigative agency having jurisdiction. CHAMPUS fiscal intermediaries are directed to withhold payment of all CHAMPUS claims for services and supplies rendered by a provider under active investigation for possible unethical or illegal drug dispensing activities.

f. Detoxification. The above monitoring and control of drug abuse situations shall in no way be construed to deny otherwise covered medical services and supplies related to drug detoxification (including newborn, addicted infants) when medical supervision is required.

12. Custodial care. The statute under which CHAMPUS operates specifically excludes custodial care. Many beneficiaries and sponsors misunderstand what is meant by custodial care, assuming that because custodial care is not covered, it implies the custodial care is not necessary. This is not the case; it only means the care being provided is not a type of care for which CHAMPUS benefits can be extended.

a. Kinds of conditions that can result in custodial care. There is no absolute rule that can be applied. With most conditions, there is a period of active treatment before custodial care, some much more prolonged than others. Examples of potential custodial care cases may be a spinal cord injury resulting in extensive paralysis, a severe cerebral vascular accident, multiple sclerosis in its latter stages, or presenile and senile dementia. These conditions do not result necessarily in custodial care but are indicative of the types of conditions that sometimes do. It is not the condition itself that is controlling, but whether the care being rendered falls within the definition of custodial care (refer to Chapter 2 of this Regulation for the definition of "custodial care").

b. Benefits available in connection with a custodial care case. CHAMPUS benefits are not available for services related to a custodial care case, with the following specific exceptions:

(1) Prescription drugs and medicines, medical supplies and durable medical equipment. Benefits are payable for otherwise covered prescription drugs and medicines, medical supplies and durable medical equipment.

(2) Nursing services, limited. Recognizing that even though the care being received is determined primarily to be custodial, an occasional specific skilled nursing service may be required. When it is determined such skilled nursing services are needed, benefits may be extended for 1 hour of nursing care per day.

(3) Physician services, limited. Recognizing that even though the care being received is determined primarily to be custodial, occasional physician monitoring may be required to maintain the patient's condition. When it is determined that a patient is receiving custodial care, benefits may be extended for up to twelve physician visits per calendar year for the custodial condition (not to exceed one per month).

NOTE: CHAMPUS benefits may be extended for additional physician visits related to the treatment of a condition other than the condition for which the patient is receiving custodial care (an example is a broken leg as a result of a fall).

(4) Payment for prescription drugs, medical supplies, durable medical equipment and limited skilled nursing and physician services does not affect custodial care determination. The fact that CHAMPUS extends benefits for prescription drugs, medical supplies, durable medical equipment, and limited skilled nursing and physician services in no way affects the custodial care determination if the case otherwise falls within the definition of custodial care.

c. Exception to custodial care exclusion, admission to a hospital. CHAMPUS benefits may be extended for otherwise covered services or supplies directly related to a medically necessary admission to an acute care general or special hospital (as defined in paragraph B.4.a., Chapter 6, of this Regulation), if the care is at the appropriate level and meets other requirements of this Regulation.

d. Reasonable care for which benefits were authorized or reimbursed before June 1, 1977. It is recognized that care for which benefits were authorized or reimbursed before the implementation date of the Regulation may be excluded under the custodial care limitations set forth in this Regulation. Therefore, an exception to the custodial care limitations set forth in this Regulation exists whereby reasonable care for which benefits authorized or reimbursed under the Basic Program before June 1, 1977, shall continue to be authorized even though the care would be excluded as a benefit under the custodial care limitations of the Regulation. Continuation of CHAMPUS benefits in such cases is limited as follows:

(1) Initial authorization or reimbursement before June 1, 1977.

The initial CHAMPUS authorization or reimbursement for the care occurred before June 1, 1977; and,

(2) Continued care. The care has been continuous since the initial CHAMPUS authorization or reimbursement; and,

(3) Reasonable care. The care is reasonable. CHAMPUS benefits shall be continued for reasonable care up to the same level of benefits and for the same period of eligibility authorized or reimbursed before June 1, 1977. Care that is excessive or otherwise unreasonable will be reduced or eliminated from the continued care authorized under this exception.

13. Domiciliary care. The statute under which CHAMPUS operates also specifically excludes domiciliary care (refer to Chapter 2 of this Regulation for the definition of "Domiciliary Care").

a. Examples of domiciliary care situations. The following are examples of domiciliary care for which CHAMPUS benefits are not payable.

(1) Home care is not available. Institutionalization primarily because parents work, or extension of a hospital stay beyond what is medically necessary because the patient lives alone, are examples of domiciliary care provided because there is no other family member or other person available in the home.

(2) Home care is not suitable. Institutionalization of a child because a parent (or parents) is an alcoholic who is not responsible enough to care for the child, or because someone in the home has a contagious disease, are examples of domiciliary care being provided because the home setting is unsuitable.

(3) Family unwilling to care for a person in the home. A child who is difficult to manage may be placed in an institution, not because institutional care is medically necessary, but because the family does not want to handle him or her in the home. Such institutionalization would represent domiciliary care, that is, the family being unwilling to assume responsibility for the child.

b. Benefits available in connection with a domiciliary care case. Should the beneficiary receive otherwise covered medical services or supplies while also being in a domiciliary care situation, CHAMPUS benefits are payable for those medical services or supplies, or both, in the same manner as though the beneficiary resided in his or her own home. Such benefits would be cost-shared as though rendered to an outpatient.

c. General exclusion. Domiciliary care is institutionalization essentially to provide a substitute home--not because it is medically necessary for the beneficiary to be in the institution (although there may be conditions present that have contributed to the fact that domiciliary care is being rendered). CHAMPUS benefits are not payable for any costs or charges related to the provision of domiciliary care. While a substitute home or assistance may be necessary for the beneficiary, domiciliary care does not represent the kind of care for which CHAMPUS benefits can be provided.

14. CT scanning

a. Approved CT scan services. Benefits may be extended for medically necessary CT scans of the head or other anatomical regions of the body when all of the following conditions are met:

(1) The patient is referred for the diagnostic procedure by a physician.

(2) The CT scan procedure is consistent with the preliminary diagnosis or symptoms.

(3) Other noninvasive and less costly means of diagnosis have been attempted or are not appropriate.

(4) The CT scan equipment is licensed or registered by the appropriate state agency responsible for licensing or registering medical equipment that emits ionizing radiation.

(5) The CT scan equipment is operated under the general supervision and direction of a physician.

(6) The results of the CT scan diagnostic procedure are interpreted by a physician.

b. Review guidelines and criteria. The Director, OCHAMPUS, or a designee, will issue specific guidelines and criteria for CHAMPUS coverage of medically necessary head and body part CT scans.

15. Morbid obesity. The CHAMPUS morbid obesity benefit is limited to the gastric bypass, gastric stapling, or gastroplasty method.

a. Conditions for coverage. Payment may be extended for the gastric bypass, gastric stapling, or gastroplasty method only when one of the following conditions is met:

(1) The patient is 100 pounds over the ideal weight for height and bone structure and has an associated severe medical condition. These associated medical conditions are diabetes mellitus, hypertension, cholecystitis, narcolepsy, pickwickian syndrome (and other severe respiratory diseases), hypothalamic disorders, and severe arthritis of the weight-bearing joints.

(2) The patient is 200 percent or more of the ideal weight for height and bone structure. An associated medical condition is not required for this category.

(3) The patient has had an intestinal bypass or other surgery for obesity and, because of complications, requires a second surgery (a takedown). The surgeon in many cases, will do a gastric bypass, gastric stapling, or gastroplasty to help the patient avoid regaining the weight that was lost. In this situation, payment is authorized even though the patient's condition technically may not meet the definition of morbid obesity because of the weight that was already lost following the initial surgery.

b. Exclusions

(1) CHAMPUS payment may not be made for nonsurgical treatment of obesity or morbid obesity, for dietary control, or weight reduction.

(2) CHAMPUS payment may not be made for surgical procedures other than the gastric bypass, gastric stapling, or gastroplasty, even if morbid obesity is present.

16. Maternity care.

a. Benefit. The CHAMPUS Basic Program may share the cost of medically necessary services and supplies associated with maternity care which are not otherwise excluded by this Regulation. However, failure by a beneficiary to secure a required Nonavailability Statement (NAS) (DD Form 1251) as set forth in subsection A. 9. of this Chapter will waive that beneficiary's right to CHAMPUS cost-share of certain maternity care services and supplies.

b. Cost-share. Subject to applicable NAS requirements, maternity care cost-share shall be determined as follows:

(1) Inpatient cost-share formula applies to maternity care ending in childbirth in, or on the way to, a hospital inpatient childbirth unit, and for maternity care ending in a non-birth outcome not otherwise excluded by this Regulation.

(2) Ambulatory surgery cost-share formula applies to maternity care ending in childbirth in, or on the way to, a birthing center to which the beneficiary is admitted and from which the beneficiary has received prenatal care, or a hospital-based outpatient birthing room.

(3) Outpatient cost-share formula applies to maternity care which terminates in a planned childbirth at home.

(4) Otherwise covered medical services and supplies directly related to "Complications of Pregnancy," as defined in Chapter 2 will be cost-shared on the same basis as the related maternity care for a period not to exceed 42 days following termination of the pregnancy and thereafter cost-shared on the basis of the inpatient or outpatient status of the beneficiary when medically necessary services and supplies are received.

17. Biofeedback Therapy. Biofeedback therapy is a technique by which a person is taught to exercise control over a physiologic process occurring within the body. By using modern biomedical instruments the patient learns how a specific physiologic system within his body operates and how to modify the performance of this particular system.

a. Benefits provided. CHAMPUS benefits are payable for services and supplies in connection with electrothermal, electromyograph and electrodermal biofeedback therapy when there is documentation that the patient has undergone an appropriate medical evaluation, that their present condition is not responding to or no longer responds to other forms of conventional treatment, and only when provided as treatment for the following conditions:

(1) Adjunctive treatment for Raynaud's Syndrome.

(2) Adjunctive treatment for muscle re-education of specific muscle groups or for treating pathological muscle abnormalities of spasticity, or incapacitating muscle spasm or weakness.

b. Limitations. Payable benefits include initial intake evaluation. Treatment following the initial intake evaluation is limited to a maximum of 20 inpatient and outpatient biofeedback treatments per calendar year.

c. Exclusions. Benefits are excluded for biofeedback therapy for the treatment of ordinary muscle tension states or for psychosomatic conditions. Benefits are also excluded for the rental or purchase of biofeedback equipment.

d. Provider requirements. A provider of biofeedback therapy must be a CHAMPUS-authorized provider. (Refer to CHAPTER 6, "Authorized Providers.") If biofeedback treatment is provided by other than a physician, the patient must be referred by a physician.

e. Implementation Guidelines. The Director, OCHAMPUS, shall issue guidelines as are necessary to implement the provisions of this paragraph.

18. Cardiac Rehabilitation. Cardiac rehabilitation is the process by which individuals are restored to their optimal physical, medical and psychological status, after a cardiac event. Cardiac rehabilitation is often divided into three phases. Phase I begins during inpatient hospitalization and is managed by the patient's personal physician. Phase II is a medically supervised outpatient program which begins following discharge. Phase III is a lifetime maintenance program emphasizing continuation of physical fitness with periodic followup. Each phase includes an exercise component, patient education, and risk factor modification. There may be considerable variation in program components, intensity and duration.

a. Benefits Provided. CHAMPUS benefits are available on an inpatient or outpatient basis for services and supplies provided in connection with a cardiac rehabilitation program when ordered by a physician and provided as treatment for patients who have experienced the following cardiac events within the preceding twelve (12) months:

- (1) Myocardial Infarction.
- (2) Coronary Artery Bypass Graft.
- (3) Coronary Angioplasty.
- (4) Percutaneous Transluminal Coronary Angioplasty.
- (5) Chronic Stable Angina (see limitations below).

b. Limitations. Payable benefits include separate allowance for the initial evaluation and testing. Outpatient treatment following the initial intake evaluation and testing is limited to a maximum of thirty-six (36) sessions per cardiac event, usually provided 3 sessions per week for twelve weeks. Patient's diagnosed with chronic stable angina are limited to one treatment episode (36 sessions) in a calendar year.

c. Exclusions. Phase III cardiac rehabilitation lifetime maintenance programs performed at home or in medically unsupervised settings are not covered.

d. Providers. A provider of cardiac rehabilitation services must be a CHAMPUS authorized hospital. (Refer to Chapter 6, "Authorized Providers.") All cardiac rehabilitation services must be ordered by a physician.

e. Payment. Payment for outpatient treatment will be based on an all inclusive allowable charge per session. Inpatient treatment will be paid based upon the reimbursement system in place for the hospital where the services are rendered.

f. Implementation Guidelines: The Director of OCHAMPUS shall issue guidelines as are necessary to implement the provisions of this paragraph.

19. Hospice care. Hospice care is a program which provides an integrated set of services and supplies designed to care for the terminally ill. This type of care emphasizes palliative care and supportive services, such as pain control and home care, rather than cure-oriented services provided in institutions that are otherwise the primary focus under CHAMPUS. The benefit provides coverage for a humane and sensible approach to care during the last days of life for some terminally ill patients.

a. Benefit coverage. CHAMPUS beneficiaries who are terminally ill (that is, a life expectancy of six months or less if the disease runs its normal course) will be eligible for the following services and supplies in lieu of most other CHAMPUS benefits:

(1) Physician services.

(2) Nursing care provided by or under the supervision of a registered professional nurse.

(3) Medical social services provided by a social worker who has at least a bachelor's degree from a school accredited or approved by the Council on Social Work Education, and who is working under the direction of a physician. Medical social services include, but are not limited to the following:

(a) Assessment of social and emotional factors related to the beneficiary's illness, need for care, response to treatment, and adjustment to care.

(b) Assessment of the relationship of the beneficiary's medical and nursing requirements to the individual's home situation, financial resources, and availability of community resources.

(c) Appropriate action to obtain available community resources to assist in resolving the beneficiary's problem.

(d) Counseling services that are required by the beneficiary.

(4) Counseling services provided to the terminally ill individual and the family member or other persons caring for the individual at home. Counseling, including dietary counseling, may be provided both for the purpose of training the individual's family or other care-giver to provide care, and for the purpose of helping the individual and those caring for him or her to adjust to the individual's approaching death. Bereavement counseling, which consists of counseling services provided to the individual's family after the individual's death, is a required hospice service but it is not reimbursable.

(5) Home health aide services furnished by qualified aides and homemaker services. Home health aides may provide personal care services. Aides also may perform household services to maintain a safe and sanitary environment in areas of the home used by the patient. Examples of such services are changing the bed or light cleaning and laundering essential to the comfort and cleanliness of the patient. Aide services must be provided under the general supervision of a registered nurse. Homemaker services may include assistance in personal care, maintenance of a safe and healthy environment, and services to enable the individual to carry out the plan of care. Qualifications for home health aides can be found in 42 C.F.R. section 484.36.

(6) Medical appliances and supplies, including drugs and biologicals. Only drugs that are used primarily for the relief of pain and symptom control related to the individual's terminal illness are covered. Appliances may include covered durable medical equipment, as well as other self-help and personal comfort items related to the palliation or management of the patient's condition while he or she is under hospice care. Equipment is provided by the hospice for use in the beneficiary's home while he or she is under hospice care. Medical supplies include those that are part of the written plan of care. Medical appliances and supplies are included within the hospice all-inclusive rates.

(7) Physical therapy, occupational therapy and speech-language pathology services provided for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills.

(8) Short-term inpatient care provided in a Medicare participating hospice inpatient unit, or a Medicare participating hospital, skilled nursing facility (SNF) or, in the case of respite care, a Medicaid-certified nursing facility that additionally meets the special hospice standards regarding staffing and patient areas. Services provided in an inpatient setting must conform to the written plan of care. Inpatient care may be required for procedures necessary for pain control or acute or chronic symptom management. Inpatient care may also be furnished to provide respite for the individual's family or other persons caring for the individual at home. Respite care is the only type of inpatient care that may be provided in a Medicaid-certified nursing facility. The limitations on custodial care and personal comfort items applicable to other CHAMPUS services are not applicable to hospice care.

b. Core services. The hospice must ensure that substantially all core services are routinely provided directly by hospice employees; i.e., physician services, nursing care, medical social services, and counseling for individuals and care givers. Refer to paragraphs E.19.a.(1), E.19.a.(2), E.19.a.(3), and E.19.a.(4) of this chapter.

c. Non-core services. While non-core services (i.e., home health aide services, medical appliances and supplies, drugs and biologicals, physical therapy, occupational therapy, speech-language pathology and short-term inpatient care) may be provided under arrangements with other agencies or organizations, the hospice must maintain professional management of the patient at all times and in all settings. Refer to paragraphs E.19.a.(5), E.19.a.(6), E.19.a.(7), and E.19.a.(8) of this chapter.

d. Availability of services. The hospice must make nursing services, physician services, and drugs and biologicals routinely available on a 24-hour basis. All other covered services must be made available on a 24-hour basis to the extent necessary to meet the needs of individuals for care that is reasonable and necessary for the palliation and management of the terminal illness and related condition. These services must be provided in a manner consistent with accepted standards of practice.

e. Periods of care. Hospice care is divided into distinct periods/episodes of care. The terminally ill beneficiary may elect to receive hospice benefits for an initial period of 90 days, a subsequent period of 90 days, a second subsequent period of 30 days, and a final period of unlimited duration.

f. Conditions for coverage. The CHAMPUS beneficiary must meet the following conditions/criteria in order to be eligible for the hospice benefits and services referenced in paragraph E.19.a. of this chapter.

(1) There must be written certification in the medical record that the CHAMPUS beneficiary is terminally ill with a life expectancy of six months or less if the terminal illness runs its normal course.

(a) Timing of certification. The hospice must obtain written certification of terminal illness for each of the election periods described in paragraph E.19.f.(2) of this chapter, even if a single election continues in effect for two, three or four periods.

1 Basic requirement. Except as provided in paragraph E.19.f.(1)(a)2 of this chapter, the hospice must obtain the written certification no later than two calendar days after the period begins.

2 Exception. For the initial 90-day period, if the hospice cannot obtain the written certifications within two calendar days, it must obtain oral certifications within two calendar days, and written certifications no later than eight calendar days after the period begins.

(b) Sources of certification. Physician certification is required for both initial and subsequent election periods.

1 For the initial 90-day period, the hospice must obtain written certification statements (and oral certification statements if required under paragraph E.19.f.(1)(a)2 of this chapter) from:

a The individual's attending physician if the individual has an attending physician; and

b The medical director of the hospice or the physician member of the hospice interdisciplinary group.

2 For subsequent periods, the only requirement is certification by one of the physicians listed in paragraph E.19.f.(1)(b)1 b of this section.

(2) The terminally ill beneficiary must elect to receive hospice care for each specified period of time; i.e., the two 90-day periods, a subsequent 30-day period, and a final period of unlimited duration. If the individual is found to be mentally incompetent, his or her representative may file the election statement. Representative means an individual who has been authorized under State law to terminate medical care or to elect or revoke the election of hospice care on behalf of a terminally ill individual who is found to be mentally incompetent.

(a) The episodes of care must be used consecutively; i.e., the two 90-day periods first, then the 30-day period, followed by the final period. The periods of care may be elected separately at different times.

(b) The initial election will continue through subsequent election periods without a break in care as long as the individual remains in the care of the hospice and does not revoke the election.

(c) The effective date of the election may begin on the first day of hospice care or any subsequent day of care, but the effective date cannot be made prior to the date that the election was made.

(d) The beneficiary or representative may revoke a hospice election at any time, but in doing so, the remaining days of that particular election period are forfeited and standard CHAMPUS coverage resumes. To revoke the hospice benefit, the beneficiary or representative must file a signed statement of revocation with the hospice. The statement must provide the date that the revocation is to be effective. An individual or representative may not designate an effective date earlier than the date that the revocation is made.

(e) If an election of hospice benefits has been revoked, the individual, or his or her representative may at any time file a hospice election for any period of time still available to the individual, in accordance with Chapter 4.E.19.f.(2).

(f) A CHAMPUS beneficiary may change, once in each election period, the designation of the particular hospice from which he or she elects to receive hospice care. To change the designation of hospice programs the individual or representative must file, with the hospice from which care has been received and with the newly designated hospice, a statement that includes the following information:

1 The name of the hospice from which the individual has received care and the name of the hospice from which he or she plans to receive care.

2 The date the change is to be effective.

(g) Each hospice will design and print its own election statement to include the following information:

1 Identification of the particular hospice that will provide care to the individual.

2 The individual's or representative's acknowledgment that he or she has been given a full understanding of the palliative rather than curative nature of hospice care, as it relates to the individual's terminal illness.

3 The individual's or representative's acknowledgment that he or she understands that certain other CHAMPUS services are waived by the election.

4 The effective date of the election.

5 The signature of the individual or representative, and the date signed.

(h) The hospice must notify the CHAMPUS contractor of the initiation, change or revocation of any election.

(3) The beneficiary must waive all rights to other CHAMPUS payments for the duration of the election period for:

(a) Care provided by any hospice program other than the elected hospice unless provided under arrangements made by the elected hospice; and

(b) Other CHAMPUS basic program services/benefits related to the treatment of the terminal illness for which hospice care was elected, or to a related condition, or that are equivalent to hospice care, except for services provided by:

1 the designated hospice;

2 another hospice under arrangements made by the designated hospice; or

3 an attending physician who is not employed by or under contract with the hospice program.

(c) Basic CHAMPUS coverage will be reinstated upon revocation of the hospice election.

(4) A written plan of care must be established by a member of the basic interdisciplinary group assessing the patient's needs. This group must have at least one physician, one registered professional nurse, one social worker, and one pastoral or other counselor.

(a) In establishing the initial plan of care the member of the basic interdisciplinary group who assesses the patient's needs must meet or call at least one other group member before writing the initial plan of care.

(b) At least one of the persons involved in developing the initial plan must be a nurse or physician.

(c) The plan must be established on the same day as the assessment if the day of assessment is to be a covered day of hospice care.

(d) The other two members of the basic interdisciplinary group -- the attending physician and the medical director or physician designee -- must review the initial plan of care and provide their input to the process of establishing the plan of care within two calendar days following the day of assessment. A meeting of group members is not required within this 2-day period. Input may be provided by telephone.

(e) Hospice services must be consistent with the plan of care for coverage to be extended.

(f) The plan must be reviewed and updated, at intervals specified in the plan, by the attending physician, medical director or physician designee and interdisciplinary group. These reviews must be documented in the medical records.

(g) The hospice must designate a registered nurse to coordinate the implementation of the plan of care for each patient.

(h) The plan must include an assessment of the individual's needs and identification of the services, including the management of discomfort and symptom relief. It must state in detail the scope and frequency of services needed to meet the patient's and family's needs.

(5) Complete medical records and all supporting documentation must be submitted to the CHAMPUS contractor within 30 days of the date of its request. If records are not received within the designated time frame, authorization of the hospice benefit will be denied and any prior payments made will be recouped. A denial issued for this reason is not an initial determination under Chapter 10, and is not appealable.

g. Appeal rights under hospice benefit. A beneficiary or provider is entitled to appeal rights for cases involving a denial of benefits in accordance with the provisions of this Chapter and Chapter 10.

F. BENEFICIARY OR SPONSOR LIABILITY

1. General. As stated in the introductory paragraph to this chapter, the Basic Program is essentially a supplemental program to the Uniformed Services direct medical care system. To encourage use of the Uniformed Services direct medical care system wherever its facilities are available and appropriate, the Basic Program benefits are designed so that it is to the financial advantage of a CHAMPUS beneficiary or sponsor to use the direct medical care system. When medical care is received from civilian sources, a CHAMPUS beneficiary is responsible for payment of certain deductible and cost-sharing amounts in connection with otherwise covered services and supplies. By statute, this joint financial responsibility between the beneficiary or sponsor and CHAMPUS is more favorable for dependents of active duty members than for other classes of beneficiaries.

2. Dependents of active duty members of the Uniformed Services. CHAMPUS beneficiary or sponsor liability set forth for dependents of active duty members is as follows:

a. Annual fiscal year deductible for outpatient services and supplies.

(1) For care rendered all eligible beneficiaries prior to April 1, 1991, or when the active duty sponsor's pay grade is E-4 or below, regardless of the date of care:

(a) **Individual Deductible:** Each beneficiary is liable for the first fifty dollars (\$50.00) of the CHAMPUS-determined allowable amount on claims for care provided in the same fiscal year.

(b) **Family Deductible:** The total deductible amount for all members of a family with the same sponsor during one fiscal year shall not exceed one hundred dollars (\$100.00).

(2) For care rendered on or after April 1, 1991, for all CHAMPUS beneficiaries except dependents of active duty sponsors of pay grades E-4 or below:

(a) **Individual Deductible:** Each beneficiary is liable for the first one hundred and fifty dollars (\$150.00) of the CHAMPUS-determined allowable amount on claims for care provided in the same fiscal year.

(b) **Family Deductible:** The total deductible amount for all members of a family with the same sponsor during one fiscal year shall not exceed three hundred dollars (\$300.00).

(3) CHAMPUS-Approved Ambulatory Surgical Centers or Birthing Centers. No deductible shall be applied to allowable amounts for services or items rendered to active duty or authorized NATO dependents.

(4) Allowable Amount does not exceed Deductible Amount. If fiscal year allowable amounts for two or more beneficiary members of a family total less than \$100.00 (\$300.00 if 2.a.(2)(b) above applies), but none of the beneficiary members submit a claim for over \$50.00 (\$150.00 if 2.a.(2)(a) above applies), neither the family nor the individual deductible will have been met and no CHAMPUS benefits are payable.

(5) For any family the outpatient deductible amounts will be applied sequentially as the CHAMPUS claims are processed.

(6) If the fiscal year outpatient deductible under either F.2.a.(1) or F.2.a.(2) above has been met by a beneficiary or a family through the submission of a claim or claims to a CHAMPUS fiscal intermediary in another geographic location from the location where a current claim is being submitted, the beneficiary or sponsor must obtain a deductible certificate from the CHAMPUS fiscal intermediary where the applicable beneficiary or family fiscal year deductible was met. Such deductible certificate must be attached to the current claim being submitted for benefits. Failure to obtain a deductible certificate under such circumstances will result in a second beneficiary or family fiscal year deductible being applied. However, this second deductible may be reimbursed once appropriate documentation, as described in this subparagraph F.2.a.(6), is supplied to the CHAMPUS fiscal intermediary applying the second deductible (refer to section A. of Chapter 7 of this Regulation).

(7) Notwithstanding the dates specified in paragraphs F.2.a.(1) and (2), in the case of the dependents of active duty members of rank E-5 or above with Persian Gulf conflict service, the deductible shall be the amount specified in paragraph (1) for care rendered prior to October 1, 1991, and the amount specific in

paragraph (2) for care rendered after October 1, 1991. For purposes of the preceding sentence, a member with Persian Gulf conflict service is a member who is, or was entitled to special pay for hostile fire/imminent danger authorized by 37 U.S.C. 310, for services in the Persian Gulf area in connection with Operation Desert Shield or Operation Desert Storm.

b. Inpatient cost-sharing. Except in the case of mental health services (see paragraph F.2.b.(4) of this chapter), dependents of active duty members of the Uniformed Services or their sponsors are responsible for the payment of the first \$25 of the allowable institutional costs incurred with each covered inpatient admission to a hospital or other authorized institutional provider (refer to chapter 6), or the amount the beneficiary or sponsor would have been charged had the inpatient care been provided in a Uniformed Service hospital, whichever is greater.

NOTE: The Secretary of Defense (after consulting with the Secretary of Health and Human Services and the Secretary of Transportation) prescribes the fair charges for inpatient hospital care provided through Uniformed Services medical facilities. This determination is made each fiscal year.

(1) Inpatient cost-sharing payable with each separate inpatient admission. A separate cost-sharing amount (as described in this subsection F.2.) is payable for each inpatient admission to a hospital or other authorized institution, regardless of the purpose of the admission (such as medical or surgical), regardless of the number of times the beneficiary is admitted, and regardless of whether or not the inpatient admissions are for the same or related conditions; except that successive inpatient admissions shall be deemed one inpatient confinement for the purpose of computing the inpatient cost-share payable, provided not more than 60 days have elapsed between the successive admissions. However, notwithstanding this provision, all admissions related to a single maternity episode shall be considered one confinement, regardless of the number of days between admissions (refer to section B. of this chapter).

(2) Multiple family inpatient admissions. A separate cost-sharing amount is payable for each inpatient admission, regardless of whether or not two or more beneficiary members of a family are admitted at the sametime or from the same cause (such as an accident). A separate beneficiary inpatient cost-sharing amount must be applied for each separate admission on each beneficiary member of the family.

(3) Newborn patient in his or her own right. When a newborn infant remains as an inpatient in his or her own right (usually after the mother is discharged), the newborn child becomes the beneficiary and patient and the extended inpatient stay becomes a separate inpatient admission. In such a situation, a new, separate inpatient cost-sharing amount is applied. If a multiple birth is involved (such as twins or triplets) and two or more newborn infants become patients in their own right, a separate inpatient cost-sharing amount must be applied to the inpatient stay for each newborn child who has remained as an inpatient in his or her own right.

(4) Inpatient cost-sharing for mental health services. For care provided on or after October 1, 1995, the inpatient cost-sharing for mental health services is \$20 per day for each day of the inpatient admission. This \$20 per day cost sharing amount applies to admissions to any hospital for mental health services, any residential treatment facility, any substance abuse rehabilitation facility, and any partial hospitalization program providing mental health or substance use disorder rehabilitation services.

c. Outpatient cost-sharing. Dependents of active duty members of the Uniformed Services or their sponsors are responsible for payment of 20 percent of the CHAMPUS-determined allowable cost or charge beyond the annual fiscal year deductible amount (as described in paragraph F.2.a. of this chapter) for otherwise covered services or supplies provided on an outpatient basis by authorized providers.

d. Ambulatory surgery. Notwithstanding the above provisions pertaining to outpatient cost-sharing, dependents of active duty members of the Uniformed Services or their sponsors are responsible for payment of \$25 for surgical care that is authorized and received while in an outpatient status and that has been designated in guidelines issued by the Director, OCHAMPUS, or a designee.

e. Psychiatric partial hospitalization services. Institutional and professional services provided under the psychiatric partial hospitalization program authorized by paragraph B.10. of this chapter shall be cost-shared as inpatient services.

3. Retirees, dependents of retirees, dependents of deceased active duty members, and dependents of deceased retirees. CHAMPUS beneficiary liability set forth for retirees, dependents of retirees, dependents of deceased active duty members, and dependents of deceased retirees is as follows:

a. Annual fiscal year deductible for outpatient services or supplies. The annual fiscal year deductible for otherwise covered outpatient services or supplies provided retirees, dependents of retirees, dependents of deceased active duty members, and dependents of deceased retirees, is the same as the annual fiscal year outpatient deductible applicable to dependents of active duty members of rank E-5 or above (refer to paragraph F.2.a.(1) or (2) of this chapter).

b. Inpatient cost-sharing. Cost-sharing amounts for inpatient services shall be as follows:

(1) Services subject to the CHAMPUS DRG-based payment system. The cost-share shall be the lesser of an amount calculated by multiplying a per diem amount for each day of the hospital stay except the day of discharge or 25 percent of the hospital's billed charges. The per diem amount shall be calculated so that total cost-sharing amounts for these beneficiaries is equivalent to 25 percent of the CHAMPUS-determined allowable costs for covered services or supplies provided on an inpatient basis by authorized providers. The per diem amount shall be published annually by CHAMPUS.

(2) Services subject to the mental health per diem payment system. The cost-share is dependent upon whether the hospital is paid a hospital-specific per diem or a regional per diem under the provisions of subsection A.2. of Chapter 14. With respect to care paid for on the basis of a hospital-specific per diem, the cost-share shall be 25% of the hospital-specific per diem amount. For care paid for on the basis of a regional per diem, the cost share shall be the lower of a fixed daily amount or 25% of the hospital's billed charges. The fixed daily amount shall be 25% of the per diem adjusted so that total beneficiary cost-shares will equal 25% of total payments under the mental health per diem payment system. This fixed daily amount shall be updated annually and published in the Federal Register along with the per diems published pursuant to subparagraph A.2.d.(2) of Chapter 14.

(3) Other services. For services exempt from the CHAMPUS DRG-based payment system and the CHAMPUS mental health per diem payment system and services provided by institutions other than hospitals, the cost-share shall be 25% of the CHAMPUS-determined allowable charges.

c. Outpatient cost-sharing.

(1) For services other than ambulatory surgery services. Retirees, dependents of retirees, dependents of deceased active duty members, and dependents of deceased retirees are responsible for payment of 25 percent of the CHAMPUS-determined allowable costs or charges beyond the annual fiscal year deductible amount (as described in paragraph F.2.a. of this chapter) for otherwise covered services or supplies provided on an outpatient basis by authorized providers.

(2) For services subject to the ambulatory surgery payment method. For services subject to the ambulatory surgery payment method set forth in Chapter 14 D., of this regulation, the cost share shall be the lesser of: 25 percent of the payment amount provided pursuant to Chapter 14.D.; or 25 percent of the center's billed charges.

d. Psychiatric partial hospitalization services. Institutional and professional services provided under the psychiatric partial hospitalization program authorized by paragraph B.10. of this chapter shall be cost-shared as inpatient services.

4. Former spouses. CHAMPUS beneficiary liability set forth for former spouses eligible under the provisions of paragraph B.2.b. of Chapter 3 is as follows:

a. Annual fiscal year deductible for outpatient services or supplies. An eligible former spouse is responsible for the payment of the first \$150 of the CHAMPUS-determined reasonable costs or charges for otherwise covered outpatient services or supplies provided in any one fiscal year. (Except for services received prior to April 1, 1991, the deductible amount is \$50.00). The former spouse cannot contribute to, nor benefit from, any family deductible of the member or former member to whom the former spouse was married or of any CHAMPUS-eligible children.

b. Inpatient cost-sharing. Eligible former spouses are responsible for the payment of cost-sharing amounts the same as those required for retirees, dependents of retirees, dependents of deceased active duty members, and dependents of deceased retirees.

c. Outpatient cost-sharing. Eligible former spouses are responsible for payment of 25 percent of the CHAMPUS-determined reasonable costs or charges beyond the annual fiscal year deductible amount for otherwise covered services or supplies provided on an outpatient basis by authorized providers.

5. Cost-Sharing under the Military-Civilian Health Services Partnership Program. Cost-sharing is dependent upon the type of partnership program entered into, whether external or internal. (See section P. of Chapter 1, for general requirements of the Military-Civilian Health Services Partnership Program.)

a. External Partnership Agreement. Authorized costs associated with the use of the civilian facility will be financed through CHAMPUS under the normal cost-sharing and reimbursement procedures applicable under CHAMPUS.

b. Internal Partnership Agreement. Beneficiary cost-share under internal agreements will be the same as charges prescribed for care in military treatment facilities.

6. Amounts over CHAMPUS-determined allowable costs or charges. It is the responsibility of the CHAMPUS fiscal intermediary to determine allowable costs for services and supplies provided by hospitals and other institutions and allowable charges for services and supplies provided by physicians, other individual professional providers, and other providers. Such CHAMPUS-determined allowable costs or charges are made in accordance with the provisions of Chapter 14. All CHAMPUS benefits, including calculation of the CHAMPUS or beneficiary cost-sharing amounts, are based on such CHAMPUS-determined allowable costs or charges. The effect on the beneficiary when the billed cost or charge is over the CHAMPUS-determined allowable amount is dependent upon whether or not the applicable claim was submitted on a participating basis on behalf of the beneficiary or submitted directly by the beneficiary on a nonparticipating basis and on whether the claim is for inpatient hospital services subject to the CHAMPUS DRG-based payment system. This provision applies to all classes of CHAMPUS beneficiaries.

NOTE: When the provider "forgives" or "waives" any beneficiary liability, such as amounts applicable to the annual fiscal year deductible for outpatient services or supplies, or the inpatient or outpatient cost-sharing as previously set forth in this section, the CHAMPUS-determined allowable charge or cost allowance (whether payable to the CHAMPUS beneficiary or sponsor, or to a participating provider) shall be reduced by the same amount.

a. Participating providers. There are several circumstances under which institutional and individual providers may be Participating Providers, either on a mandatory basis or a voluntary basis. See Chapter 6, A.8. A Participating Provider, whether participating for all claims or on a claim-by-claim basis, must accept the CHAMPUS-determined allowable amount as payment in full for the medical

services or supplies provided, and must accept the amount paid by CHAMPUS or the CHAMPUS payment combined with the cost-sharing and deductible amounts paid by or on behalf of the beneficiary as payment in full for the covered medical services or supplies. Therefore, when costs or charges are submitted on a participating basis, the patient is not obligated to pay any amounts disallowed as being over the CHAMPUS-determined allowable cost or charge for authorized services or supplies.

b. Nonparticipating providers. Nonparticipating providers are those providers who do not agree on the CHAMPUS claim form to participate and thereby do not agree to accept the CHAMPUS-determined allowable costs or charges as the full charge. For otherwise covered services and supplies provided by such nonparticipating CHAMPUS providers, payment is made directly to the beneficiary or sponsor and the beneficiary is liable under applicable law for any amounts over the CHAMPUS-determined allowable costs or charges. CHAMPUS shall have no responsibility for any amounts over allowable costs or charges as determined by CHAMPUS.

7. [Reserved]

8. Cost-sharing for services provided under special discount arrangements.

a. General rule. With respect to services determined by the Director, OCHAMPUS (or designee) to be covered by Chapter 14, section I., the Director, OCHAMPUS (or designee) has authority to establish, as an exception to the cost-sharing amount normally required pursuant to this chapter, a different cost-share amount that appropriately reflects the application of the statutory cost-share to the discount arrangement.

b. Specific applications. The following are examples of applications of the general rule; they are not all inclusive.

(1) In the case of services provided by individual health care professionals and other noninstitutional providers, the cost-share shall be the usual percentage of the CHAMPUS allowable charge determined under Chapter 14, section I.

(2) In the case of services provided by institutional providers normally paid on the basis of a pre-set amount (such as DRG-based amount under Chapter 14, section A.1. or per-diem amount under Chapter 14, section A.2.), if the discount rate is lower than the pre-set rate, the cost-share amount that would apply for a beneficiary other than an active duty dependent pursuant to the normal pre-set rate would be reduced by the same percentage by which the pre-set rate was reduced in setting the discount rate.

9. Waiver of deductible amounts or cost-sharing not allowed.

a. General rule. Because deductible amounts and cost sharing are statutorily mandated, except when specifically authorized by law (as determined by the Director, OCHAMPUS), a provider may not waive or forgive beneficiary liability for annual deductible amounts or inpatient or outpatient cost-sharing, as set forth in this chapter.

b. Exception for bad debts. This general rule is not violated in cases in which a provider has made all reasonable attempts to effect collection, without success, and determines in accordance with generally accepted fiscal management standards that the beneficiary liability in a particular case is an uncollectible bad debt.

c. Remedies for noncompliance. Potential remedies for noncompliance with this requirement include:

(1) A claim for services regarding which the provider has waived the beneficiary's liability may be disallowed in full, or, alternatively, the amount payable for such a claim may be reduced by the amount of the beneficiary liability waived.

(2) Repeated noncompliance with this requirement is a basis for exclusion of a provider.

G. EXCLUSIONS AND LIMITATIONS

In addition to any definitions, requirements, conditions, or limitations enumerated and described in other chapters of this Regulation, the following specifically are excluded from the Basic Program:

1. Not medically or psychologically necessary. Services and supplies that are not medically or psychologically necessary for the diagnosis or treatment of a covered illness (including mental disorder) or injury, for the diagnosis and treatment of pregnancy, or for well-baby care except as provided in the following paragraph.

2. Unnecessary diagnostic tests. X-ray, laboratory, and pathological services and machine diagnostic tests not related to a specific illness or injury or a definitive set of symptoms except for cancer screening mammography and cancer screening papanicolaou (PAP) smears provided under the terms and conditions contained in the guidelines adopted by the Director, OCHAMPUS.

3. Institutional level of care. Services and supplies related to inpatient stays in hospitals or other authorized institutions above the appropriate level required to provide necessary medical care.

4. Diagnostic admission. Services and supplies related to an inpatient admission primarily to perform diagnostic tests, examinations, and procedures that could have been and are performed routinely on an outpatient basis.

NOTE: If it is determined that the diagnostic x-ray, laboratory, and pathological services and machine tests performed during such admission were medically necessary and would have been covered if performed on an outpatient basis, CHAMPUS benefits may be extended for such diagnostic procedures only, but cost-sharing will be computed as if performed on an outpatient basis.

5. Unnecessary postpartum inpatient stay, mother or newborn. Postpartum inpatient stay of a mother for purposes of staying with the newborn infant (usually primarily for the purpose of breast feeding the infant) when the infant (but not the mother) requires the extended stay; or continued inpatient stay of a newborn infant primarily for purposes of remaining with the mother when the mother (but not the newborn infant) requires extended postpartum inpatient stay.
6. Therapeutic absences. Therapeutic absences from an inpatient facility, except when such absences are specifically included in a treatment plan approved by the Director, OCHAMPUS, or a designee. For cost-sharing provisions refer to Chapter 14, paragraph F.3.
7. Custodial care. Custodial care regardless of where rendered, except as otherwise specifically provided in paragraphs E.12.b., E.12.c. and E.12.d. of this chapter.
8. Domiciliary care. Inpatient stays primarily for domiciliary care purposes.
9. Rest or rest cures. Inpatient stays primarily for rest or rest cures.
10. Amounts above allowable costs or charges. Costs of services and supplies to the extent amounts billed are over the CHAMPUS determined allowable cost or charge, as provided for in Chapter 14.
11. No legal obligation to pay, no charge would be made. Services or supplies for which the beneficiary or sponsor has no legal obligation to pay; or for which no charge would be made if the beneficiary or sponsor was not eligible under CHAMPUS; or whenever CHAMPUS is a secondary payer for claims subject to the CHAMPUS DRG-based payment system, amounts, when combined with the primary payment, which would be in excess of charges (or the amount the provider is obligated to accept as payment in full, if it is less than the charges).
12. Furnished without charge. Services or supplies furnished without charge.
13. Furnished by local, state, or Federal Government. Services and supplies paid for, or eligible for payment, directly or indirectly by a local, state, or Federal Government, except as provided under CHAMPUS, or by government hospitals serving the general public, or medical care provided by a Uniformed Service medical care facility, or benefits provided under title XIX of the Social Security Act (Medicaid) (reference (h)) (refer to Chapter 8 of this Regulation).
14. Study, grant, or research programs. Services and supplies provided as a part of or under a scientific or medical study, grant, or research program.
15. Not in accordance with accepted standards, experimental or investigational. Services and supplies not provided in accordance with accepted professional medical standards; or related to essentially experimental or investigational procedures or treatment regimens.

16. Immediate family, household. Services or supplies provided or prescribed by a member of the beneficiary's immediate family, or a person living in the beneficiary's or sponsor's household.

17. Double coverage. Services and supplies that are (or are eligible to be) payable under another medical insurance or program, either private or governmental, such as coverage through employment or Medicare (refer to Chapter 8 of this Regulation).

18. Nonavailability Statement required. Services and supplies provided under circumstances or in geographic locations requiring a Nonavailability Statement (DD Form 1251), when such a statement was not obtained.

19. Preauthorization required. Services or supplies which require preauthorization if preauthorization was not obtained. Services and supplies which were not provided according to the terms of the preauthorization. The Director, OCHAMPUS, or a designee, may grant an exception to the requirement for preauthorization if the services otherwise would be payable except for the failure to obtain preauthorization.

20. Psychoanalysis or psychotherapy, part of education. Psychoanalysis or psychotherapy provided to a beneficiary or any member of the immediate family that is credited towards earning a degree or furtherance of the education or training of a beneficiary or sponsor, regardless of diagnosis or symptoms that may be present.

21. Runaways. Inpatient stays primarily to control or detain a runaway child, whether or not admission is to an authorized institution.

22. Services or supplies ordered by a court or other government agency. Services or supplies, including inpatient stays, directed or agreed to by a court or other governmental agency. However, those services and supplies (including inpatient stays) that otherwise are medically or psychologically necessary for the diagnosis or treatment of a covered condition and that otherwise meet all CHAMPUS requirements for coverage are not excluded.

23. Work-related (occupational) disease or injury. Services and supplies required as a result of occupational disease or injury for which any benefits are payable under a worker's compensation or similar law, whether or not such benefits have been applied for or paid; except if benefits provided under such laws are exhausted.

24. Cosmetic, reconstructive, or plastic surgery. Services and supplies in connection with cosmetic, reconstructive, or plastic surgery except as specifically provided in subsection E.8. of this chapter.

25. Surgery, psychological reasons. Surgery performed primarily for psychological reasons (such as psychogenic).

26. Electrolysis.

27. Dental care. Dental care or oral surgery, except as specifically provided in subsection E.10. of this chapter.

28. Obesity, weight reduction. Services and supplies related to obesity or weight reduction whether surgical or nonsurgical; wiring of the jaw or any procedure of similar purpose, regardless of the circumstances under which performed; except that benefits may be provided for the gastric bypass, gastric stapling, or gastroplasty procedures in connection with morbid obesity as provided in subsection E.15. of this chapter.

29. Transsexualism or such other conditions as gender dysphoria. Services and supplies related to transsexualism or such other conditions as gender dysphoria (including, but not limited, to intersex surgery, psychotherapy, and prescription drugs), except as specifically provided in subsection E.7. of this chapter.

30. Therapy or counseling for sexual dysfunctions or sexual inadequacies. Sex therapy, sexual advice, sexual counseling, sex behavior modification, psychotherapy for mental disorders involving sex deviations (e.g., transvestic fetishism), or other similar services, and any supplies provided in connection with therapy for sexual dysfunctions or inadequacies.

31. Corns, calluses, and toenails. Removal of corns or calluses or trimming of toenails and other routine podiatry services, except those required as a result of a diagnosed systemic medical disease affecting the lower limbs, such as severe diabetes.

32. Dyslexia.

33. Surgical sterilization, reversal. Surgery to reverse surgical sterilization procedures.

34. Noncoital reproductive procedures including artificial insemination, in-vitro fertilization, gamete intrafallopian transfer and all other such reproductive technologies. Services and supplies related to artificial insemination (including semen donors and semen banks), in-vitro fertilization, gamete intrafallopian transfer and all other noncoital reproductive technologies.

35. Nonprescription contraceptives.

36. Tests to determine paternity or sex of a child. Diagnostic tests to establish paternity of a child; or tests to determine sex of an unborn child.

37. Preventive care. Preventive care, such as routine, annual, or employment requested physical examinations; routine screening procedures; immunizations; except that the following are not excluded:

a. Well-baby care, including newborn examination, Phenylketonuria (PKU) testing and newborn circumcision.

b. Rabies shots.

c. Tetanus shot following an accidental injury.

d. Rh immune globulin.

e. Genetic tests as specified in paragraph E.3.b. of this chapter.

f. Immunizations and physical examinations provided when required in the case of dependents of active duty military personnel who are traveling outside the United States as a result of an active member's duty assignment and such travel is being performed under orders issued by a Uniformed Service.

g. Screening mammography for asymptomatic women 35 years of age and older when provided under the terms and conditions contained in the guidelines adopted by the Director OCHAMPUS.

h. Cancer screening papanicolaou (PAP) smear for women who are or have been sexually active, and women 18 years of age and older under the terms and conditions contained in the guidelines adopted by the Director, OCHAMPUS.

38. Chiropractors and naturopaths. Services of chiropractors and naturopaths whether or not such services would be eligible for benefits if rendered by an authorized provider.

39. Counseling. Counseling services that are not medically necessary in the treatment of a diagnosed medical condition; for example, educational counseling, vocational counseling, nutritional counseling, counseling for socioeconomic purposes, diabetic self-education programs, stress management, life style modification, etc. Services provided by a certified marriage and family therapist, pastoral or mental health counselor in the treatment of a mental disorder are covered only as specifically provided in Chapter 6. Services provided by alcoholism rehabilitation counselors and certified addiction counselors are covered only when rendered in a CHAMPUS-authorized treatment setting and only when the cost of those services is included in the facility's CHAMPUS-determined allowable cost-rate.

40. Acupuncture. Acupuncture, whether used as a therapeutic agent or as an anesthetic.

41. Hair transplants, wigs, or hairpieces

NOTE: In accordance with Section 744 of the DoD Appropriation Act for 1981 (reference (o)), CHAMPUS coverage for wigs or hairpieces is permitted effective December 15, 1980, under the conditions listed below. Continued availability of benefits will depend on the language of the annual DoD Appropriation Acts.

a. Benefits provided. Benefits may be extended, in accordance with the CHAMPUS-determined allowable charge, for one wig or hairpiece per beneficiary (lifetime maximum) when the attending physician certifies that alopecia has resulted from treatment of a malignant disease and the beneficiary certifies that a wig or hairpiece has not been obtained previously through the U.S. Government (including the Veterans Administration).

b. Exclusions. The wig or hairpiece benefit does not include coverage for the following:

(1) Alopecia resulting from conditions other than treatment of malignant disease.

(2) Maintenance, wig or hairpiece supplies, or replacement of the wig or hairpiece.

(3) Hair transplants or any other surgical procedure involving the attachment of hair or a wig or hairpiece to the scalp.

(4) Any diagnostic or therapeutic method or supply intended to encourage hair regrowth.

42. Education or training. Self-help, academic education or vocational training services and supplies, unless the provisions of Chapter 4, paragraph B.1.e., relating to general or special education, apply.

43. Exercise/Relaxation/Comfort Devices. Exercise equipment, spas, whirlpools, hot tubs, swimming pools, health club membership or other such charges or items.

44. Exercise. General exercise programs, even if recommended by a physician and regardless of whether or not rendered by an authorized provider. In addition, passive exercises and range of motion exercises also are excluded, except when prescribed by a physician and rendered by a physical therapist concurrent to, and as an integral part of, a comprehensive program of physical therapy.

45. Audiologist, speech therapist. Services of an audiologist or speech therapist, except when prescribed by a physician and rendered as a part of treatment addressed to the physical defect itself and not to any educational or occupational deficit.

46. Vision care. Eye exercises or visual training (orthoptics).

47. Eye and hearing examinations. Eye and hearing examinations except as specifically provided in paragraph C.2.p. of this chapter or except when rendered in connection with medical or surgical treatment of a covered illness or injury. Vision and hearing screening in connection with well-baby care is not excluded.

48. Prosthetic devices. Prostheses, except artificial limbs and eyes, or if an item is inserted surgically in the body as an integral part of a surgical procedure. All dental prostheses are excluded, except for those specifically required in connection with otherwise covered orthodontia directly related to the surgical correction of a cleft palate anomaly.

49. Orthopedic shoes. Orthopedic shoes, arch supports, shoe inserts, and other supportive devices for the feet, including special-ordered, custom-made built-up shoes, or regular shoes later built up.

50. Eyeglasses. Eyeglasses, spectacles, contact lenses, or other optical devices, except as specifically provided under subsection E.6. of this chapter.
51. Hearing aids. Hearing aids or other auditory sensory enhancing devices.
52. Telephonic services. Services or advice rendered by telephone or other telephonic device, including remote monitoring, except for transtelephonic monitoring of cardiac pacemakers.
53. Air conditioners, humidifiers, dehumidifiers, and purifiers.
54. Elevators or chair lifts.
55. Alterations. Alterations to living spaces or permanent features attached thereto, even when necessary to accommodate installation of covered durable medical equipment or to facilitate entrance or exit.
56. Clothing. Items of clothing or shoes, even if required by virtue of an allergy (such as cotton fabric as against synthetic fabric and vegetable dyed shoes).
57. Food, food substitutes. Food, food substitutes, vitamins, or other nutritional supplements, including those related to prenatal care.
58. Enuresis. Enuretic devices; enuretic conditioning programs.
59. RESERVED.
60. Autopsy and postmortem.
61. Camping. All camping even though organized for a specific therapeutic purpose (such as diabetic camp or a camp for emotionally disturbed children), and even though offered as a part of an otherwise covered treatment plan or offered through a CHAMPUS-approved facility.
62. Housekeeper, companion. Housekeeping, homemaker, or attendant services; sitter or companion.
63. Noncovered condition, unauthorized provider. All services and supplies (including inpatient institutional costs) related to a noncovered condition or treatment, or provided by an unauthorized provider.
64. Comfort or convenience. Personal, comfort, or convenience items such as beauty and barber services, radio, television, and telephone.
65. "Stop smoking" programs. Services and supplies related to "stop smoking" regimens.

66. Megavitamin psychiatric therapy, orthomolecular psychiatric therapy.

67. Transportation. All transportation except by ambulance, as specifically provided under section D. of this chapter, and except as authorized in subsection E.5. of this chapter.

68. Travel. All travel even though prescribed by a physician and even if its purpose is to obtain medical care, except as specified in subsection A.6. of this chapter in connection with a CHAMPUS-required physical examination.

69. Institutions. Services and supplies provided by other than a hospital, unless the institution has been approved specifically by OCHAMPUS. Nursing homes, intermediate care facilities, halfway houses, homes for the aged, or institutions of similar purpose are excluded from consideration as approved facilities under the Basic Program.

NOTE: In order to be approved under CHAMPUS, an institution must, in addition to meeting CHAMPUS standards, provide a level of care for which CHAMPUS benefits are payable.

70. Supplemental diagnostic services. Diagnostic services including clinical laboratory examinations, x-ray examinations, pathological examinations, and machine tests that produce hard-copy results performed by civilian providers at the request of the attending Uniformed Service medical department physician (active duty or civil service).

71. Supplemental consultations. Consultations provided by civilian providers at the request of the attending Uniformed Services medical department physician (active duty or civil service).

72. Inpatient mental health services. Effective for care received on or after October 1, 1991, services in excess of 30 days in any fiscal year (or in an admission), in the case of a patient nineteen years of age or older, 45 days in any fiscal year (or in an admission) in the case of a patient under 19 years of age, or 150 days in any fiscal year (or in an admission) in the case of inpatient mental health services provided as residential treatment care, unless coverage for such services is granted by a waiver by the Director, OCHAMPUS, or a designee. In cases involving the day limitations, waivers shall be handled in accordance with paragraphs B.8. or B.9. of this chapter. For services prior to October 1, 1991, services in excess of 60 days in any calendar year unless additional coverage is granted by the Director, OCHAMPUS, or a designee.

73. Economic interest in connection with mental health admissions. Inpatient mental health services (including both acute care and RTC services) are excluded for care received when a patient is referred to a provider of such services by a physician (or other health care professional with authority to admit) who has an economic interest in the facility to which the patient is referred, unless a waiver is granted. Requests for waiver shall be considered under the same procedure and based on the same criteria as used for obtaining preadmission authorization (or continued stay authorization for

emergency admissions), with the only additional requirement being that the economic interest be disclosed as part of the request. The same reconsideration and appeals procedures that apply to day limit waivers shall also apply to decisions regarding requested waivers of the economic interest exclusion. However, a provider may appeal a reconsidered determination that an economic relationship constitutes an economic interest within the scope of the exclusion to the same extent that a provider may appeal determinations under paragraph I.3., Chapter 15. This exclusion does not apply to services under the Program for the Handicapped (Chapter 5 of this Regulation) or provided as partial hospital care. If a situation arises where a decision is made to exclude CHAMPUS payment solely on the basis of the provider's economic interest, the normal CHAMPUS appeals process will be available.

74. Not specifically listed. Services and supplies not specifically listed as a benefit in this Regulation. This exclusion is not intended to preclude extending benefits for those services or supplies specifically determined to be covered within the intent of this Regulation by the Director, OCHAMPUS, or a designee, even though not otherwise listed.

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

H. Payment and liability for certain potentially excludable services under the Peer Review Organization program.

1. Applicability. This section provides special rules that apply only to services retrospectively determined under the Peer Review Organization (PRO) program (operated pursuant to Chapter 15) to be potentially excludable (in whole or in part) from the Basic Program under section G. of this chapter. Services may be excluded by reason of being not medically necessary (subsection G.1.) at an inappropriate level (subsection G.3.) custodial care (subsection G.7.) or other reason relative to reasonableness, necessity or appropriateness (which services shall throughout the remainder of this section, be referred to as "not medically necessary"). (Also throughout the remainder of the section, "services" includes items and "provider" includes supplier.) This section does not apply to coverage determinations made by OCHAMPUS or the fiscal intermediaries which are not based on medical necessity determinations made under the PRO program.

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

3. Liability for certain excludable services. In any case in which items or services are determined excludable by the PRO program by reason of being not

medically necessary and payment may not be made under subsection H.2., above because the requirements of subsection H.2. are not met, the beneficiary may not be held liable (and shall be entitled to a full refund from the provider of the amount excluded and any cost-share amount already paid) if:

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

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

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

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

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

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

c. The provider had informed the beneficiary that the services were excludable.

d. 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.

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

f. Preadmission authorization was available but not requested, or concurrent review requirements were not followed.



CHAPTER 6

AUTHORIZED PROVIDERS

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CHAPTER 6
AUTHORIZED PROVIDERS

A. GENERAL

This chapter sets forth general policies and procedures that are the basis for the CHAMPUS cost-sharing of medical services and supplies provided by institutions, individuals, or other types of providers. Providers seeking payment from the Federal Government through programs such as CHAMPUS have a duty to familiarize themselves with, and comply with, the program requirements.

1. Listing of provider does not guarantee payment of benefits. The fact that a type of provider is listed in this chapter is not to be construed to mean that CHAMPUS will automatically pay a claim for services or supplies provided by such a provider. The provider who actually furnishes the service(s) must, in fact, meet all licensing and other requirements established by this Regulation to be an authorized provider; the provider must not be the subject of sanction under Chapter 9; and, cost-sharing of the services must not otherwise be prohibited by this Regulation. In addition, the patient must in fact be an eligible beneficiary and the services or supplies billed must be authorized and medically necessary, regardless of the standing of the provider.

2. Outside the United States or emergency situations within the United States. Outside the United States or within the United States and Puerto Rico in emergency situations, the Director, OCHAMPUS, or a designee, after review of the facts, may provide payment to or on behalf of a beneficiary who receives otherwise covered services or supplies from a provider of service that does not meet the standards described in this Regulation.

NOTE: Only the Secretary of Defense, the Secretary of Health and Human Services, or the Secretary of Transportation, or their designees, may authorize (in emergency situations) payment to civilian facilities in the United States that are not in compliance with title VI of the Civil Rights Act of 1964 (reference (z)). For the purpose of the Civil Rights Act only, the United States includes the 50 states, the District of Columbia, Puerto Rico, Virgin Islands, American Samoa, Guam, Wake Island, Canal Zone, and the territories and possessions of the United States.

3. Dual compensation/conflict of interest. Title 5, United States Code, section 5536 (reference (bb)) prohibits medical personnel who are active duty Uniformed Service members or civilian employees of the Government from receiving additional Government compensation above their normal pay and allowances for medical care furnished. In addition, Uniformed Service members and civilian employees of the Government are generally prohibited by law and agency regulations and policies from participating in apparent or actual conflict of interest situations in which a potential for personal gain exists or in

which there is an appearance of impropriety or incompatibility with the performance of their official duties or responsibilities. The Departments of Defense, Health and Human Services, and Transportation have a responsibility, when disbursing appropriated funds in the payment of CHAMPUS benefits, to ensure that the laws and regulations are not violated. Therefore, active duty Uniformed Service members (including a reserve member while on active duty) and civilian employees of the United States Government shall not be authorized to be CHAMPUS providers. While individual employees of the Government may be able to demonstrate that the furnishing of care to CHAMPUS beneficiaries may not be incompatible with their official duties and responsibilities, the processing of millions of CHAMPUS claims each year does not enable Program administrators to efficiently review the status of the provider on each claim to ensure that no conflict of interest or dual compensation situation exists. The problem is further complicated given the numerous interagency agreements (for example, resource sharing arrangements between the Department of Defense and the Veterans Administration in the provision of health care) and other unique arrangements which exist at individual treatment facilities around the country. While an individual provider may be prevented from being an authorized CHAMPUS provider even though no conflict of interest or dual compensation situation exists, it is essential for CHAMPUS to have an easily administered, uniform rule which will ensure compliance with the existing laws and regulations. Therefore, a provider who is an active duty Uniformed Service member or civilian employee of the Government shall not be an authorized CHAMPUS provider. In addition, a provider shall certify on each CHAMPUS claim that he/she is not an active duty Uniformed Service member or civilian employee of the Government.

4. For-profit institutions excluded under the Program for the Handicapped (PFTH). 10 U.S.C. 1079(d)(4) (reference (a)) precludes payment of benefits under the PFTH for otherwise covered services and supplies provided by a for-profit institution (refer to Chapter 5 of this Regulation).

5. Utilization review and quality assurance. Providers approved as authorized CHAMPUS providers have certain obligations to provide services and supplies under CHAMPUS which are (i) furnished at the appropriate level and only when and to the extent medically necessary under the criteria of this Regulation; (ii) of a quality that meets professionally recognized standards of health care; and, (iii) supported by adequate medical documentation as may be reasonably required under this Regulation by the Director, OCHAMPUS, or a designee, to evidence the medical necessity and quality of services furnished, as well as the appropriateness of the level of care. Therefore, the authorization of CHAMPUS benefits is contingent upon the services and supplies furnished by any provider being subject to pre-payment or post-payment utilization and quality assurance review under professionally recognized standards, norms, and criteria, as well as any standards or criteria issued by the Director, OCHAMPUS, or a designee, pursuant to this Regulation. (Refer to Chapters 4, 5, and 7 of this Regulation.)

6. Exclusion of beneficiary liability. In connection with certain utilization review, quality assurance and preauthorization requirements of Chapter 4, providers may not hold patients liable for payment for certain services for which CHAMPUS payment is disallowed. With respect to such

services, providers may not seek payment from the patient or the patient's family. Any such effort to seek payment is a basis for termination of the provider's authorized status.

7. Provider required. In order to be considered for benefits, all services and supplies shall be rendered by, prescribed by, or furnished at the direction of, or on the order of a CHAMPUS-authorized provider practicing within the scope of his or her license.

8. Participating providers.

a. In general. A Participating Provider is an individual or institutional provider that has agreed to accept the CHAMPUS-determined allowable amount as payment in full for the medical services and supplies provided to the CHAMPUS beneficiary, and has agreed to accept the amount paid by CHAMPUS or the CHAMPUS payment combined with the cost-sharing and deductible amounts paid by, or on behalf of, the beneficiary as full payment for the covered medical services or supplies. In addition, Participating Providers submit the appropriate claims forms to the appropriate CHAMPUS contractor on behalf of the beneficiary. There are several circumstances under which providers are Participating Providers.

b. Mandatory participation Medicare-participating hospitals are required by law to be Participating Providers on all inpatient claims under CHAMPUS. Hospitals that are not Medicare-participating providers but are subject to the CHAMPUS DRG-based payment system or the CHAMPUS mental health payment system (see Chapter 14.A.), must sign agreements to participate on all CHAMPUS inpatient claims in order to be authorized providers under CHAMPUS.

c. Participating Provider Program.

(1) In general. An institutional provider not required to participate pursuant to paragraph A.8.b, of this chapter and any individual provider may become a Participating Provider by signing a Participating Provider agreement. In such an agreement, the provider agrees that all CHAMPUS claims filed during the time period covered by the agreement will be on a participating basis.

(2) Agreement required. Under the Participating Provider Program, the provider must sign an agreement or memorandum of understanding under which the provider agrees to become a Participating Provider. Such an agreement may be with the nearby military treatment facility, a CHAMPUS contractor, or other authorized official. Such an agreement may include other provisions pertaining to the Participating Provider Program. The Director, OCHAMPUS shall establish a standard model agreement and other procedures to promote uniformity in the administration of the Participating Provider Program.

(3) Relationship to other activities. Participating Provider agreements may include other provisions, such as provisions regarding discounts (see Chapter 14.1) or other provisions in connection with the delivery and financing of health care services, as authorized by this chapter or other DoD Directives or Instructions. Participating Provider agreement provisions may also be incorporated into other types of agreements, such as preferred provider

arrangements where such arrangements are established under CHAMPUS.

d. Claim-by-claim-participation. Institutional and individual providers that are not participating providers pursuant to paragraphs A.8.b., or c., of this chapter, may elect to participate on a claim-by-claim basis. They may do so by signing the appropriate space on the claims form and submitting it to the appropriate CHAMPUS contractor on behalf of the beneficiary.

9. Limitation to authorized institutional provider designation. Authorized institutional provider status granted to a specific institutional provider applicant does not extend to any institution-affiliated provider, as defined in Chapter 2 of this Regulation, of that specific applicant.

10. Authorized provider. A hospital or institutional provider, physician, or other individual professional provider, or other provider of services or supplies specifically authorized in this chapter to provide benefits under CHAMPUS. In addition, to be an authorized CHAMPUS provider, any hospital which is a CHAMPUS participating provider under Section A.7. of this chapter, shall be a participating provider for all care, services, or supplies furnished to an active duty member of the uniformed services for which the active duty member is entitled under title 10, United States Code, section 1074(c). As a participating provider for active duty members, the CHAMPUS authorized hospital shall provide such care, services, and supplies in accordance with the payment rules of Chapter 16. The failure of any CHAMPUS participating hospital to be a participating provider for any active duty member subjects the hospital to termination of the hospital's status as a CHAMPUS authorized provider for failure to meet the qualifications established by this chapter.

11. Submittal of claims by provider required.

a. General rule. Unless waived pursuant to paragraph A.11.b., of this chapter, every CHAMPUS-authorized institutional and individual provider is required to submit CHAMPUS claims to the appropriate CHAMPUS contractor on behalf of the beneficiary for all services and supplies. In addition, the provider may not impose any charge relating to completing and submitting the applicable claim form (or any other related information). (Although CHAMPUS encourages provider participation, this paragraph A.11., requires only the submission of claim forms by providers on behalf of beneficiaries; it does not require that providers accept assignment of beneficiaries' claims or become participating providers.)

b. Waiver of claims submission requirement. The requirement that providers submit claims on behalf of beneficiaries may be waived in circumstances set forth in this paragraph A.11.b. A decision by the Director, OCHAMPUS to waive or not to waive the requirement in any particular circumstance is not subject to the appeal and hearing procedures of Chapter 10 of this regulation.

(1) General requirement for waiver. The requirement that providers submit claims on behalf of beneficiaries may be waived by the Director, OCHAMPUS when the Director determines that the waiver is necessary in order to ensure adequate access for CHAMPUS beneficiaries to health care services. However, the requirement may not be waived for Participating Providers (see paragraph A.8., of this chapter).

(2) Blanket waiver for provider outside the United States. The requirement that providers submit claims is waived with respect to providers outside the United States (the United States includes Puerto Rico for this purpose).

(3) Blanket waiver in double coverage cases. The requirement that providers submit claims is waived in cases in which another insurance plan or program provides primary coverage for the services.

(4) Waivers for particular categories of care. The Director, OCHAMPUS may waive the requirement that providers submit claims if the Director determines that available evidence clearly shows that the requirement would impair adequate access. For this purpose, such evidence may include consideration of the number of providers in the locality who provide the affected services, the number of such providers who are CHAMPUS Participating Providers, the number of CHAMPUS beneficiaries in the area, and other relevant factors. Providers or beneficiaries in a locality may submit to the Director, OCHAMPUS a petition, together with appropriate documentation regarding relevant factors, for a determination that adequate access would be impaired. The Director, OCHAMPUS will consider and respond to all such petitions. The Director, OCHAMPUS may establish procedures for handling such petitions.

(5) Case-by-case waivers. On a case-by-case basis, the Director, OCHAMPUS may waive the provider's obligation to submit that claim if the Director determines that a waiver in that case is necessary in order to ensure adequate access for CHAMPUS beneficiaries to the health care services involved. Such case-by-case waivers may be requested by providers or beneficiaries pursuant to procedures established by the Director.

c. Remedies for noncompliance.

(1) In any case in which a provider fails to submit a claim, or charges an administrative fee for filing a claim (or any other related information), in violation of the requirements of this paragraph A.11., the amount that would otherwise be allowable for the claim shall be reduced by ten percent, unless the reduction is waived by the Director, OCHAMPUS based on special circumstances. The amount disallowed by such a reduction may not be billed to the patient (or the patient's sponsor or family).

(2) Repeated failures by a provider to comply with the requirements of this paragraph A.11., shall be considered abuse and/or fraud and grounds for exclusion or suspension of the provider under Chapter 9., of this regulation.

12. Balance billing limits.

a. In general. Individual providers who are not participation providers may not balance bill a beneficiary an amount which exceeds the applicable billing limit. The balance billing limit shall be the same percentage as the Medicare limiting charge percentage for nonparticipating physicians.

b. Waiver. The balance billing limit may be waived by the Director, OCHAMPUS on a case-by-case basis if requested by a CHAMPUS beneficiary. A decision by the Director, OCHAMPUS to waive or not to waive the limit in any particular case is not subject to the appeal and hearing procedures in Chapter 10., of this regulation.

c. Compliance. Failure to comply with the balance billing limit shall be considered abuse and/or fraud and grounds for exclusion or suspension of the provider under Chapter 9., of this regulation.

B. INSTITUTIONAL PROVIDERS

1. General. Institutional providers are those providers who bill for services in the name of an organizational entity (such as hospital and skilled nursing facility), rather than in the name of a person. The term "institutional provider" does not include professional corporations or associations qualifying as a domestic corporation under section 301.7701-5 of the Internal Revenue Service Regulations (reference (cc)), nor does it include other corporations that provide principally professional services. Institutional providers may provide medical services and supplies on either an inpatient or outpatient basis.

a. Preauthorization. Preauthorization may be required by the Director, OCHAMPUS for any health care service for which payment is sought under CHAMPUS. (See Chapters 4 and 15 for further information on preauthorization requirements.)

b. Billing practices.

(1) Each institutional billing, including those institutions subject to the CHAMPUS DRG-based reimbursement method or a CHAMPUS-determined all-inclusive rate reimbursement method, must be itemized fully and sufficiently descriptive for the CHAMPUS to make a determination of benefits.

(2) Institutional claims subject to the CHAMPUS DRG-based reimbursement method or a CHAMPUS-determined all-inclusive rate reimbursement method, may be submitted only after the beneficiary has been discharged or transferred from the institutional provider's facility or program.

(3) Institutional claims for Residential Treatment Centers and all other institutional providers, except those listed in subparagraph (2) above, should be submitted to the appropriate CHAMPUS fiscal intermediary at least every 30 days.

c. Medical records. Institutional providers must provide adequate contemporaneous clinical records to substantiate that specific care was actually furnished, was medically necessary, and appropriate, and to identify the individual(s) who provided the care. The minimum requirements for medical record documentation are set forth by the following:

(1) The cognizant state licensing authority;

(2) The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or other health care accreditation organizations as may be appropriate;

(3) Standards of practice established by national medical organizations; and

(4) This Regulation.

2. Nondiscrimination policy. Except as provided below, payment may not be made for inpatient or outpatient care provided and billed by an institutional provider found by the Federal Government to practice discrimination in the admission of patients to its services on the basis of race, color, or national origin. Reimbursement may not be made to a beneficiary who pays for care provided by such a facility and submits a claim for reimbursement. In the following circumstances, the Secretary of Defense, or a designee, may authorize payment for care obtained in an ineligible facility:

a. Emergency care. Emergency inpatient or outpatient care.

b. Care rendered before finding of a violation. Care initiated before a finding of a violation and which continues after such violation when it is determined that a change in the treatment facility would be detrimental to the health of the patient, and the attending physician so certifies.

c. Other facility not available. Care provided in an ineligible facility because an eligible facility is not available within a reasonable distance.

3. Procedures for qualifying as a CHAMPUS-approved institutional provider. General and special hospitals otherwise meeting the qualifications outlined in paragraphs B.4.a., b., and c., of this chapter are not required to request CHAMPUS approval formally.

a. JCAHO accreditation status. Each CHAMPUS fiscal intermediary shall keep informed as to the current JCAHO accreditation status of all hospitals and skilled nursing facilities in its area; and the provider's status under Medicare, particularly with regard to compliance with title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d(1)). The Director, OCHAMPUS, or a designee, shall specifically approve all other authorized institutional providers providing services to CHAMPUS beneficiaries. At the discretion of the Director, OCHAMPUS, any facility that is certified and participating as a provider of services under title XVIII of the Social Security Act (Medicare), may be deemed to meet CHAMPUS requirements. The facility must be providing a type and level of service that is authorized by this Regulation.

b. Required to comply with criteria. Facilities seeking CHAMPUS approval will be expected to comply with appropriate criteria set forth in subsection B.4. of this chapter. An onsite evaluation, either scheduled or unscheduled, may be conducted at the discretion of the Director, OCHAMPUS, or a designee. The final determination regarding approval, reapproval, or disapproval of a facility will be provided in writing to the facility and the appropriate CHAMPUS fiscal intermediary.

c. Notice of peer review rights. All health care facilities subject to the DRG-based payment system shall provide CHAMPUS beneficiaries, upon admission, with information about peer review including their appeal rights. The notices shall be in a form specified by the Director, OCHAMPUS.

d. Surveying of facilities. The surveying of newly established institutional providers and the periodic resurveying of all authorized institutional providers is a continuing process conducted by OCHAMPUS.

e. Institutions not in compliance with CHAMPUS standards. If a determination is made that an institution is not in compliance with one or more of the standards applicable to its specific category of institution, OCHAMPUS shall take immediate steps to bring about compliance or terminate the approval as an authorized institution in accordance with Chapter 9.F.2.

f. Participation agreements required for some hospitals which are not Medicare-participating. Notwithstanding the provisions of this paragraph B.3., a hospital which is subject to the CHAMPUS DRG-based payment system but which is not a Medicare-participating hospital must request and sign an agreement with OCHAMPUS. By signing the agreement, the hospital agrees to participate on all CHAMPUS inpatient claims and accept the requirements for a participating provider as contained in subsection A.7. of this chapter. Failure to sign such an agreement shall disqualify such hospital as a CHAMPUS-approved institutional provider.

4. Categories of institutional providers. The following categories of institutional providers may be reimbursed by CHAMPUS for services provided CHAMPUS beneficiaries subject to any and all definitions, conditions, limitations, and exclusions specified or enumerated in this Regulation.

a. Hospitals, acute care, general and special. An institution that provides inpatient services, that also may provide outpatient services (including clinical and ambulatory surgical services), and that:

(1) Is engaged primarily in providing to inpatients, by or under the supervision of physicians, diagnostic and therapeutic services for the medical or surgical diagnosis and treatment of illness, injury, or bodily malfunction (including maternity).

(2) Maintains clinical records on all inpatients (and outpatients if the facility operates an outpatient department or emergency room).

(3) Has bylaws in effect with respect to its operations and medical staff.

(4) Has a requirement that every patient be under the care of a physician.

(5) Provides 24-hour nursing service rendered or supervised by a registered professional nurse, and has a licensed practical nurse or registered professional nurse on duty at all times.

(6) Has in effect a hospital utilization review plan that is operational and functioning.

(7) In the case of an institution in a state in which state or applicable local law provides for the licensing of hospitals, the hospital:

(a) Is licensed pursuant to such law, or

(b) Is approved by the agency of such state or locality responsible for licensing hospitals as meeting the standards established for such licensing.

(8) Has in effect an operating plan and budget.

(9) Is accredited by the JCAHO or meets such other requirements as the Secretary of Health and Human Services or the Secretary of Defense finds necessary in the interest of the health and safety of patients who are admitted to and furnished services in the institution.

b. Liver transplantation centers.

(1) CHAMPUS shall provide coverage for liver transplantation procedures performed only by experienced transplant surgeons at centers complying with the provisions outlined in paragraph B.4.a. of this section and meeting the following criteria:

(a) The center is a tertiary care facility affiliated with an academic health center. The center must have accredited programs in graduate medical education related to the function of liver transplantation such as internal medicine, pediatrics, surgery, and anesthesiology;

(b) The center has an active solid organ transplantation program (involving liver transplants as well as other organs);

(c) The transplantation center must have at least a 50 percent one-year survival rate for ten cases. At the time CHAMPUS approval is requested, the transplant center must provide evidence that at least ten liver transplants have been performed at the center and that at least 50 percent of those transplanted patients have survived one year following surgery. A 50 percent one-year survival rate for all subsequent liver transplantations must be maintained for continued CHAMPUS approval;

(d) The center has allocated sufficient operating room, recovery room, laboratory, and blood bank support and a sufficient number of intensive care and general surgical beds and specialized staff for these areas;

(e) The center participates in a donor procurement program and network;

(f) The center systematically collects and shares data on its transplant program;

(g) The center has an interdisciplinary body to determine the suitability of candidates for transplantation on an equitable basis;

(h) The transplantation surgeon is specifically trained for liver grafting and must assemble and train a team to function whenever a donor liver is available;

(i) The transplantation center must have on staff board eligible or board certified physicians and other experts in the field of hepatology, pediatrics, infectious disease, nephrology with dialysis capability, pulmonary medicine with respiratory therapy support, pathology, immunology, and anesthesiology to complement a qualified transplantation team;

(j) The transplantation center has the assistance of appropriate microbiology, clinical chemistry, and radiology support;

(k) The transplantation center has blood bank support to accommodate normal demands and the transplant procedure; and

(l) The transplantation center includes the availability of psychiatric and social services support for patients and family.

(2) In order to receive approval as a CHAMPUS authorized liver transplant center, a center must submit a request to the Director, OCHAMPUS, or a designee. The CHAMPUS authorized liver transplant center shall agree to the following:

(a) Bill for all services and supplies related to the liver transplantation performed by its staff and bill also for services rendered by the donor hospital following declaration of brain death and after all existing legal requirements for excision of the donor organ have been met; and

(b) The center shall agree to submit all charges on the basis of fully itemized bills. This means that each service and supply and the charge for each is individually identified.

c. Heart transplantation centers.

(1) CHAMPUS shall provide coverage for heart transplantation procedures performed only by experienced transplant surgeons at centers complying with provisions outlined in paragraph B.4.a. of this section and meeting the following criteria:

(a) The center has experts in the fields of cardiology, cardiovascular surgery, anesthesiology, immunology, infectious disease, nursing, social services and organ procurement to complement the transplant team;

(b) The center has an active cardiovascular medical and surgical program as evidenced by a minimum of 500 cardiac catheterizations and coronary arteriograms and 250 open heart procedures per year;

(c) The center has an anesthesia team that is available at all times;

(d) The center has infectious disease services with both the professional skills and the laboratory resources that are needed to discover, identify, and manage a whole range of organisms;

(e) The center has a nursing service team trained in the hemodynamic support of the patient and in managing immunosuppressed patients;

(f) The center has pathology resources that are available for studying and reporting the pathological responses of transplantation;

(g) The center has legal counsel familiar with transplantation laws and regulations;

(h) The commitment of the transplant center must be at all levels and broadly evident throughout the facility;

(i) Responsible team members must be board certified or board eligible in their respective disciplines;

(j) Component teams must be integrated into a comprehensive transplant team with clearly defined leadership and responsibility;

(k) The center has adequate social service resources;

(l) The transplant center must comply with applicable State transplant laws and regulations;

(m) The transplant center must safeguard the rights and privacy of patients;

- (n) The transplant center must have adequate patient management plans and protocols;
 - (o) The center participates in a donor procurement program and network;
 - (p) The center systematically collects and shares data on its transplant program;
 - (q) The center has an interdisciplinary body to determine the suitability of candidates for transplantation on an equitable basis;
 - (r) The center has extensive blood bank support;
 - (s) The center must have an established heart transplantation program with documented evidence of 12 or more heart transplants in each of the two consecutive preceding 12-month periods prior to application and 12 heart transplants prior to that; and
 - (t) The center must demonstrate actuarial survival rates of 73 percent for one year and 65 percent for two years for patients who have had heart transplants since January 1, 1982, at that facility.
- (2) CHAMPUS approval will lapse if either the number of heart transplants falls below 8 in 12 months or if the one-year survival rate falls below 60 percent for a consecutive 24-month period.
- (3) CHAMPUS-approval may also be extended for a heart transplant center that meets other certification or accreditation standards provided the standards are equivalent to or exceed the criteria listed above and have been approved by the Director, OCHAMPUS.
- (4) In order to receive approval as a CHAMPUS heart transplant center, a facility must submit a request to the Director, OCHAMPUS, or a designee. The CHAMPUS-authorized heart transplant center shall agree to the following:
- (a) Bill for all services and supplies related to the heart transplantation performed by its staff and bill also for services rendered by the donor hospital following declaration of brain death;
 - (b) Submit all charges on the basis of fully itemized bills. Each service and supply must be individually identified and the first claim submitted for the heart transplantation must include a copy of the admission history and physical examination; and
 - (c) Report any significant decrease in the experience level or survival rates and loss of key members of the transplant team to the Director, OCHAMPUS.

d. Hospitals, psychiatric. A psychiatric hospital is an institution which is engaged primarily in providing services to inpatients for the diagnosis and treatment of mental disorders.

(1) There are two major categories of psychiatric hospitals:

(a) The private psychiatric hospital category includes both proprietary and the not-for-profit nongovernmental institutions.

(b) The second category is those psychiatric hospitals that are controlled, financed, and operated by departments or agencies of the local, state, or Federal Government and always are operated on a not-for-profit basis.

(2) In order for the services of a psychiatric hospital to be covered, the hospital shall comply with the provisions outlined in paragraph B.4.a. of this chapter. All psychiatric hospitals shall be accredited under the JCAHO Accreditation Manual for Hospitals (AMH) standards in order for their services to be cost-shared under CHAMPUS. In the case of those psychiatric hospitals that are not JCAHO-accredited because they have not been in operation a sufficient period of time to be eligible to request an accreditation survey by the JCAHO, the Director, OCHAMPUS, or a designee, may grant temporary approval if the hospital is certified and participating under Title XVIII of the Social Security Act (Medicare, Part A). This temporary approval expires 12 months from the date on which the psychiatric hospital first becomes eligible to request an accreditation survey by the JCAHO.

(3) Factors to be considered in determining whether CHAMPUS will cost-share care provided in a psychiatric hospital include, but are not limited to, the following considerations:

(a) Is the prognosis of the patient such that care provided will lead to resolution or remission of the mental illness to the degree that the patient is of no danger to others, can perform routine daily activities, and can be expected to function reasonably outside the inpatient setting?

(b) Can the services being provided be provided more economically in another facility or on an outpatient basis?

(c) Are the charges reasonable?

(d) Is the care primarily custodial or domiciliary?
(Custodial or domiciliary care of the permanently mentally ill or retarded is not a benefit under the Basic Program.)

(4) Although psychiatric hospitals are accredited under JCAHO AMH standards, their medical records must be maintained in accordance with the JCAHO Consolidated Standard Manual for Child, Adolescent, and Adult Psychiatric, Alcoholism, and Drug Abuse Facilities and Facilities Serving the Mentally Retarded, along with the requirements set forth in Section 199.7(b)(3). The hospital is responsible for assuring that patient services and all treatment are accurately documented and completed in a timely manner.

e. Hospitals, long-term (tuberculosis, chronic care, or rehabilitation).

To be considered a long-term hospital, an institution for patients that have tuberculosis or chronic diseases must be an institution (or distinct part of an institution) primarily engaged in providing by or under the supervision of a physician appropriate medical or surgical services for the diagnosis and active treatment of the illness or condition in which the institution specializes.

(1) In order for the service of long-term hospitals to be covered, the hospital must comply with the provisions outlined in paragraph B.4.a. of this chapter. In addition, in order for services provided by such hospitals to be coverable by CHAMPUS, they must be primarily for the treatment of the presenting illness.

(2) Custodial or domiciliary care is not coverable under CHAMPUS, even if rendered in an otherwise authorized long-term hospital.

(3) The controlling factor in determining whether a beneficiary's stay in a long-term hospital is coverable by CHAMPUS is the level of professional care, supervision, and skilled nursing care that the beneficiary requires, in addition to the diagnosis, type of condition, or degree of functional limitations. The type and level of medical services required or rendered is controlling for purposes of extending CHAMPUS benefits; not the type of provider or condition of the beneficiary.

f. Skilled nursing facility. A skilled nursing facility is an institution (or a distinct part of an institution) that is engaged primarily in providing to inpatients medically necessary skilled nursing care, which is other than a nursing home or intermediate facility, and which:

(1) Has policies that are developed with the advice of (and with provisions for review on a periodic basis by) a group of professionals, including one or more physicians and one or more registered nurses, to govern the skilled nursing care and related medical services it provides.

(2) Has a physician, a registered nurse, or a medical staff responsible for the execution of such policies.

(3) Has a requirement that the medical care of each patient must be under the supervision of a physician, and provides for having a physician available to furnish necessary medical care in case of an emergency.

(4) Maintains clinical records on all patients.

(5) Provides 24-hour skilled nursing service that is sufficient to meet nursing needs in accordance with the policies developed as provided in subparagraph B.4.f.(1), above, and has at least one registered professional nurse employed full-time.

(6) Provides appropriate methods and procedures for the dispensing and administering of drugs and biologicals.

(7) Has in effect a utilization review plan that is operational and functioning.

(8) In the case of an institution in a state in which state or applicable local law provides for the licensing of this type facility, the institution:

(a) Is licensed pursuant to such law, or

(b) Is approved by the agency of such state or locality responsible for licensing such institutions as meeting the standards established for such licensing.

(9) Has in effect an operating plan and budget.

(10) Meets such provisions of the most current edition of the Life Safety Code (reference (dd)) as are applicable to nursing facilities; except that if the Secretary of Health and Human Services has waived, for such periods, as deemed appropriate, specific provisions of such code which, if rigidly applied, would result in unreasonable hardship upon a nursing facility.

g. Residential treatment centers. This paragraph B.4.g. establishes standards and requirements for residential treatment centers (RTCs).

(1) Organization and administration.

(a) Definition. A Residential Treatment Center (RTC) is a facility or a distinct part of a facility that provides to beneficiaries under 21 years of age a medically supervised, interdisciplinary program of mental health treatment. An RTC is appropriate for patients whose predominant symptom presentation is essentially stabilized, although not resolved, and who have persistent dysfunction in major life areas. The extent and pervasiveness of the patient's problems require a protected and highly structured therapeutic environment. Residential treatment is differentiated from:

1 Acute psychiatric care, which requires medical treatment and 24-hour availability of a full range of diagnostic and therapeutic services to establish and implement an effective plan of care which will reverse life-threatening and/or severely incapacitating symptoms;

2 Partial hospitalization, which provides a less than 24-hour-per-day, seven-day-per-week treatment program for patients who continue to exhibit psychiatric problems but can function with support in some of the major life areas;

3 A group home, which is a professionally directed living arrangement with the availability of psychiatric consultation and treatment for patients with significant family dysfunction and/or chronic but stable psychiatric disturbances;

4 Therapeutic school, which is an educational program supplemented by psychological and psychiatric services;

5 Facilities that treat patients with a primary diagnosis of chemical abuse or dependence; and

6 Facilities providing care for patients with a primary diagnosis of mental retardation or developmental disability.

(b) Eligibility.

1 Every RTC must be certified pursuant to CHAMPUS certification standards. Such standards shall incorporate the basic standards set forth in paragraphs B.4.g.(1) through (4) of this chapter, and shall include such additional elaborative criteria and standards as the Director, OCHAMPUS determines are necessary to implement the basic standards.

2 To be eligible for CHAMPUS certification, the facility is required to be licensed and fully operational for six months (with a minimum average daily census of 30 percent of total bed capacity) and operate in substantial compliance with state and federal regulations.

3 The facility is currently accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) under the current edition of the Manual for Mental Health, Chemical Dependency, and Mental Retardation/Developmental Disabilities Services which is available from JCAHO, P.O. Box 75751, Chicago, IL 60675.

4 The facility has a written participation agreement with OCHAMPUS. The RTC is not a CHAMPUS-authorized provider and CHAMPUS benefits are not paid for services provided until the date upon which a participation agreement is signed by the Director, OCHAMPUS.

(c) Governing body.

1 The RTC shall have a governing body which is responsible for the policies, bylaws, and activities of the facility. If the RTC is owned by a partnership or single owner, the partners or single owner are regarded as the governing body. The facility will provide an up-to-date list of names, addresses, telephone numbers and titles of the members of the governing body.

2 The governing body ensures appropriate and adequate services for all patients and oversees continuing development and improvement of care. Where business relationships exist between the governing body and facility, appropriate conflict-of-interest policies are in place.

3 Board members are fully informed about facility services and the governing body conducts annual review of its performance in meeting purposes, responsibilities, goals and objectives.

(d) Chief executive officer. The chief executive officer, appointed by and subject to the direction of the governing body, shall assume overall administrative responsibility for the operation of the facility according to governing body policies. The chief executive officer shall have five years' administrative experience in the field of mental health. Beginning October 1, 1997, the CEO shall possess a degree in business administration, public health, hospital administration, nursing, social work, or psychology, or meet similar educational requirements as prescribed by the Director, OCHAMPUS.

(e) Clinical Director. The clinical director, appointed by the governing body, shall be a psychiatrist or doctoral level psychologist who meets applicable CHAMPUS requirements for individual professional providers and is licensed to practice in the state where the residential treatment center is located. The clinical director shall possess requisite education and experience, credentials applicable under state practice and licensing laws appropriate to the professional discipline, and a minimum of five years' clinical experience in the treatment of children and adolescents. The clinical director shall be responsible for planning, development, implementation, and monitoring of all clinical activities.

(f) Medical director. The medical director, appointed by the governing body, shall be licensed to practice medicine in the state where the residential treatment center is located and shall possess requisite education and experience, including graduation from an accredited school of medicine or osteopathy, an approved residency in psychiatry and a minimum of five years clinical experience in the treatment of children and adolescents. The Medical Director shall be responsible for the planning, development, implementation, and monitoring of all activities relating to medical treatment of patients. If qualified, the Medical Director may also serve as Clinical Director.

(g) Medical or professional staff organization. The governing body shall establish a medical or professional staff organization to assure effective implementation of clinical privileging, professional conduct rules, and other activities directly affecting patient care.

(h) Personnel policies and records. The RTC shall maintain written personnel policies, updated job descriptions and personnel records to assure the selection of qualified personnel and successful job performance of those personnel.

(i) Staff development. The facility shall provide appropriate training and development programs for administrative, professional support, and direct care staff.

(j) Fiscal accountability. The RTC shall assure fiscal accountability to applicable government authorities and patients.

(k) Designated teaching facilities. Students, residents, interns or fellows providing direct clinical care are under the supervision of a qualified staff member approved by an accredited university. The teaching program is approved by the Director, OCHAMPUS.

(1) Emergency reports and records. The facility notifies OCHAMPUS of any serious occurrence involving CHAMPUS beneficiaries.

(2) Treatment services.

(a) Staff composition.

1 The RTC shall follow written plans which assure that medical and clinical patient needs will be appropriately addressed 24 hours a day, seven days a week by a sufficient number of fully qualified (including license, registration or certification requirements, educational attainment, and professional experience) health care professionals and support staff in the respective disciplines. Clinicians providing individual, group, and family therapy meet CHAMPUS requirements as qualified mental health providers and operate within the scope of their licenses. The ultimate authority for planning, development, implementation, and monitoring of all clinical activities is vested in a psychiatrist or doctoral level psychologist. The management of medical care is vested in a physician.

2 The RTC shall ensure adequate coverage by fully qualified staff during all hours of operation, including physician availability, other professional staff coverage, and support staff in the respective disciplines.

(b) Staff qualifications. The RTC will have a sufficient number of qualified mental health providers, administrative, and support staff to address patients' clinical needs and to coordinate the services provided. RTCs which employ individuals with master's or doctoral level degrees in a mental health discipline who do not meet the licensure, certification and experience requirements for a qualified mental health provider but are actively working toward licensure or certification, may provide services within the all-inclusive per diem rate, provided the individual works under the clinical supervision of a fully qualified mental health provider employed by the RTC. All other program services shall be provided by trained, licensed staff.

(c) Patient rights.

1 The RTC shall provide adequate protection for all patient rights, including rights provided by law, privacy, personnel rights, safety, confidentiality, informed consent, grievances, and personal dignity.

2 The facility has a written policy regarding patient abuse and neglect.

3 Facility marketing and advertising meets professional standards.

(d) Behavioral management. The RTC shall adhere to a comprehensive, written plan of behavioral management, developed by the clinical director and the medical or professional staff and approved by the governing body, including strictly limited procedures to assure that the restraint or seclusion are used only in extraordinary circumstances, are carefully monitored, and are fully documented. Only trained and clinically privileged RNs or qualified mental health professionals may be responsible for the implementation of seclusion and restraint procedures in an emergency situation.

(e) Admission process. The RTC shall maintain written policies and procedures to ensure that, prior to an admission, a determination is made, and approved pursuant to CHAMPUS preauthorization requirements, that the admission is medically and/or psychologically necessary and the program is appropriate to meet the patient's needs. Medical and/or psychological necessity determinations shall be rendered by qualified mental health professionals who meet CHAMPUS requirements for individual professional providers and who are permitted by law and by the facility to refer patients for admission.

(f) Assessments. The professional staff of the RTC shall complete a current multidisciplinary assessment which includes, but is not limited to physical, psychological, developmental, family, educational, social, spiritual and skills assessment of each patient admitted. Unless otherwise specified, all required clinical assessments are completed prior to development of the multidisciplinary treatment plan.

(g) Clinical formulation. A qualified mental health professional of the RTC will complete a clinical formulation on all patients. The clinical formulation will be reviewed and approved by the responsible individual professional provider and will incorporate significant findings from each of the multidisciplinary assessments. It will provide the basis for development of an interdisciplinary treatment plan.

(h) Treatment planning. A qualified mental health professional shall be responsible for the development, supervision, implementation, and assessment of a written, individualized, interdisciplinary plan of treatment, which shall be completed within 10 days of admission and shall include individual, measurable, and observable goals for incremental progress and discharge. A preliminary treatment plan is completed within 24 hours of admission and includes at least an admission note and orders written by the admitting mental health professional. The master treatment plan is reviewed and revised at least every 30 days, or when major changes occur in treatment.

(i) Discharge and transition planning. The RTC shall maintain a transition planning process to address adequately the anticipated needs of the patient prior to the time of discharge. The planning involves determining necessary modifications in the treatment plan, facilitating the termination of treatment, and identifying resources to maintain therapeutic stability following discharge.

(j) Clinical documentation. Clinical records shall be maintained on each patient to plan care and treatment and provide ongoing evaluation of the patient's progress. All care is documented and each clinical record contains at least the following: demographic data, consent forms, pertinent legal documents, all treatment plans and patient assessments, consultation and laboratory reports, physician orders, progress notes, and a discharge summary. All documentation will adhere to applicable provisions of the JCAHO and requirements set forth in chapter 7, section B.3. of this regulation. An appropriately qualified records administrator or technician will supervise and maintain the quality of the records. These requirements are in addition to other records requirements of this Part, and documentation requirements of the Joint Commission on Accreditation of Healthcare Organizations.

(k) Progress notes. RTC's shall document the course of treatment for patients and families using progress notes which provide information to review, analyze, and modify the treatment plans. Progress notes are legible, contemporaneous, sequential, signed and dated and adhere to applicable provisions of the Manual for Mental Health, Chemical Dependency, and Mental Retardation/Developmental Disabilities Services and requirements set forth in chapter 7, section B.3. of this regulation.

(l) Therapeutic services.

1 Individual, group, and family psychotherapy are provided to all patients, consistent with each patient's treatment plan, by qualified mental health providers.

2 A range of therapeutic activities, directed and staffed by qualified personnel, are offered to help patients meet the goals of the treatment plan.

3 Therapeutic educational services are provided or arranged that are appropriate to the patients educational and therapeutic needs.

(m) Ancillary services. A full range of ancillary services is provided. Emergency services include policies and procedures for handling emergencies with qualified personnel and written agreements with each facility providing the service. Other ancillary services include physical health, pharmacy and dietary services.

(3) Standards for physical plant and environment.

(a) Physical environment. The buildings and grounds of the RTC shall be maintained so as to avoid health and safety hazards, be supportive of the services provided to patients, and promote patient comfort, dignity, privacy, personal hygiene, and personal safety.

(b) Physical plant safety. The RTC shall be of permanent construction and maintained in a manner that protects the lives and ensures the physical safety of patients, staff, and visitors, including conformity with all applicable building, fire, health, and safety codes.

(c) Disaster planning. The RTC shall maintain and rehearse written plans for taking care of casualties and handling other consequences arising from internal and external disasters.

(4) Standards for evaluation system.

(a) Quality assessment and improvement. The RTC shall develop and implement a comprehensive quality assurance and quality improvement program that monitors the quality, efficiency, appropriateness, and effectiveness of the care, treatments, and services it provides for patients and their families, primarily utilizing explicit clinical indicators to evaluate all functions of the RTC and contribute to an ongoing process of program improvement. The clinical director is responsible for developing and implementing quality assessment and improvement activities throughout the facility.

(b) Utilization review. The RTC shall implement a utilization review process, pursuant to a written plan approved by the professional staff, the administration, and the governing body, that assesses the appropriateness of admissions, continued stay, and timeliness of discharge as part of an effort to provide quality patient care in a cost-effective manner. Findings of the utilization review process are used as a basis for revising the plan of operation, including a review of staff qualifications and staff composition.

(c) Patient records review. The RTC shall implement a process, including monthly reviews of a representative sample of patient records, to determine the completeness and accuracy of the patient records and the timeliness and pertinence of record entries, particularly with regard to regular recording of progress/non-progress in treatment.

(d) Drug utilization review. The RTC shall implement a comprehensive process for the monitoring and evaluating of the prophylactic, therapeutic, and empiric use of drugs to assure that medications are provided appropriately, safely, and effectively.

(e) Risk management. The RTC shall implement a comprehensive risk management program, fully coordinated with other aspects of the quality assurance and quality improvement program, to prevent and control risks to patients and staff and costs associated with clinical aspects of patient care and safety.

(f) Infection control. The RTC shall implement a comprehensive system for the surveillance, prevention, control, and reporting of infections acquired or brought into the facility.

(g) Safety. The RTC shall implement an effective program to assure a safe environment for patients, staff, and visitors, including an incident report system, a continuous safety surveillance system, and an active multidisciplinary safety committee.

(h) Facility evaluation. The RTC annually evaluates accomplishment of the goals and objectives of each clinical program and service of the RTC and reports findings and recommendations to the governing body.

(5) Participation agreement requirements. In addition to other requirements set forth in paragraph B.4.g., of this chapter in order for the services of an RTC to be authorized, the RTC shall have entered into a Participation Agreement with OCHAMPUS. The period of a participation agreement shall be specified in the agreement, and will generally be for not more than five years. Participation agreements entered into prior to April 6, 1995, must be renewed not later than October 1, 1995. In addition to review of a facility's application and supporting documentation, an on-site inspection by OCHAMPUS authorized personnel may be required prior to signing a Participation Agreement. Retroactive approval is not given. In addition, the Participation Agreement shall include provisions that the RTC shall, at a minimum:

(a) Render residential treatment center inpatient services to eligible CHAMPUS beneficiaries in need of such services, in accordance with the participation agreement and CHAMPUS regulation;

(b) Accept payment for its services based upon the methodology provided in chapter 14, section F. or such other method as determined by the Director, OCHAMPUS;

(c) Accept the CHAMPUS all-inclusive per diem 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 chapter 4, and charges for services and supplies that are not a benefit of CHAMPUS;

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

(e) Comply with the provisions of chapter 8, and submit claims first to all health insurance coverage to which the beneficiary is entitled that is primary to CHAMPUS;

(f) Submit claims for services provided to CHAMPUS 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 RTC agrees not to bill the beneficiary or the beneficiary's family for any amounts disallowed by CHAMPUS;

(g) Certify that:

1 It is and will remain in compliance with the provisions of paragraph B.4.g. of this chapter establishing standards for Residential Treatment Centers;

2 It has conducted a self assessment of the facility's compliance with the CHAMPUS Standards for Residential Treatment Centers Serving Children and Adolescents with Mental Disorders, as issued by the Director, OCHAMPUS and notified the Director, OCHAMPUS of any matter regarding which the facility is not in compliance with such standards; and

3 It will maintain compliance with the CHAMPUS Standards for Residential Treatment Centers Serving Children and Adolescents with Mental Disorders, as issued by the Director, OCHAMPUS, except for any such standards regarding which the facility notifies the Director, OCHAMPUS that it is not in compliance.

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

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

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

(k) Grant the Director, OCHAMPUS, 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 includes, but is not limited to:

1 Examination of fiscal and all other records of the RTC which would confirm compliance with the participation agreement and designation as an authorized CHAMPUS RTC provider;

2 Conducting such audits of RTC 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;

3 Examining reports of evaluations and inspections conducted by federal, state and local government, and private agencies and organizations;

4 Conducting on-site inspections of the facilities of the RTC and interviewing employees, members of the staff, contractors, board members, volunteers, and patients, as required;

5 Audits conducted by the United States General Accounting Office.

(6) Other requirements applicable to RTCs.

(a) Even though an RTC may qualify as a CHAMPUS-authorized provider and may have entered into a participation agreement with CHAMPUS, payment by CHAMPUS for particular services provided is contingent upon the RTC also meeting all conditions set forth in chapter 4 especially all requirements of section B.4. of that chapter.

(b) The RTC shall provide inpatient services to CHAMPUS beneficiaries in the same manner it provides inpatient services to all other patients. The RTC 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.

(c) The RTC shall assure that all certifications and information provided to the Director, OCHAMPUS 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 status will be denied or terminated, and the RTC will be ineligible for consideration for authorized provider status for a twoyear period.

h. Christian Science sanatoriums. The services obtained in Christian Science sanatoriums are covered by CHAMPUS as inpatient care. To qualify for coverage, the sanatorium either must be operated by, or be listed and certified by the First Church of Christ, Scientist.

i. Infirmaries. Infirmaries are facilities operated by student health departments of colleges and universities to provide inpatient or outpatient care to enrolled students. Charges for care provided by such facilities will not be cost-shared by CHAMPUS if the student would not be charged in the absence of CHAMPUS, or if student is covered by a mandatory student health insurance plan, in which enrollment is required as a part of the student's school registration and the charges by the college or university include a premium for the student health insurance coverage. CHAMPUS will cost-share only if enrollment in the student health program or health insurance plan is voluntary.

NOTE: An infirmary in a boarding school also may qualify under this provision, subject to review and approval by the Director, OCHAMPUS, or a designee.

j. Other special institutional providers.

(1) General

(a) Care provided by certain special institutional providers (on either an inpatient or outpatient basis), may be cost-shared by CHAMPUS under specified circumstances and only if the provider is specifically identified in paragraph B.4.j of this Chapter.

1 The course of treatment is prescribed by a doctor of medicine or osteopathy.

2 The patient is under the supervision of a physician during the entire course of the inpatient admission or the outpatient treatment.

3 The type and level of care and service rendered by the institution are otherwise authorized by this Regulation.

4 The facility meets all licensing or other certification requirements that are extant in the jurisdiction in which the facility is located geographically.

5 Is other than a nursing home, intermediate care facility, home for the aged, halfway house, or other similar institution.

6 Is accredited by the JCAHO or other CHAMPUS-approved accreditation organization, if an appropriate accreditation program for the given type of facility is available. As future accreditation programs are developed to cover emerging specialized treatment programs, such accreditation will be a prerequisite to coverage by CHAMPUS for services provided by such facilities.

(b) To ensure that CHAMPUS beneficiaries are provided quality care at a reasonable cost when treated by a special institutional provider, the Director, OCHAMPUS, may:

1 Require prior approval of all admissions to special institutional providers.

2 Set appropriate standards for special institutional providers in addition to or in the absence of JCAHO accreditation.

3 Monitor facility operations and treatment programs on a continuing basis and conduct onsite inspections on a scheduled and unscheduled basis.

4 Negotiate agreements of participation.

5 Terminate approval of a case when it is ascertained that a departure from the facts upon which the admission was based originally has occurred.

6 Declare a special institutional provider not eligible for CHAMPUS payment if that facility has been found to have engaged in fraudulent or deceptive practices.

(c) In general, the following disclaimers apply to treatment by special institutional providers:

1 Just because one period or episode of treatment by a facility has been covered by CHAMPUS may not be construed to mean that later episodes of care by the same or similar facility will be covered automatically.

2 The fact that one case has been authorized for treatment by a specific facility or similar type of facility may not be construed to mean that similar cases or later periods of treatment will be extended CHAMPUS benefits automatically.

(2) Types of providers. The following is a list of facilities that have been designated specifically as special institutional providers.

(a) Free-standing ambulatory surgical centers. Care provided by freestanding ambulatory surgical centers may be cost-shared by CHAMPUS under the following circumstances:

1 The treatment is prescribed and supervised by a physician.

2 The type and level of care and services rendered by the center are otherwise authorized by this Regulation.

3 The center meets all licensing or other certification requirements of the jurisdiction in which the facility is located.

4 The center is accredited by the JCAHO, the Accreditation Association for Ambulatory Health Care, Inc. (AAAHC), or such other standards as authorized by the Director, OCHAMPUS.

5 A childbirth procedure provided by a CHAMPUS-approved free-standing ambulatory surgical center shall not be cost-shared by CHAMPUS unless the surgical center is also a CHAMPUS-approved birthing center institutional provider as established by the birthing center provider certification requirement of this Regulation.

(b) PFTH facilities. Special institutional providers also include facilities that seek approval to provide care authorized under the PFTH. (Refer to Chapter 5 of this Regulation.)

k. Birthing centers. A birthing center is a freestanding or institution-affiliated outpatient maternity care program which principally provides a planned course of outpatient prenatal care and outpatient childbirth service limited to low-risk pregnancies; excludes care for high-risk pregnancies; limits childbirth to the use of natural childbirth procedures; and provides immediate newborn care.

(1) Certification requirements. A birthing center which meets the following criteria may be designated as an authorized CHAMPUS institutional provider:

(a) The predominant type of service and level of care rendered by the center is otherwise authorized by this Regulation.

(b) The center is licensed to operate as a birthing center where such license is available, or is specifically licensed as a type of ambulatory health care facility where birthing center specific license is not available, and meets all applicable licensing or certification requirements that are extant in the state, county, municipality, or other political jurisdiction in which the center is located.

(c) The center is accredited by a nationally recognized accreditation organization whose standards and procedures have been determined to be acceptable by the Director, OCHAMPUS, or a designee.

(d) The center complies with the CHAMPUS birthing center standards set forth in this Chapter.

(e) The center has entered into a participation agreement with OCHAMPUS in which the center agrees, in part, to:

1 Participate in CHAMPUS and accept payment for maternity services based upon the reimbursement methodology for birthing centers;

2 Collect from the CHAMPUS beneficiary only those amounts that represent the beneficiary's liability under the participation agreement and the reimbursement methodology for birthing centers, and the amounts for services and supplies that are not a benefit of the CHAMPUS;

3 Permit access by the Director, OCHAMPUS, or a designee, to the clinical record of any CHAMPUS beneficiary, to the financial and organizational records of the center, and to reports of evaluations and inspections conducted by state or private agencies or organizations;

4 Submit claims first to all health benefit and insurance plans primary the CHAMPUS to which the beneficiary is entitled and to comply with the double coverage provisions of this Regulation.

5 Notify OCHAMPUS in writing within 7 days of the emergency transport of any CHAMPUS beneficiary from the center to an acute care hospital or of the death of any CHAMPUS beneficiary in the center.

(f) A birthing center shall not be a CHAMPUS-authorized institutional provider and CHAMPUS benefits shall not be paid for any service provided by a birthing center before the date the participation agreement is signed by the Director, OCHAMPUS, or a designee.

(2) CHAMPUS birthing center standards.

(a) Environment. The center has a safe and sanitary environment, properly constructed, equipped, and maintained to protect health and safety and meets the applicable provisions of the "Life Safety Code" of the National Fire Protection Association.

(b) Policies and procedures. The center has written administrative, fiscal, personnel and clinical policies and procedures which collectively promote the provision of high-quality maternity care and childbirth services in an orderly, effective, and safe physical and organizational environment.

(c) Informed consent. Each CHAMPUS beneficiary admitted to the center will be informed in writing at the time of admission of the nature and scope of the center's program and of the possible risks associated with maternity care and childbirth in the center.

(d) Beneficiary care. Each woman admitted will be cared for by or under the direct supervision of a specific physician or a specific certified nurse-midwife who is otherwise eligible as a CHAMPUS individual professional provider.

(e) Medical direction. The center has written memoranda of understanding (MOU) for routine consultation and emergency care with an obstetrician-gynecologist who is certified or is eligible for certification by the American Board of Obstetrics and Gynecology or the American Osteopathic Board of Obstetrics and Gynecology and with a pediatrician who is certified or eligible for certification by the American Board of Pediatrics or by the American Osteopathic Board of Pediatrics, each of whom have admitting privileges to at least one back-up hospital. In lieu of a required MOU, the center may employ a physician with the required qualifications. Each MOU must be renewed annually.

(f) Admission and emergency care criteria and procedures. The center has written clinical criteria and administrative procedures, which are reviewed and approved annually by a physician related to the center as required by subparagraph (e) above, for the exclusion of a woman with a high-risk pregnancy from center care and for management of maternal and neonatal emergencies.

(g) Emergency treatment. The center has a written memorandum of understanding (MOU) with at least one backup hospital which documents that the hospital will accept and treat any woman or newborn transferred from the center who is in need of emergency obstetrical or neonatal medical care. In lieu of this MOU with a hospital, a birthing center may have an MOU with a physician, who otherwise meets the requirements as a CHAMPUS individual professional provider, and who has admitting privileges to a back-up hospital capable of providing care for critical maternal and neonatal patients as demonstrated by a letter from that hospital certifying the scope and expected duration of the admitting privileges granted by the hospital to the physician. The MOU must be renewed annually.

(h) Emergency medical transportation. The center has a written memorandum of understanding (MOU) with at least one ambulance service which documents that the ambulance service is routinely staffed by qualified personnel who are capable of the management of critical maternal and neonatal patients during transport and which specifies the estimated transport time to each backup hospital with which the center has arranged for emergency treatment as required in subparagraph (g) above. Each MOU must be renewed annually.

(i) Professional staff. The center's professional staff is legally and professionally qualified for the performance of their professional responsibilities.

(j) Medical records. The center maintains full and complete written documentation of the services rendered to each woman admitted and each newborn delivered. A copy of the informed consent document required by subparagraph (c), above, which contains the original signature of the CHAMPUS beneficiary, signed and dated at the time of admission, must be maintained in the medical record of each CHAMPUS beneficiary admitted.

(k) Quality assurance. The center has an organized program for quality assurance which includes, but is not limited to, written procedures for regularly scheduled evaluation of each type of service provided, of each mother or newborn transferred to a hospital, and of each death within the facility.

(l) Governance and administration. The center has a governing body legally responsible for overall operation and maintenance of the center and a full-time employee who has authority and responsibility for the day-to-day operation of the center.

1. Psychiatric partial hospitalization programs. Paragraph B.4.1. of this chapter establishes standards and requirements for psychiatric partial hospitalization programs.

(1) Organization and administration.

(a) Definition. Partial hospitalization is defined as a time-limited, ambulatory, active treatment program that offers therapeutically intensive, coordinated, and structured clinical services within a stable therapeutic milieu. Partial hospitalization programs serve patients who exhibit psychiatric symptoms, disturbances of conduct, and decompensating conditions affecting mental health.

(b) Eligibility.

1 Every psychiatric partial hospitalization program must be certified pursuant to CHAMPUS certification standards. Such standards shall incorporate the basic standards set forth in paragraphs B.4.1.(1) through (4) of this chapter, and shall include such additional elaborative criteria and standards as the Director, OCHAMPUS determines are necessary to implement the basic standards. Each psychiatric partial hospitalization program must be either a distinct part of an otherwise authorized institutional provider or a freestanding program.

2 To be eligible for CHAMPUS certification, the facility is required to be licensed and fully operational for a period of at least six months (with a minimum patient census of at least 30 percent of bed capacity) and operate in substantial compliance with state and federal regulations.

3 The facility is currently accredited by the Joint Commission on Accreditation of Healthcare Organizations under the current edition of the Accreditation Manual for Mental Health, Chemical Dependency, and Mental Retardation/Developmental Disabilities Services.

4 The facility has a written participation agreement with OCHAMPUS. Beginning October 1, 1995, the PHP is not a CHAMPUS-authorized provider and CHAMPUS benefits are not paid for services provided until the date upon which a participation agreement is signed by the Director, OCHAMPUS. Partial hospitalization is capable of providing an interdisciplinary program of medical and therapeutic services a minimum of three hours per day, five days per week, and may include full- or half-day, evening, and weekend treatment programs.

(c) Governing body.

1 The PHP shall have a governing body which is responsible for the policies, bylaws, and activities of the facilities. If the PHP is owned by a partnership or single owner, the partners or single owner are regarded as the governing body. The facility will provide an up-to-date list of names, addresses, telephone numbers, and titles of the members of the governing body.

2 The governing body ensures appropriate and adequate services for all patients and oversees continuing development and improvement of care. Where business relationships exist between the governing body and facility, appropriate conflict-of-interest policies are in place.

3 Board members are fully informed about facility services and the governing body conducts annual review of its performance in meeting purposes, responsibilities, goals and objectives.

(d) Chief executive officer. The Chief Executive Officer, appointed by and subject to the direction of the governing body, shall assume overall administrative responsibility for the operation of the facility according to governing body policies. The chief executive officer shall have five years' administrative experience in the field of mental health. Beginning October 1, 1997, the CEO shall possess a degree in business administration, public health, hospital administration, nursing, social work, or psychology, or meet similar educational requirements as prescribed by the Director, OCHAMPUS.

(e) Clinical Director. The clinical director, appointed by the governing body, shall be a psychiatrist or doctoral level psychologist who meets applicable CHAMPUS requirements for individual professional providers and is licensed to practice in the state where the PHP is located. The clinical director shall possess requisite education and experience, credentials applicable

under state practice and licensing laws appropriate to the professional discipline, and a minimum of five years' clinical experience in the treatment of mental disorders specific to the ages and disabilities of the patients served. The clinical director shall be responsible for planning, development, implementation, and monitoring of all clinical activities.

(f) Medical director. The medical director, appointed by the governing body, shall be licensed to practice medicine in the state where the residential treatment center is located and shall possess requisite education and experience, including graduation from an accredited school of medicine or osteopathy, an approved residency in psychiatry and a minimum of five years clinical experience in the treatment of mental disorders specific to the ages and disabilities of the patients served. The Medical Director shall be responsible for the planning, development, implementation, and monitoring of all activities relating to medical treatment of patients. If qualified, the Medical Director may also serve as Clinical Director.

(g) Medical or professional staff organization. The governing body shall establish a medical or professional staff organization to assure effective implementation of clinical privileging, professional conduct rules, and other activities directly affecting patient care.

(h) Personnel policies and records. The PHP shall maintain written personnel policies, updated job descriptions, personnel records to assure the selection of qualified personnel and successful job performance of those personnel.

(i) Staff development. The facility shall provide appropriate training and development programs for administrative, professional support, and direct care staff.

(j) Fiscal accountability. The PHP shall assure fiscal accountability to applicable government authorities and patients.

(k) Designated teaching facilities. Students, residents, interns, or fellows providing direct clinical care are under the supervision of a qualified staff member approved by an accredited university. The teaching program is approved by the Director, OCHAMPUS.

(l) Emergency reports and records. The facility notifies OCHAMPUS of any serious occurrence involving CHAMPUS beneficiaries.

(2) Treatment services.

(a) Staff composition.

1 The PHP shall ensure that patient care needs will be appropriately addressed during all hours of operation by a sufficient number of fully qualified (including license, registration or certification requirements, educational attainment, and professional experience) health care professionals. Clinicians providing individual, group, and family therapy meet CHAMPUS

requirements as qualified mental health providers, and operate within the scope of their licenses. The ultimate authority for managing care is vested in a psychiatrist or licensed doctor level psychologist. The management of medical care is vested in a physician.

2 The PHP shall establish and follow written plans to assure adequate staff coverage during all hours of operation, including physician availability, other professional staff coverage, and support staff in the respective disciplines.

(b) Staff qualifications. The PHP will have a sufficient number of qualified mental health providers, administrative, and support staff to address patients' clinical needs and to coordinate the services provided. PHPs which employ individuals with master's or doctoral level degrees in a mental health discipline who do not meet the licensure, certification and experience requirements for a qualified mental health provider but are actively working toward licensure or certification, may provide services within the all-inclusive per diem rate, provided the individual works under the clinical supervision of a fully qualified mental health provider employed by the PHP. All other program services shall be provided by trained, licensed staff.

(c) Patient rights.

1 The PHP shall provide adequate protection for all patient rights, including rights provided by law, privacy, personal rights, safety, confidentiality, informed consent, grievances, and personal dignity.

2 The facility has a written policy regarding patient abuse and neglect.

3 Facility marketing and advertising meets professional standards.

(d) Behavioral management. The PHP shall adhere to a comprehensive, written plan of behavior management, developed by the clinical director and the medical or professional staff and approved by the governing body, including strictly limited procedures to assure that restraint or seclusion are used only in extraordinary circumstances, are carefully monitored, and are fully documented. Only trained and clinically privileged RNs or qualified mental health professionals may be responsible for implementation of seclusion and restraint procedures in an emergency situation.

(e) Admission process. The PHP shall maintain written policies and procedures to ensure that prior to an admission, a determination is made, and approved pursuant to CHAMPUS preauthorization requirements, that the admission is medically and/or psychologically necessary and the program is appropriate to meet the patient's needs. Medical and/or psychological necessity determinations shall be rendered by qualified mental health professionals who meet CHAMPUS requirements for individual professional providers and who are permitted by law and by the facility to refer patients for admission.

(f) Assessments. The professional staff of the PHP shall complete a multidisciplinary assessment which includes, but is not limited to physical health, psychological health, physiological, developmental, family, educational, spiritual, and skills assessment of each patient admitted. Unless otherwise specified, all required clinical assessments are completed prior to development of the interdisciplinary treatment plan.

(g) Clinical formulation. A qualified mental health provider of the PHP will complete a clinical formulation on all patients. The clinical formulation will be reviewed and approved by the responsible individual professional provider and will incorporate significant findings from each of the multidisciplinary assessments. It will provide the basis for development of an interdisciplinary treatment plan.

(h) Treatment planning. A qualified mental health professional with admitting privileges shall be responsible for the development, supervision, implementation, and assessment of a written, individualized, interdisciplinary plan of treatment, which shall be completed by the fifth day following admission to a full-day PHP, or by the seventh day following admission to a half-day PHP, and shall include measurable and observable goals for incremental progress and discharge. The treatment plan shall undergo review at least every two weeks, or when major changes occur in treatment.

(i) Discharge and transition planning. The PHP shall develop an individualized transition plan which addresses anticipated needs of the patient at discharge. The transition plan involves determining necessary modifications in the treatment plan, facilitating the termination of treatment, and identifying resources for maintaining therapeutic stability following discharge.

(j) Clinical documentation. Clinical records shall be maintained on each patient to plan care and treatment and provide ongoing evaluation of the patient's progress. All care is documented and each clinical record contains at least the following: demographic data, consent forms, pertinent legal documents, all treatment plans and patient assessments, consultation and laboratory reports, physician orders, progress notes, and a discharge summary. All documentation will adhere to applicable provisions of the JCAHO and requirements set forth in chapter 7, section B.3. of this regulation. An appropriately qualified records administrator or technician will supervise and maintain the quality of the records. These requirements are in addition to other records requirements of this Regulation, and documentation requirements of the Joint Commission on Accreditation of Health Care Organizations.

(k) Progress notes. PHPs shall document the course of treatment for patients and families using progress notes which provide information to review, analyze, and modify the treatment plans. Progress notes are legible, contemporaneous, sequential, signed and dated and adhere to applicable provisions of the Manual for Mental Health, Chemical Dependency, and Mental Retardation/Developmental Disabilities Services and requirements set forth in chapter 7, section B.3. of this regulation.

(1) Therapeutic services.

1 Individual, group, and family therapy are provided to all patients, consistent with each patient's treatment plan by qualified mental health providers.

2 A range of therapeutic activities, directed and staffed by qualified personnel, are offered to help patients meet the goals of the treatment plan.

3 Educational services are provided or arranged that are appropriate to the patient's needs.

(m) Ancillary services. A full range of ancillary services are provided. Emergency services include policies and procedures for handling emergencies with qualified personnel and written agreements with each facility providing these services. Other ancillary services include physical health, pharmacy and dietary services.

(3) Standards for physical plant and environment.

(a) Physical environment. The buildings and grounds of the PHP shall be maintained so as to avoid health and safety hazards, be supportive of the services provided to patients, and promote patient comfort, dignity, privacy, personal hygiene, and personal safety.

(b) Physical plant safety. The PHP shall be of permanent construction and maintained in a manner that protects the lives and ensures the physical safety of patients, staff, and visitors, including conformity with all applicable building, fire, health, and safety codes.

(c) Disaster planning. The PHP shall maintain and rehearse written plans for taking care of casualties and handling other consequences arising from internal and external disasters.

(4) Standards for evaluation system.

(a) Quality assessment and improvement. The PHP shall develop and implement a comprehensive quality assurance and quality improvement program that monitors the quality, efficiency, appropriateness, and effectiveness of care, treatments, and services the PHP provides for patients and their families. Explicit clinical indicators shall be used to evaluate all functions of the PHP and contribute to an ongoing process of program improvement. The clinical director is responsible for developing and implementing quality assessment and improvement activities throughout the facility.

(b) Utilization review. The PHP shall implement a utilization review process, pursuant to a written plan approved by the professional staff, the administration and the governing body, that assesses

distribution of services, clinical necessity of treatment, appropriateness of admission, continued stay, and timeliness of discharge, as part of an overall effort to provide quality patient care in a cost-effective manner. Findings of the utilization review process are used as a basis for revising the plan of operation, including a review of staff qualifications and staff composition.

(c) Patient records. The PHP shall implement a process, including regular monthly reviews of a representative sample of patient records, to determine completeness, accuracy, timeliness of entries, appropriate signatures, and pertinence of clinical entries. Conclusions, recommendations, actions taken, and the results of actions are monitored and reported.

(d) Drug utilization review. The PHP shall implement a comprehensive process for the monitoring and evaluating of the prophylactic, therapeutic, and empiric use of drugs to assure that medications are provided appropriately, safely, and effectively.

(e) Risk management. The PHP shall implement a comprehensive risk management program, fully coordinated with other aspects of the quality assurance and quality improvement program, to prevent and control risks to patients and staff, and to minimize costs associated with clinical aspects of patient care and safety.

(f) Infection control. The PHP shall implement a comprehensive system for the surveillance, prevention, control, and reporting of infections acquired or brought into the facility.

(g) Safety. The PHP shall implement an effective program to assure a safe environment for patients, staff, and visitors, including an incident reporting system, disaster training and safety education, a continuous safety surveillance system, and an active multidisciplinary safety committee.

(h) Facility evaluation. The PHP annually evaluates accomplishment of the goals and objectives of each clinical program component or facility service of the PHP and reports findings and recommendations to the governing body.

(5) Participation agreement requirements. In addition to other requirements set forth in paragraph B.4.1. of this chapter, in order for the services of a PHP to be authorized, the PHP shall have entered into a Participation Agreement with OCHAMPUS. The period of a Participation Agreement shall be specified in the agreement, and will generally be for not more than five years. On October 1, 1995, the PHP shall not be considered to be a CHAMPUS authorized provider and CHAMPUS payments shall not be made for services provided by the PHP until the date the participation agreement is signed by the Director, OCHAMPUS. In addition to review of a facility's application and supporting documentation, an on-site inspection by OCHAMPUS authorized personnel may be required prior to signing a participation agreement. The Participation Agreement shall include at least the following requirements:

(a) Render partial hospitalization program services to eligible CHAMPUS beneficiaries in need of such services, in accordance with the participation agreement and CHAMPUS regulation.

(b) Accept payment for its services based upon the methodology provided in chapter 14, or such other method as determined by the Director, OCHAMPUS;

(c) Accept the CHAMPUS all-inclusive per diem 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 chapter 4,, and charges for services and supplies that are not a benefit of CHAMPUS;

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

(e) Comply with the provisions of chapter 8, and submit claims first to all health insurance coverage to which the beneficiary is entitled that is primary to CHAMPUS;

(f) Submit claims for services provided to CHAMPUS 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 PHP agrees not to bill the beneficiary or the beneficiary's family for any amounts disallowed by CHAMPUS;

(g) Certify that:

1 It is and will remain in compliance with the provisions of paragraph B.4.1. of this chapter establishing standards for psychiatric partial hospitalization programs;

2 It has conducted a self assessment of the facility's compliance with the CHAMPUS Standards for Psychiatric Partial Hospitalization Programs, as issued by the Director, OCHAMPUS, and notified the Director, OCHAMPUS of any matter regarding which the facility is not in compliance with such standards; and

3 It will maintain compliance with the CHAMPUS Standards for Psychiatric Partial Hospitalization Programs, as issued by the Director, OCHAMPUS, except for any such standards regarding which the facility notifies the Director, OCHAMPUS that it is not in compliance.

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

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

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

(k) Grant the Director, OCHAMPUS, 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 includes, but is not limited to:

1 Examination of fiscal and all other records of the PHP which would confirm compliance with the participation agreement and designation as an authorized CHAMPUS PHP provider;

2 Conducting such audits of PHP 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;

3 Examining reports of evaluations and inspections conducted by federal, state and local government, and private agencies and organizations;

4 Conducting on-site inspections of the facilities of the PHP and interviewing employees, members of the staff, contractors, board members, volunteers, and patients, as required;

5 Audits conducted by the United States General Accounting Office.

(6) Other requirements applicable to PHPs.

(a) Even though a PHP may qualify as a CHAMPUS-authorized provider and may have entered into a participation agreement with CHAMPUS, payment by CHAMPUS for particular services provided is contingent upon the PHP also meeting all conditions set forth in chapter 4 of this regulation.

(b) The PHP shall provide patient services to CHAMPUS beneficiaries in the same manner it provides inpatient services to all other patients. The PHP 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.

(c) The PHP shall assure that all certifications and information provided to the Director, OCHAMPUS 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 PHP will be ineligible for consideration for authorized provider status for a two year period.

m. Hospice programs. Hospice programs must be Medicare approved and meet all Medicare conditions of participation (42 CFR Part 418) in relation to CHAMPUS patients in order to receive payment under the CHAMPUS program. A hospice program may be found to be out of compliance with a particular Medicare condition of participation and still participate in the CHAMPUS as long as the hospice is allowed continued participation in Medicare while the condition of noncompliance is being corrected. The hospice program can be either a public agency or private organization (or a subdivision thereof) which:

(1) Is primarily engaged in providing the care and services described under Section 199.4(e)(19) and makes such services available on a 24-hour basis.

(2) Provides bereavement counseling for the immediate family or terminally ill individuals.

(3) Provides for such care and services in individuals' homes, on an outpatient basis, and on a short-term inpatient basis, directly or under arrangements made by the hospice program, except that the agency or organization must:

(a) Ensure that substantially all the core services are routinely provided directly by hospice employees.

(b) Maintain professional management responsibility for all services which are not directly furnished to the patient, regardless of the location or facility in which the services are rendered.

(c) Provide assurances that the aggregate number of days of inpatient care provided in any 12-month period does not exceed 20 percent of the aggregate number of days of hospice care during the same period.

(d) Have an interdisciplinary group composed of the following personnel who provide the care and services described under Chapter 4.E.19 and who establish the policies governing the provision of such care/services:

1 a physician;

2 a registered professional nurse;

3 a social worker; and

4 a pastoral or other counselor.

(e) Maintain central clinical records on all patients.

(f) Utilize volunteers.

(g) The hospice and all hospice employees must be licensed in accordance with applicable Federal, State and local laws and regulations.

(h) The hospice must enter into an agreement with CHAMPUS in order to be qualified to participate and to be eligible for payment under the program. In this agreement the hospice and CHAMPUS agree that the hospice will:

1 Not charge the beneficiary or any other person for items or services for which the beneficiary is entitled to have payment made under the CHAMPUS hospice benefit.

2 Be allowed to charge the beneficiary for items or services requested by the beneficiary in addition to those that are covered under the CHAMPUS hospice benefit.

(i) Meet such other requirements as the 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.

n. Substance use disorder rehabilitation facilities. Paragraph B.4.n. of this chapter establishes standards and requirements for substance use disorder rehabilitation facilities (SUDRF). This includes both inpatient rehabilitation centers for the treatment of substance use disorders and partial hospitalization centers for the treatment of substance use disorders.

(1) Organization and administration.

(a) Definition of inpatient rehabilitation center. An inpatient rehabilitation center is a facility, or distinct part of a facility, that provides medically monitored, interdisciplinary addiction-focused treatment to beneficiaries who have psychoactive substance use disorders. Qualified health care professionals provide 24-hour, seven-day-per-week, medically monitored assessment, treatment, and evaluation. An inpatient rehabilitation center is appropriate for patients whose addiction-related symptoms, or concomitant physical and emotional/behavioral problems reflect persistent dysfunction in several major life areas. Inpatient rehabilitation is differentiated from:

1 Acute psychoactive substance use treatment and from treatment of acute biomedical/emotional/behavioral problems; which problems are either life-threatening and/or severely incapacitating and often occur within the context of a discrete episode of addiction-related biomedical or psychiatric dysfunction;

2 A partial hospitalization center, which serves patients who exhibit emotional/behavioral dysfunction but who can function in the community for defined periods of time with support in one or more of the major life areas;

3 A group home, sober-living environment, halfway house, or three-quarter way house;

4 Therapeutic schools, which are educational programs supplemented by addiction-focused services;

5 Facilities that treat patients with primary psychiatric diagnoses other than psychoactive substance use or dependence; and

6 Facilities that care for patients with the primary diagnosis of mental retardation or developmental disability.

(b) Definition of partial hospitalization center for the treatment of substance use disorders. A partial hospitalization center for the treatment of substance use disorders is an addiction-focused service that provides active treatment to adolescents between the ages of 13 and 18 or adults aged 18 and over. Partial hospitalization is a generic term for day, evening, or weekend programs that treat patients with psychoactive substance use disorders according to a comprehensive, individualized, integrated schedule of care. A partial hospitalization center is organized, interdisciplinary, and medically monitored. Partial hospitalization is appropriate for those whose addiction-related symptoms or concomitant physical and emotional/behavioral problems can be managed outside the hospital environment for defined periods of time with support in one or more of the major life areas.

(c) Eligibility.

1 Every inpatient rehabilitation center and partial hospitalization center for the treatment of substance use disorders must be certified pursuant to CHAMPUS certification standards. Such standards shall incorporate the basic standards set forth in paragraphs B.4.n.(1) through (4) of this chapter, and shall include such additional elaborative criteria and standards as the Director, OCHAMPUS determines are necessary to implement the basic standards.

2 To be eligible for CHAMPUS certification, the SUDRF is required to be licensed and fully operational (with a minimum patient census of the lesser of: six patients or 30 percent of bed capacity) for a period of at least six months and operate in substantial compliance with state and federal regulations.

3 The SUDRF is currently accredited by the Joint Commission on Accreditation of Healthcare Organizations under the Accreditation Manual for Mental Health, Chemical Dependency, and Mental Retardation/Developmental Disabilities Services, or by the Commission on Accreditation of Rehabilitation Facilities as an alcoholism and other drug dependency rehabilitation program under the Standards Manual for Organizations Serving People with Disabilities, or other designated standards approved by the Director, OCHAMPUS.

4 The SUDRF has a written participation agreement with OCHAMPUS. On October 1, 1995, the SUDRF is not considered a CHAMPUS-authorized provider, and CHAMPUS benefits are not paid for services provided until the date upon which a participation agreement is signed by the Director, OCHAMPUS.

(d) Governing body.

1 The SUDRF shall have a governing body which is responsible for the policies, bylaws, and activities of the facility. If the SUDRF is owned by a partnership or single owner, the partners or single owner are regarded as the governing body. The facility will provide an up-to-date list of names, addresses, telephone numbers and titles of the members of the governing body.

2 The governing body ensures appropriate and adequate services for all patients and oversees continuing development and improvement of care. Where business relationships exist between the governing body and facility, appropriate conflict-of-interest policies are in place.

3 Board members are fully informed about facility services and the governing body conducts annual reviews of its performance in meeting purposes, responsibilities, goals and objectives.

(e) Chief executive officer. The chief executive officer, appointed by and subject to the direction of the governing body, shall assume overall administrative responsibility for the operation of the facility according to governing body policies. The chief executive officer shall have five years' administrative experience in the field of mental health or addictions. On October 1, 1997, the CEO shall possess a degree in business administration, public health, hospital administration, nursing, social work, or psychology, or meet similar educational requirements as prescribed by the Director, OCHAMPUS.

(f) Clinical Director. The clinical director, appointed by the governing body, shall be a qualified psychiatrist or doctoral level psychologist who meets applicable CHAMPUS requirements for individual professional providers and is licensed to practice in the state where the SUDRF is located. The clinical director shall possess requisite education and experience, including credentials applicable under state practice and licensing laws appropriate to the professional discipline. The clinical director shall satisfy at least one of the following requirements: certification by the American Society of Addiction Medicine; one year or 1,000 hours of experience in the treatment of psychoactive substance use disorders; or is a psychiatrist or doctoral level psychologist with experience in the treatment of substance use disorders. The clinical director shall be responsible for planning, development, implementation, and monitoring of all clinical activities.

(g) Medical director. The medical director, appointed by the governing body, shall be licensed to practice medicine in the state where the center is located and shall possess requisite education including graduation from an accredited school of medicine or osteopathy. The medical director shall satisfy at least one of the following requirements: certification by the American Society of Addiction Medicine; one year or 1,000 hours of experience in the treatment of psychoactive substance use disorders; or is a psychiatrist with experience in the treatment of substance use disorders. The medical director shall be responsible for the planning, development, implementation, and monitoring of all activities relating to medical treatment of patients. If qualified, the Medical Director may also serve as Clinical Director.

(h) Medical or professional staff organization. The governing body shall establish a medical or professional staff organization to assure effective implementation of clinical privileging, professional conduct rules, and other activities directly affecting patient care.

(i) Personnel policies and records. The SUDRF shall maintain written personnel policies, updated job descriptions, personnel records to assure the selection of qualified personnel and successful job performance of those personnel.

(j) Staff development. The SUDRF shall provide appropriate training and development programs for administrative, support, and direct care staff.

(k) Fiscal accountability. The SUDRF shall assure fiscal accountability to applicable government authorities and patients.

(l) Designated teaching facilities. Students, residents, interns, or fellows providing direct clinical care are under the supervision of a qualified staff member approved by an accredited university or approved training program. The teaching program is approved by the Director, OCHAMPUS.

(m) Emergency reports and records. The facility notifies OCHAMPUS of any serious occurrence involving CHAMPUS beneficiaries.

(2) Treatment services.

(a) Staff composition.

1 The SUDRF shall follow written plans which assure that medical and clinical patient needs will be appropriately addressed during all hours of operation by a sufficient number of fully qualified (including license, registration or certification requirements, educational attainment, and professional experience) health care professionals and support staff in the respective disciplines. Clinicians providing individual, group and family therapy meet CHAMPUS requirements as qualified mental health providers and operate within the scope of their licenses. The ultimate authority for planning, development, implementation, and monitoring of all clinical activities is vested in a psychiatrist or doctoral level clinical psychologist. The management of medical care is vested in a physician.

2 The SUDRF shall establish and follow written plans to assure adequate staff coverage during all hours of operation of the center, including physician availability and other professional staff coverage 24 hours per day, seven days per week for an inpatient rehabilitation center and during all hours of operation for a partial hospitalization center.

(b) Staff qualifications. Within the scope of its programs and services, the SUDRF has a sufficient number of professional, administrative, and support staff to address the medical and clinical needs of patients and to coordinate the services provided. SUDRFs that employ individuals with master's

or doctoral level degrees in a mental health discipline who do not meet the licensure, certification and experience requirements for a qualified mental health provider but are actively working toward licensure or certification, may provide services within the DRG, provided the individual works under the clinical supervision of a fully qualified mental health provider employed by the SUDRF.

(c) Patient rights.

1 The SUDRF shall provide adequate protection for all patient rights, safety, confidentiality, informed consent, grievances, and personal dignity.

2 The SUDRF has a written policy regarding patient abuse and neglect.

3 SUDRF marketing and advertising meets professional standards.

(d) Behavioral management. When a SUDRF uses a behavioral management program, the center shall adhere to a comprehensive, written plan of behavioral management, developed by the clinical director and the medical or professional staff and approved by the governing body. It shall be based on positive reinforcement methods and, except for infrequent use of temporary physical holds or time outs, does not include the use of restraint or seclusion. Only trained and clinically privileged RNs or qualified mental health professionals may be responsible for the implementation of seclusion and restraint in an emergency situation.

(e) Admission process. The SUDRF shall maintain written policies and procedures to ensure that, prior to an admission, a determination is made, and approved pursuant to CHAMPUS preauthorization requirements, that the admission is medically and/or psychologically necessary and the program is appropriate to meet the patient's needs. Medical and/or psychological necessity determinations shall be rendered by qualified mental health professionals who meet CHAMPUS requirements for individual professional providers and who are permitted by law and by the facility to refer patients for admission.

(f) Assessment. The professional staff of the SUDRF shall provide a complete, multidisciplinary assessment of each patient which includes, but is not limited to, medical history, physical health, nursing needs, alcohol and drug history, emotional and behavioral factors, age-appropriate social circumstances, psychological condition, education status, and skills. Unless otherwise specified, all required clinical assessments are completed prior to development of the multidisciplinary treatment plan.

(g) Clinical formulation. A qualified mental health care professional of the SUDRF will complete a clinical formulation on all patients. The clinical formulation will be reviewed and approved by the responsible individual professional provider and will incorporate significant findings from each of the multidisciplinary assessments. It will provide the basis for development of an interdisciplinary treatment plan.

(h) Treatment planning. A qualified health care professional with admitting privileges shall be responsible for the development, supervision, implementation, and assessment of a written, individualized, and interdisciplinary plan of treatment, which shall be completed within 10 days of admission to an inpatient rehabilitation center or by the fifth day following admission to full day partial hospitalization center, and by the seventh day of treatment for half day partial hospitalization. The treatment plan shall include individual, measurable, and observable goals for incremental progress towards the treatment plan objectives and goals and discharge. A preliminary treatment plan is completed within 24 hours of admission and includes as least a physician's admission note and orders. The master treatment plan is regularly reviewed for effectiveness and revised when major changes occur in treatment.

(i) Discharge and transition planning. The SUDRF shall maintain a transition planning process to address adequately the anticipated needs of the patient prior to the time of discharge.

(j) Clinical documentation. Clinical records shall be maintained on each patient to plan care and treatment and provide ongoing evaluation of the patient's progress. All care is documented and each clinical record contains at least the following: demographic data, consent forms, pertinent legal documents, all treatment plans and patient assessments, consultation and laboratory reports, physician orders, progress notes, and a discharge summary. All documentation will adhere to applicable provisions of the JCAHO and requirements set forth in chapter 7, section B.3. of this regulation. An appropriately qualified records administrator or technician will supervise and maintain the quality of the records. These requirements are in addition to other records requirements of this regulation, and provisions of the JCAHO Manual for Mental Health, Chemical Dependency, and Mental Retardation/Developmental Disabilities Services.

(k) Progress notes. Timely and complete progress notes shall be maintained to document the course of treatment for the patient and family.

(l) Therapeutic services.

1 Individual, group, and family psychotherapy and addiction counseling services are provided to all patients, consistent with each patient's treatment plan by qualified mental health providers.

2 A range of therapeutic activities, directed and staffed by qualified personnel, are offered to help patients meet the goals of the treatment plan.

3 Therapeutic educational services are provided or arranged that are appropriate to the patient's educational and therapeutic needs.

(m) Ancillary services. A full range of ancillary services is provided. Emergency services include policies and procedures for handling emergencies with qualified personnel and written agreements with each facility providing the service. Other ancillary services include physical health, pharmacy and dietary services.

(3) Standards for physical plant and environment.

(a) Physical environment. The buildings and grounds of the SUDRF shall be maintained so as to avoid health and safety hazards, be supportive of the services provided to patients, and promote patient comfort, dignity, privacy, personal hygiene, and personal safety.

(b) Physical plant safety. The SUDRF shall be maintained in a manner that protects the lives and ensures the physical safety of patients, staff, and visitors, including conformity with all applicable building, fire, health, and safety codes.

(c) Disaster planning. The SUDRF shall maintain and rehearse written plans for taking care of casualties and handling other consequences arising from internal or external disasters.

(4) Standards for evaluation system.

(a) Quality assessment and improvement. The SUDRF develop and implement a comprehensive quality assurance and quality improvement program that monitors the quality, efficiency, appropriateness, and effectiveness of the care, treatments, and services it provides for patients and their families, utilizing clinical indicators of effectiveness to contribute to an ongoing process of program improvement. The clinical director is responsible for developing and implementing quality assessment and improvement activities throughout the facility.

(b) Utilization review. The SUDRF shall implement a utilization review process, pursuant to a written plan approved by the professional staff, the administration, and the governing body, that assesses the appropriateness of admissions, continued stay, and timeliness of discharge as part of an effort to provide quality patient care in a cost-effective manner. Findings of the utilization review process are used as a basis for revising the plan of operation, including a review of staff qualifications and staff composition.

(c) Patient records review. The center shall implement a process, including monthly reviews of a representative sample of patient records, to determine the completeness and accuracy of the patient records and the timeliness and pertinence of record entries, particularly with regard to regular recording of progress/non-progress in treatment plan.

(d) Drug utilization review. An inpatient rehabilitation center and, when applicable, a partial hospitalization center, shall implement a comprehensive process for the monitoring and evaluating of the prophylactic, therapeutic, and empiric use of drugs to assure that medications are provided appropriately, safely, and effectively.

(e) Risk management. The SUDRF shall implement a comprehensive risk management program, fully coordinated with other aspects of the quality assurance and quality improvement program, to prevent and control risks to patients and staff and costs associated with clinical aspects of patient care and safety.

(f) Infection control. The SUDRF shall implement a comprehensive system for the surveillance, prevention, control, and reporting of infections acquired or brought into the facility.

(g) Safety. The SUDRF shall implement an effective program to assure a safe environment for patients, staff, and visitors.

(h) Facility evaluation. The SUDRF annually evaluates accomplishment of the goals and objectives of each clinical program and service of the SUDRF and reports findings and recommendations to the governing body.

(5) Participation agreement requirements. In addition to other requirements set forth in paragraph B.4.n. of this chapter, in order for the services of an inpatient rehabilitation center or partial hospitalization center for the treatment of substance abuse disorders to be authorized, the center shall have entered into a Participation Agreement with OCHAMPUS. The period of a Participation Agreement shall be specified in the agreement, and will generally be for not more than five years. On October 1, 1995, 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, OCHAMPUS. 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. In addition, such a Participation Agreement may not be signed until an SUDRF has been licensed and operational for at least six months. The Participation Agreement shall include at least the following requirements:

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

(b) Accept payment for its services based upon the methodology provided in chapter 14, or such other method as determined by the Director, OCHAMPUS;

(c) 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 chapter 4, and charges for services and supplies that are not a benefit of CHAMPUS;

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

(e) Comply with the provisions of chapter 8, and submit claims first to all health insurance coverage to which the beneficiary is entitled that is primary to CHAMPUS;

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

(g) Certify that:

1 It is and will remain in compliance with the provisions of paragraph B.4.n. of the section establishing standards for substance use disorder rehabilitation facilities;

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

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

(h) Grant the Director, OCHAMPUS, 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:

1 Examination of fiscal and all other records of the center which would confirm compliance with the participation agreement and designation as an authorized CHAMPUS provider;

2 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;

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

4 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.

5 Audits conducted by the United States General Accounting Office.

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

(a) Even though a SUDRF may qualify as a CHAMPUS-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 forth in chapter 4.

(b) 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.

(c) The substance use disorder facility shall assure that all certifications and information provided to the Director, OCHAMPUS 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.

C. INDIVIDUAL PROFESSIONAL PROVIDERS OF CARE

1. General. Individual professional providers of care are those providers who bill for their services on a fee-for-service basis and are not employed or under a contract which provides for payment to the individual professional provider by an institutional provider. This category also includes those individuals who have formed professional corporations or associations qualifying as a domestic corporation under section 301.7701-5 of the Internal Revenue Service Regulations (reference (cc)). Such individual professional providers must be licensed or certified by the local licensing or certifying agency for the jurisdiction in which the care is provided; or in the absence of state licensure/certification, be a member of or demonstrate eligibility for full clinical membership in, the appropriate national or professional certifying association that sets standards for the profession of which the provider is a member. Services provided must be in accordance with good medical practice and prevailing standards of quality of care and within recognized utilization norms.

a. Licensing/Certification required, scope of license. Otherwise covered services shall be cost-shared only if the individual professional provider holds a current, valid license or certification to practice his or her profession in the jurisdiction where the service is rendered. Licensure/certification must be at the full clinical practice level. The services provided must be within the scope of the license, certification or other legal authorization. Licensure or certification is required to be a CHAMPUS authorized provider if offered in the jurisdiction where the service is rendered, whether such licensure or certification is required by law or provided on a voluntary basis. The requirement also applies for those categories of providers that would otherwise be exempt by the state because the provider is working in a non-profit, state-owned or church setting. Licensure/certification is mandatory for a provider to become a CHAMPUS-authorized provider.

b. Monitoring required. The Director, OCHAMPUS, or a designee, shall develop appropriate monitoring programs and issue guidelines, criteria, or norms necessary to ensure that CHAMPUS expenditures are limited to necessary medical supplies and services at the most reasonable cost to the government and beneficiary. The Director, OCHAMPUS, or a designee, also will take such steps as necessary to deter overutilization of services.

c. Christian Science. Christian Science practitioners and Christian Science nurses are authorized to provide services under CHAMPUS. Inasmuch as they provide services of an extramedical nature, the general criteria outlined above do not apply to Christian Science services (refer to subparagraph C.3.d.(2), below, regarding services of Christian Science practitioners and nurses).

d. Physician referral and supervision. Physician referral and supervision is required for the services of paramedical providers as listed in subparagraph C.3.c.8. and for pastoral counselors, and mental health counselors. Physician referral means that the physician must actually see the patient, perform an evaluation, and arrive at an initial diagnostic impression prior to referring the patient. Documentation is required of the physician's examination, diagnostic impression, and referral. Physician supervision means that the physician provides overall medical management of the case. The physician does not have to be physically located on the premises of the provider to whom the referral is made. Communication back to the referring physician is an indication of medical management.

e. Medical records: Individual professional providers must maintain adequate clinical records to substantiate that specific care was actually furnished, was medically necessary, and appropriate, and identify(ies) the individual(s) who provided the care. This applies whether the care is inpatient or outpatient. The minimum requirements for medical record documentation are set forth by the following:

- (1) The cognizant state licensing authority;
- (2) The Joint Commission on Accreditation of Healthcare Organizations, or other health care accreditation organizations as may be appropriate;
- (3) Standards of practice established by national medical organizations; and
- (4) This Regulation.

2. Interns and residents. Interns and residents may not be paid 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.

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

a. Physicians

- (1) Doctors of Medicine (M.D.).
- (2) Doctors of Osteopathy (D.O.).

b. Dentists. Except for covered oral surgery as specified in section E. of Chapter 4 of this Regulation, all otherwise covered services rendered by dentists require preauthorization.

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

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

c. 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 chapters of this Regulation.

(1) 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:

(a) Possesses a doctoral degree in psychology from a regionally accredited university; and

(b) Has had 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

(c) As an alternative to (a) and (b) above, is listed in the National Register of Health Service Providers in Psychology (reference (ee)).

(2) Doctors of Optometry.

(3) Doctors of Podiatry or Surgical Chiropody.

(4) Certified nurse midwives.

(a) A certified nurse midwife may provide covered care independent of physician referral and supervision, provided the nurse midwife is:

1 Licensed, when required, by the local licensing agency for the jurisdiction in which the care is provided; and

2 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.

(b) 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.

(5) 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:

(a) A licensed, registered nurse; and

(b) 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

(c) 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.

(6) Certified Clinical Social Worker. A clinical social worker may provide covered services independent of physician referral and supervision, provided the clinical social worker:

(a) Is licensed or certified as a clinical social worker by the jurisdiction where practicing; or, if the jurisdiction does not provide for licensure or certification of clinical social workers, is certified by a national professional organization offering certification of clinical social workers; and

(b) Has at least a master's degree in social work from a graduate school of social work accredited by the Council on Social Work Education; and

(c) Has had a minimum of 2 years or 3,000 hours of post master's degree supervised clinical social work practice under the supervision of a master's level social worker in an appropriate clinical setting, as determined by the Director, OCHAMPUS, or a designee.

NOTE: Patients' organic medical problems must receive appropriate concurrent management by a physician.

(7) Certified psychiatric nurse specialist. A certified psychiatric nurse specialist may provide covered care independent of physician referral and supervision. For purposes of CHAMPUS, a certified psychiatric nurse specialist is an individual who:

(a) Is a licensed, registered nurse; and

(b) Has at least a master's degree in nursing from a regionally accredited institution with a specialization in psychiatric and mental health nursing; and

(c) Has had at least 2 years of post-master's degree practice in the field of psychiatric and mental health nursing, including an average of 8 hours of direct patient contact per week; or

(d) Is listed in a CHAMPUS-recognized, professionally sanctioned listing of clinical specialists in psychiatric and mental health nursing.

(8) Certified physician assistant. A physician assistant may provide care under general supervision of a physician (see Chapter 14 G.1.c. for limitations on reimbursement). For purposes of CHAMPUS, a physician assistant must meet the applicable state requirements governing the qualifications of physician assistants and at least one of the following conditions:

(a) Is currently certified by the National Commission on Certification of Physician Assistants to assist primary care physicians, or

(b) Has satisfactorily completed a program for preparing physician assistants that:

1 Was at least 1 academic year in length;

2 Consisted of supervised clinical practice and at least 4 months (in the aggregate) of classroom instruction directed toward preparing students to deliver health care; and

3 Was accredited by the American Medical Association's Committee on Allied Health Education and Accreditation; or

(c) Has satisfactorily completed a formal educational program for preparing physician assistants that does not meet the requirements of subparagraph (1)(b) of this paragraph and had been assisting primary care physicians for a minimum of 12 months during the 18-month period immediately preceding January 1, 1987.

(9) Other individual paramedical providers. The services of the following individual professional providers of care to be considered for benefits on a fee-for-service basis may be provided only if the beneficiary is referred by a physician for the treatment of a medically-diagnosed condition and a physician must also provide continuing and ongoing oversight and supervision of the program or episode of treatment provided by these individual paramedical providers.

(a) Licensed registered nurses.

(b) Licensed practical or vocational nurses.

(c) Licensed registered physical therapists.

(d) Audiologists.

(e) Speech therapists (speech pathologists).

d. Extramedical individual providers. Extramedical individual providers are those who do counseling or nonmedical therapy and whose training and therapeutic concepts are outside the medical field. The services of extramedical individual professionals are coverable following the CHAMPUS determined allowable charge methodology provided such services are otherwise authorized in this or other chapters of the regulation.

(1) Certified marriage and family therapists. For the purposes of CHAMPUS, a certified marriage and family therapist is an individual who meets the following requirements:

(a) Recognized graduate professional education with the minimum of an earned master's degree from a regionally accredited educational institution in an appropriate behavioral science field, mental health discipline;
and

(b) The following experience:

1 Either 200 hours of approved supervision in the practice of marriage and family counseling, ordinarily to be completed in a 2- to 3-year period, of which at least 100 hours must be in individual supervision. This supervision will occur preferably with more than one supervisor and should include a continuous process of supervision with at least three cases; and

2 1,000 hours of clinical experience in the practice of marriage and family counseling under approved supervision, involving at least 50 different cases; or

3 150 hours of approved supervision in the practice of psychotherapy, ordinarily to be completed in a 2- to 3-year period, of which at least 50 hours must be individual supervision; plus at least 50 hours of approved individual supervision in the practice of marriage and family counseling, ordinarily to be completed within a period of not less than 1 nor more than 2 years; and

4 750 hours of clinical experience in the practice of psychotherapy under approved supervision involving at least 30 cases; plus at least 250 hours of clinical practice in marriage and family counseling under approved supervision, involving at least 20 cases; and

(c) Is licensed or certified to practice as a marriage and family therapist by the jurisdiction where practicing (see C.3.d.(4) of this part for more specific information regarding licensure); and

(d) Agrees that a patients' organic medical problems must receive appropriate concurrent management by a physician.

(e) Agrees to accept the CHAMPUS determined allowable charge as payment in full, except for applicable deductibles and cost-shares, and hold CHAMPUS beneficiaries harmless for noncovered care (i.e., may not bill a beneficiary for noncovered care, and may not balance bill a beneficiary for amounts above the allowable charge). The certified marriage and family therapist must enter into a participation agreement with the Office of CHAMPUS within which the certified marriage and family therapist agrees to all provisions specified above.

(f) As of the effective date of termination, the certified marriage and family therapist, will no longer be recognized as an authorized provider under CHAMPUS. Subsequent to termination, the certified marriage and family therapist may only be reinstated as an authorized CHAMPUS extramedical provider by entering into a new participation agreement as a certified marriage and family therapist.

(2) Pastoral counselors. For the purposes of CHAMPUS a pastoral counselor is an individual who meets the following requirements:

(a) Recognized graduate professional education with the minimum of an earned master's degree from a regionally accredited educational institution in an appropriate behavioral science field, mental health discipline; and

(b) The following experience:

1 Either 200 hours of approved supervision in the practice of pastoral counseling, ordinarily to be completed in a 2- to 3-year period, of which at least 100 hours must be in individual supervision. This supervision will occur preferably with more than one supervisor and should include a continuous process of supervision with at least three cases; and

2 1,000 hours of clinical experience in the practice of pastoral counseling under approved supervision, involving at least 50 different cases; or

3 150 hours of approved supervision in the practice of psychotherapy, ordinarily to be completed in a 2- to 3-year period, of which at least 50 hours must be individual supervision; plus at least 50 hours of approved individual supervision in the practice of pastoral counseling, ordinarily to be completed within a period of not less than 1 nor more than 2 years; and

4 750 hours of clinical experience in the practice of psychotherapy under approved supervision involving at least 30 cases; plus at least 250 hours of clinical practice in pastoral counseling under approved supervision, involving at least 20 cases; and

(c) Is licensed or certified to practice by the jurisdiction where practicing (see C.3.d.(4) of this part for more specific information regarding licensure); and

(d) The services of a pastoral counselor meeting the above requirements are coverable following the CHAMPUS determined allowable charge methodology, under the following specified conditions:

1 The CHAMPUS beneficiary must be referred for therapy by a physician; and

2 A physician is providing ongoing oversight and supervision of the therapy being provided; and

3 The pastoral counselor must certify on each claim for reimbursement that a written communication has been made or will be made to the referring physician of the results of the treatment. Such communication will be made at the end of the treatment, or more frequently, as required by the referring physician (refer to Chapter 7).

(e) Because of the similarity of the requirements for licensure, certification, experience and education a pastoral counselor may elect to be authorized under CHAMPUS as a certified marriage and family therapist, and as such, be subject to all previously defined criteria for the certified marriage and family therapist category, to include acceptance of the CHAMPUS determined allowable charge as payment in full, except for applicable deductibles and cost-shares, (i.e., balance billing of a beneficiary above the allowable charge is prohibited; may not bill beneficiary for noncovered care). The pastoral counselor must also agree to enter into the same participation agreement as a certified marriage and family therapist with the Office of CHAMPUS within which the pastoral counselor agrees to all provisions, including licensure, national association membership and conditions upon termination, outlined above for certified marriage and family therapists.

NOTE: No dual status will be recognized by the Office of CHAMPUS. Pastoral counselors must elect to become one of the categories of extramedical CHAMPUS providers specified above. Once authorized as either a pastoral counselor, or a certified marriage and family therapist, claims review and reimbursement will be in accordance with the criteria established for the elected provider category.

(3) Mental Health Counselor. For the purposes of CHAMPUS, a mental health counselor is an individual who meets the following requirements:

(a) Minimum of a master's degree in mental health counseling or allied mental health field from a regionally accredited institution; and

(b) Two years of post-master's experience which includes 3000 hours of clinical work and 100 hours of face-to-face supervision; and

(c) Is licensed or certified to practice as a mental health counselor by the jurisdiction where practicing (see C.3.d.(4) of this part for more specific information); and

(d) May only be reimbursed when:

1 The CHAMPUS beneficiary is referred for therapy by a physician; and

2 A physician is providing ongoing oversight and supervision of the therapy being provided; and

3 The mental health counselor certifies on each claim for reimbursement that a written communication has been made or will be made to the referring physician of the results of the treatment. Such communication will be made at the end of the treatment, or more frequently, as required by the referring physician (refer to Chapter 7).

(4) The following additional information applies to each of the above categories of extramedical individual providers:

(a) These providers must also be licensed or certified to practice as a certified marriage and family therapist, pastoral counselor or mental health counselor by the jurisdiction where practicing. In jurisdictions that do not provide for licensure or certification, the provider must be certified by or eligible for full clinical membership in the appropriate national professional association that sets standards for the specific profession.

(b) Grace period for therapists or counselors in states where licensure/certification is optional. CHAMPUS is providing a grace period for those therapists or counselors who did not obtain optional licensure/certification in their jurisdiction, not realizing it was a CHAMPUS requirement for authorization. The exemption by state law for pastoral counselors may have misled this group into thinking licensure was not required. The same situation may have occurred with the other therapist or counselor categories. This grace period pertains only to the licensure/certification requirement, applies only to therapists or counselors who are already approved as of October 29, 1990, and only in those areas where the licensure/certification is optional. Any therapist or counselor who is not licensed/certified in the state in which he/she is practicing by August 1, 1991, will be terminated under the provisions of Section 199.9 of this part. This grace period does not change any of the other existing requirements which remain in effect. During this grace period, membership or proof of eligibility for full clinical membership in a recognized professional association is required for those therapists or counselors who are not licensed or certified by the state. The following organizations are recognized for therapists or counselors at the level indicated: full clinical member of the American Association of Marriage and Family Therapy; membership at the fellow or diplomate level of the American Association of Pastoral Counselors; and membership in the National Academy of Certified Clinical Mental Health Counselors. Acceptable proof of eligibility for membership is a letter from the appropriate certifying organization. This opportunity for delayed certification/licensure is limited to the counselor or therapist category only as the language in all of the other provider categories has been consistent and unmodified from the time each of the other provider categories were added. The grace period does not apply in those states where licensure is mandatory.

(5) Christian Science practitioners and Christian Science nurses. CHAMPUS cost shares the services of Christian Science practitioners and nurses. In order to bill as such, practitioners or nurses must be listed or be eligible for listing in the Christian Science Journal at the time the service is provided.

D. OTHER PROVIDERS

Certain medical supplies and services of an ancillary or supplemental nature are coverable by CHAMPUS, subject to certain controls. This category of provider includes the following:

1. Independent laboratory. Laboratory services of independent laboratories may be cost-shared if the laboratory is approved for participation under Medicare and certified by the Medicare Bureau, Health Care Financing Administration.
2. Suppliers of portable x-ray services. Such suppliers must meet the conditions of coverage of the Medicare program, set forth in the Medicare regulations (reference (h)), or the Medicaid program in that state in which the covered service is provided.
3. Pharmacies. Pharmacies must meet the applicable requirements of state law in the state in which the pharmacy is located.
4. Ambulance companies. Such companies must meet the requirements of state and local laws in the jurisdiction in which the ambulance firm is licensed.
5. Medical equipment firms, medical supply firms. As determined by the Director, OCHAMPUS, or a designee.
6. Mammography Suppliers. Mammography services may be cost-shared only if the supplier is certified by Medicare for participation as a mammography supplier, or is certified by the American College of Radiology as having met its mammography supplier standards.

E. IMPLEMENTING INSTRUCTIONS

The Director, OCHAMPUS, or a designee, shall issue CHAMPUS policies, instructions, procedures, and guidelines, as may be necessary to implement the intent of this chapter.

F. EXCLUSION

Regardless of any provision in this chapter, a provider who is suspended, excluded, or terminated under Chapter 9 of this Regulation is specifically excluded as an authorized CHAMPUS provider.

CHAPTER 13
DEPENDENTS DENTAL PLAN

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CHAPTER 13
DEPENDENTS DENTAL PLAN

A. GENERAL PROVISIONS.

1. Purpose. This section prescribes guidelines and policies for the delivery and administration of the Active Duty Dependents Dental Plan of the Uniformed Services for the Army, the Navy, the Air Force, the Marine Corps, the Coast Guard, the Commissioned Corps of the U.S. Public Health Service (USPHS), and the Commissioned Corps of the National Oceanic and Atmospheric Administration (NOAA).

2. Applicability

a. Geographic. This section is applicable geographically within the 50 States of the United States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, and the U.S. Virgin Islands.

b. Agency. The provisions of this section apply throughout the Department of Defense (DoD), the Coast Guard, the Commissioned Corps of the USPHS, and the Commissioned Corps of the NOAA.

3. Authority and responsibility

a. Legislative authority

(1) Joint regulations. 10 U.S.C. Chapter 55, 1076a authorizes the Secretary of Defense, in consultation with the Secretary of Health and Human Services and the Secretary of Transportation, to prescribe regulations for the administration of the Active Duty Dependents Dental Plan.

(2) Administration. 10 U.S.C. Chapter 55 also authorizes the Secretary of Defense to administer the Active Duty Dependents Dental Plan for the Army, Navy, Air Force, and Marine Corps under DoD jurisdiction, the Secretary of Transportation to administer the Active Duty Dependents Dental Plan for the Coast Guard, when the Coast Guard is not operating as a service in the Navy, and the Secretary of Health and Human Services to administer the Active Duty Dependents Dental Plan for the Commissioned Corps of the NOAA and the USPHS.

(3) Care outside the United States. 10 U.S.C., Chapter 55, 1076a authorizes the Secretary of Defense to establish basic dental benefit plans for eligible dependents of members of the uniformed services accompanying the member on permanent assignments of duty outside the United States.

b. Organizational delegations and assignments

(1) Assistant Secretary of Defense (Health Affairs) (ASD(HA)). The Secretary of Defense, by DoD Directive 5136.1 (reference(b)), delegated authority to the ASD(HA) to provide policy guidance, management control, and coordination as required for all DoD health and medical

resources and functional areas including health benefit programs. Implementing authority is contained in DoD 5025.1-M (reference(c)). For additional implementing authority see Chapter 1.C. of this Regulation.

(2) Evidence of eligibility. The Department of Defense, through the Defense Enrollment Eligibility Reporting System (DEERS), is responsible for establishing and maintaining a listing of persons eligible to receive benefits under the Active Duty Dependents Dental Plan.

4. Active duty dependents dental benefit plan. This is a program of dental benefits provided by the U.S. Government under public law to specified categories of individuals who are qualified for these benefits by virtue of their relationship to one of the seven Uniformed Services, and their voluntary decision to accept enrollment in the program and cost-share with the Government in the premium cost of the benefits. The Dependents Dental Plan is an insurance, service, or prepayment plan involving a contract guaranteeing the indemnification or payment of the enrolled member's dependents against a specified loss in return for a premium paid. Where state regulations, charter requirements, or other provisions of state and local regulation governing dental insurance and prepayment programs conflict with Federal law and regulation governing this Program, Federal law and regulation shall govern. Otherwise, this Program shall comply with state and local regulatory requirements.

5. Plan funds

a. Funding sources. The funds used by the Active Duty Dependents Dental Plan are appropriated funds furnished by the Congress through the annual appropriation acts for the Department of Defense and the Department of Health and Human Services and funds collected by the Uniformed Services monthly through payroll deductions as premium shares from enrolled members.

b. Disposition of funds. Plan funds are paid by the Government as premiums to an insurer, service, or prepaid dental care organization under a contract negotiated by the Director, OCHAMPUS, or a designee, under the provisions of the Federal Acquisition Regulation (FAR).

c. Plan. The Director, OCHAMPUS or designee provides an insurance policy, service plan, or prepaid contract of benefits in accordance with those prescribed by law and regulation; as interpreted and adjudicated in accord with the policy, service plan, or contract and a dental benefits brochure; and as prescribed by requirements of the dental plan organization's contract with the government.

d. Contracting out. The method of delivery of the Active Duty Dependents Dental Benefit Plan is through a competitively procured contract. The Director, OCHAMPUS, or a designee is responsible for negotiating, under provisions of the FAR, a contract for dental benefits insurance or prepayment which includes responsibility for (1) development, publication, and enforcement of benefit policy, exclusions, and limitations in compliance with the

law, regulation, and the contract provisions; (2) adjudicating and processing claims; and (3) conduct of related supporting activities, such as eligibility verification, provider relations, and beneficiary communications.

6. Role of Health Benefits Advisor (HBA). The HBA is appointed (generally by the commander of a Uniformed Services medical treatment facility) to serve as an advisor to patients and staff in matters involving the Active Duty Dependents Dental Plan. The HBA may assist beneficiaries or sponsors in applying for benefits, in the preparation of claims, and in their relations with OCHAMPUS and the dental plan insurer. However, the HBA is not responsible for the plan's policies and procedures and has no authority to make benefit determinations or obligate the plan's funds. Advice given to beneficiaries as to determination of benefits or level of payment is not binding on OCHAMPUS or the insurer.

7. Disclosure of information to the public. Records and information acquired in the administration of the Active Duty Dependents Dental Plan are not records of the Department of Defense. The records are established by the Dependents Dental Plan insurer in accordance with standard business practices of the industry, and are used in the determination of eligibility, program management and operations, utilization review, quality assurance, program integrity, and underwriting in accordance with standard business practices. By contract, the records and information are subject to government audit and the government receives reports derived from them. Records and information specified by contract are provided by an outgoing insurer to a successor insurer in the event of a change in the contractor.

8. Equality of benefits. All claims submitted for benefits under the Active Duty Dependents Dental Plan shall be adjudicated in a consistent, fair, and equitable manner, without regard to the rank of the sponsor.

9. Coordination of benefits. The dental plan insurer shall conduct coordination of benefits for the Active Duty Dependents Dental Plan in accordance with generally accepted business practices.

10. Information on participating providers. The Director, OCHAMPUS or designee, shall develop and make available to Uniformed Services Health Benefits Advisors and military installation personnel centers copies of lists of participating providers and providers accepting assignment for all localities with significant numbers of dependents of active duty members. In addition, the Director, OCHAMPUS or designee, shall respond to inquiries regarding availability of participating providers in areas not covered by the lists of participating providers.

B. DEFINITIONS

For most definitions applicable to the provisions of this section, refer to Chapter 2 of this Regulation. The following definitions apply only to this section.

Assignment. Acceptance by a nonparticipating provider of payment directly from the insurer while reserving the right to charge the beneficiary or sponsor for any remaining amount of the fees for services which exceeds the prevailing fee allowance of the insurer.

Authorized Provider. A dentist or dental hygienist specifically authorized to provide benefits under the Active Duty Dependents Dental Plan in Section F. of this Chapter.

Beneficiary. A dependent of an active duty member who has been enrolled in the Active Duty Dependents Dental Plan, and has been determined to be eligible for benefits, as set forth in Section C. of this Chapter.

Beneficiary Liability. The legal obligation of a beneficiary, his or her estate, or responsible family member to pay for the costs of dental care or treatment received. Specifically, for the purposes of services and supplies covered by the Active Duty Dependents Dental Benefit Plan, beneficiary liability includes cost-sharing amounts and any amount above the prevailing fee determination by the insurer where the provider selected by the beneficiary is not a participating provider or a provider within an approved alternative delivery system. Beneficiary liability also includes any expenses for services and supplies not covered by the Active Duty Dependents Dental Benefit Plan, less any discount provided as a part of the insurer's agreement with an approved alternative delivery system.

By report. Dental procedures which are authorized as benefits only in unusual circumstances requiring justification of exceptional conditions related to otherwise authorized procedures. For example, a house call might be justified based on an enrolled dependent's severe handicap which prevents visits in the dentist's office for traditional prophylaxis. Alternatively, additional drugs might be required separately from an otherwise authorized procedure because of an emergent reaction caused by drug interaction during the performance of a restoration procedure. These services are further defined in Section E. of this Chapter.

Cost-Share. The amount of money for which the beneficiary (or sponsor) is responsible in connection with otherwise covered dental services (other than disallowed amounts) as set forth in Sections D. and G. of this Chapter. Cost-sharing may also be referred to as "co-payment."

Defense Enrollment Eligibility Reporting System (DEERS). The automated system that is composed of two phases:

1. Enrolling all active duty and retired service members, their dependents, and the dependents of deceased service members, and
2. Verifying their eligibility for health care benefits in the direct care facilities and through the Active Duty Dependents Dental Plan.

Dental hygienist. Practitioner in rendering complete oral prophylaxis services, applying medication, performing dental radiography, and providing dental education services with a certificate, associate degree, or bachelor's degree in the field, and licensed by an appropriate authority.

Dentist. Doctor of Dental Medicine (D.M.D.) or Doctor of Dental Surgery (D.D.S.) who is licensed to practice dentistry by an appropriate authority.

Diagnostic services. Category of dental services including (1) clinical oral examinations, (2) radiographic examinations, and (3) diagnostic laboratory tests and examinations provided in connection with other dental procedures authorized as benefits of the Active Duty Dependents Dental Plan and further defined in Section E. of this Chapter.

Emergency palliative services. Minor procedures performed for the immediate relief of pain and discomfort as further defined in Section E of this Chapter. This definition excludes those procedures other than minor palliative services which may result in the relief of pain and discomfort, but constitute the usual initial stage or conclusive treatment in procedures not otherwise defined as benefits of the Active Duty Dependents Dental Plan.

Endodontics. The etiology, prevention, diagnosis, and treatment of diseases and injuries affecting the dental pulp, tooth root, and periapical tissue as further defined in Section E. of this Chapter.

Initial Determination. A formal written decision on an Active Duty Dependents Dental Plan claim, a request by a provider for approval as an authorized provider, or a decision disqualifying or excluding a provider as an authorized provider under the Active Duty Dependents Dental Plan. Rejection of a claim or a request for benefit or provider authorization for failure to comply with administrative requirements, including failure to submit reasonably requested information, is not an initial determination. Responses to general or specific inquiries regarding Active Duty Dependent Dental Plan benefits are not initial determinations.

Laboratory and Pathology Services. Laboratory and pathology examinations (including machine diagnostic tests that produce hard-copy results) ordered by a dentist when necessary to, and rendered in connection with other covered dental services.

Nonparticipating provider. A dentist or dental hygienist that furnished dental services to an Active Duty Dependents Dental Plan beneficiary, but who has not agreed to participate or to accept the insurer's fee allowances and applicable cost-share as the total charge for the services. A nonparticipating provider looks to the beneficiary or sponsor for final responsibility for payment of his or her charge, but may accept payment (assignment of benefits) directly from the insurer or assist the beneficiary in filing the claim for reimbursement by the contractor. Where the nonparticipating provider does not accept payment directly from the insurer, the insurer pays the beneficiary or sponsor, not the provider.

Oral Surgery. Surgical procedures performed in the oral cavity as further defined in Section E. of this Chapter.

Orthodontics. The supervision, guidance, and correction of the growing or mature dentofacial structures, including those conditions that require movement of teeth or correction of malrelationships and malformations of their related structures and adjustment of relationships between and among teeth and facial bones by the application of forces and/or the stimulation and redirection of functional forces within the craniofacial complex.

Participating Provider. A dentist or dental hygienist who has agreed to accept the insurer's reasonable fee allowances or other fee arrangements as the total charge (even though less than the actual billed amount), including provision for payment to the provider by the beneficiary (or sponsor) of any cost-share for services.

Party to a Hearing. An appealing party or parties, the insurer, and OCHAMPUS.

Party to the Initial Determination. Includes the Active Duty Dependents Dental Plan, a beneficiary of the Active Duty Dependents Dental Plan and a participating provider of services whose interests have been adjudicated by the initial determination. In addition, a provider who has been denied approval as an authorized Active Duty Dependents Dental Plan provider is a party to that initial determination, as is a provider who is disqualified or excluded as an authorized provider, unless the provider is excluded under another federal or federally funded program. See Section H. of this Chapter for additional information concerning parties not entitled to administrative review under the Active Duty Dependents Dental Plan appeals procedures.

Periodontics. The examination, diagnosis, and treatment of diseases affecting the supporting structures of the teeth as further defined in Section E. of this Chapter.

Preventive Services. Traditional prophylaxis including scaling deposits from teeth, polishing teeth, and topical application of fluoride to teeth as further defined in Section E. of this Chapter.

Prosthodontics. The diagnosis, planning, making, insertion, adjustment, relinement, and repair of artificial devices intended for the replacement of missing teeth and associated tissues as further defined in Section E. of this Chapter.

Provider. A dentist or dental hygienist as specified in Section F. of this Chapter.

Representative. Any person who has been appointed by a party to the initial determination as counsel or advisor and who is otherwise eligible to serve as the counsel or advisor of the party to the initial determination, particularly in connection with a hearing.

Restorative services. Restoration of teeth including those procedures commonly described as amalgam restorations, resin restorations, pin retention, and stainless steel crowns for primary teeth as further defined in Section E. of this Chapter.

Sealants. A material designed for application on the occlusal surfaces of specified teeth to seal the surface irregularities to prevent ingress of oral fluids, food, and debris in order to prevent tooth decay.

C. ENROLLMENT AND ELIGIBILITY

1. General. Sections 1076a, 1072(2)(A), (D) or (I) and 1072(6) of 10 U.S.C., Chapter 55 set forth those persons who are eligible for voluntary enrollment in the Active Duty Dependents Dental Benefit Plan. A determination that a person is eligible for voluntary enrollment does not entitle such a person automatically to benefit payments. The active duty member must enroll his or her dependents as defined in this Part, and other Parts of this Regulation set forth additional requirements that must be met before eligibility for the plan is extended.

2. Persons eligible. Dependent. A person who bears one of the following relationships to an active duty member (under a call or order that does not specify a period of 30 days or less):

a. Spouse. A lawful husband or wife, regardless of whether or not dependent upon the active duty member.

b. Child. To be eligible, the child must be unmarried and meet one of the requirements of this section.

(1) A legitimate child.

(2) An adopted child whose adoption has been completed legally.

(3) A legitimate stepchild.

(4) An illegitimate child of a male member whose paternity has been determined judicially, or an illegitimate child of record of a female member who has been directed judicially to support the child.

(5) An illegitimate child of a male active duty member whose paternity has not been determined judicially, or an illegitimate child of record of a female active duty member who:

(a) Resides with or in a home provided by the member and

(b) Is and continues to be dependent upon the member for over 50 percent of his or her support.

(6) An illegitimate child of the spouse of an active duty member (that is, the active duty member's stepchild) who:

(a) Resides with or in a home provided by the active duty member or the parent who is the spouse of the member and

(b) Is and continues to be dependent upon the member for over 50 percent of his or her support.

(7) A child placed in the custody of a service member by a court or recognized adoption agency on or after October 5, 1994, in anticipation of a legal adoption.

(8) In addition to meeting one of the criteria (1) through (6) of this paragraph C.2., the child:

(a) Must not be married.

(b) Must be in one of the following three age groups:

1 Not passed his or her 21st birthday.

2 Passed his or her 21st birthday, but incapable of self-support because of a mental or physical incapacity that existed before his or her 21st birthday and dependent on the member for over 50 percent of his or her support. Such incapacity must be continuous. If the incapacity significantly improves or ceases at any time after age 21, even if such incapacity recurs subsequently, eligibility cannot be reinstated on the basis of the incapacity. If the child was not handicapped mentally or physically at his or her 21st birthday, but becomes so incapacitated after that time, no eligibility exists on the basis of the incapacity.

3 Passed his or her 21st birthday, but not his or her 23rd birthday, dependent upon the member for over 50 percent of his or her support, and pursuing a full-time course of education in an institution of higher learning approved by the Secretary of Defense or the Department of Education (as appropriate) or by a state agency under 38 U.S.C., Chapters 34 and 35.

NOTE: Courses of education offered by institutions listed in the "Education Directory, Part 3, Higher Education" or "Accredited Higher Institutions," issued periodically by the Department of Education meet the criteria approved by the Secretary of Defense or the Department of Education, (refer to Chapter 3, B.2.d.(3)(c) of this Regulation). For determination of approval of courses offered by a foreign institution, by an institution not listed in either of the above directories, or by an institution not approved by a state agency pursuant to Chapters 34 and 35 of 38 U.S.C., a statement may be obtained from the Department of Education, Washington, D.C. 20202.

3. Enrollment

a. Basic active duty dependents dental benefit plan. The dependents dental plan is effective from August 1, 1987, up to the date of implementation of the Expanded Active Duty Dependents Dental Benefit Plan.

(1) Initial enrollment. Eligible dependents of members on active duty status as of August 1, 1987 are automatically enrolled in the Active Duty Dependents Dental Plan; except where any of the following conditions apply:

(a) Remaining period of active duty at the time of contemplated enrollment is expected by the active duty member or the Uniformed Service to be less than two years, except that such members' dependents may be enrolled during the initial enrollment period for benefits beginning August 1, 1987 provided that the member had at least six months remaining in the initial enlistment term. Enrollment of dependents is for a period of 24 months, subject to the exceptions provided in C.5. of this section.

(b) Active duty member had completed an election to disenroll his or her dependents from the Basic Active Duty Dependents Dental Benefit Plan.

(c) Active duty member had only one dependent who is under four years of age as of August 1, 1987, and the member did not complete an election form to enroll the child.

(2) Subsequent enrollment. Eligible active duty members may elect to enroll their dependents for a period of not less than 24 months, provided there is an intent to remain on active duty for a period of not less than two years by the member and the Uniformed Service.

(3) Inclusive family enrollment. All eligible dependents of the active duty member must be enrolled if any were enrolled, except that a member may elect to enroll only those dependents who are remotely located from the member (e.g., a child living with a divorced spouse or a child in college).

b. Expanded active duty dependents dental benefit plan. The expanded dependents dental plan is effective on April 1, 1993. The Basic Active Duty Dependents Dental Benefit Plan terminated upon implementation of the expanded plan.

(1) Initial enrollment. Enrollment in the Expanded Active Duty Dependents Dental Benefit Plan is automatic for all eligible dependents of active duty members known to have at least 24 months remaining in service, and for those dependents enrolled in the Basic Dependents Dental Benefit Plan regardless of the military member's remaining time in service unless the active duty member elects to disenroll his or her dependents during the

one-time disenrollment option period (one-month period before the date on which the expanded plan went into effect, and for 4 months after the beginning date). Those active duty members who intend to remain in the service for 24 months or more, whose dependents were not automatically enrolled, may enroll them at their military personnel office by completing the appropriate Uniformed Services Active Duty Dependents Dental Plan Enrollment Election Form.

NOTE: Use of the new plan during the one-time disenrollment option period by a dependent enrolled in the Basic Active Duty Dependents Dental Benefit Plan, constitutes acceptance of the plan by the military sponsor and his or her family. Once the new plan is used, the family cannot be disenrolled, and the premiums will not be refunded.

(2) Subsequent enrollment. Eligible active duty members may elect to enroll their dependents for a period of not less than 24 months, provided there is an intent to remain on active duty for a period of not less than two years by the member and the Uniformed Service.

(3) Inclusive family enrollment. All eligible dependents of the active duty member must be enrolled if any are enrolled, except as defined in paragraphs C.3.b.(3)(a) and (b) below.

(a) Enrollment will be by either single or family premium as defined herein:

1 Single premium.

a Sponsors with only one family member age four (4) or older who elect to enroll that family member; or

b Sponsors who have more than one family member under age four (4) may elect to enroll one (1) family member under age four (4); or

c Sponsors who elect to enroll one (1) family member age four or older but may have any number of family members under age four (4) who are not elected to be covered.

NOTE: At such time when the sponsor elects to enroll more than one (1) eligible family member, regardless of age, the sponsor must then enroll under a family premium which covers all eligible family members.

2 Family premium.

a Sponsors with two (2) or more eligible family members age four (4) or older must enroll under the family premium.

b Sponsors with one (1) eligible family member age four (4) or older and one (1) or more eligible family members under the age of four may elect to enroll under a family premium.

c Under the family premium, all eligible family members of the sponsor are enrolled.

(b) Exceptions.

1 A sponsor may elect to enroll only those eligible family members residing in one location when the sponsor has other eligible family members residing in two or more physically separate locations (e.g., children living with a divorced spouse; children attending college).

2 In instances where a family member requires hospital or special treatment environment (due to a medical, physical handicap, or mental condition) for dental care otherwise covered by the dental plan, the family member may be excluded from the dental plan enrollment and may continue to receive care from a military treatment facility.

(4) Enrollment Period. Enrollment of dependents is for a period of 24 months except when:

(a) The dependent's enrollment is based on his or her enrollment in the Basic Active Duty Dependents Dental Benefit; or

(b) One of the conditions for disenrollment in C.5. of this section is met.

4. Beginning dates of eligibility.

a. Basic active duty dependents dental benefit plan.

(1) Initial enrollment. The beginning date of eligibility for benefits is August 1, 1987.

(2) Subsequent enrollment. The beginning date of eligibility for benefits is the first day of the month following the month in which the election of enrollment is completed, signed, and received by the active duty member's Service representative, except that the date of eligibility shall not be earlier than September 1, 1987.

b. Expanded active duty dependents dental benefit plan.

(1) Initial enrollment. The beginning date of eligibility for benefits is April 1, 1993.

(2) Subsequent enrollment. The beginning date of eligibility for benefits is the first day of the month following the month in which the election of enrollment is completed, signed, and received by the active duty member's Service representative, except that the date of eligibility shall not be earlier than the first of the month following the month of implementation of the expanded benefit.

5. Changes in and termination of enrollment

a. Changes in status of active duty member. When an active duty member's period of active duty ends for any reason, his or her dependents lose their eligibility as of 11:59 p.m. of the last day of the month in which the active duty ends.

b. Termination of eligibility for basic pay. When a member ceases to be eligible for basic pay, eligibility of the member's dependents for benefits under the Dependents Dental Plan terminates as of 11:59 p.m. of the day the member became ineligible for basic pay and the Uniformed Service must notify the Plan of disenrollment based on termination of eligibility for basic pay. The member whose eligibility for basic pay is subsequently restored may enroll his or her dependents for a minimum of two years in accordance with C.3.b.

c. Changes in status of dependent

(1) Divorce. A spouse separated from an active duty member by a final divorce decree loses all eligibility based on his or her former marital relationship as of 11:59 p.m. of the last day of the month in which the divorce becomes final. The eligibility of the member's own children (including adopted and eligible illegitimate children) is unaffected by the divorce. An unadopted stepchild, however, loses eligibility with the termination of the marriage, also as of 11:59 p.m. the last day of the month in which the divorce becomes final.

(2) Annulment. A spouse whose marriage to an active duty member is dissolved by annulment loses eligibility as of 11:59 p.m. of the last day of the month in which the court grants the annulment order. The fact that the annulment legally declares the entire marriage void from its inception does not affect the termination date of eligibility. When there are children, the eligibility of the member's own children (including adopted and eligible illegitimate children) is unaffected by the annulment. An unadopted stepchild, however, loses eligibility with the annulment of the marriage, also as of 11:59 p.m. of the last day of the month in which the court grants the annulment order.

(3) Adoption. A child of an active duty member who is adopted by a person, other than a person whose dependents are eligible for the Active Duty Dependents Dental Plan benefits while the active duty member is living, thereby severing the legal relationship between the child and the sponsor, loses eligibility as of 11:59 p.m. of the last day of the month in which the adoption becomes final.

(4) Marriage of child. A child of an active duty member who marries a person whose dependents are not eligible for the Active Duty Dependents Dental Plan, loses eligibility as of 11:59 p.m. on the last day of the month in which the marriage takes place. However, should the marriage be terminated by death, divorce, or annulment before the child is 21 years old,

the child again becomes eligible for enrollment as a dependent as of 12:00 a.m. of the first day of the month following the month in which the occurrence takes place that terminates the marriage and continues up to age 21 if the child does not remarry before that time. If the marriage terminates after the child's 21st birthday, there is no reinstatement of eligibility.

(5) Disabling illness or injury of child age 21 or 22 who has eligibility based on his or her student status. A child 21 or 22 years old who is pursuing a full-time course of higher education and who, either during the school year or between semesters, suffers a disabling illness or injury with resultant inability to resume attendance at the institution remains eligible for dental benefits for 6 months after the disability is removed or until the student passes his or her 23rd birthday, whichever occurs first. However, if recovery occurs before the 23rd birthday and there is resumption of a full-time course of higher education, dental benefits can be continued until the 23rd birthday. The normal vacation periods during an established school year do not change the eligibility status of a dependent child 21 or 22 years old in full-time student status. Unless an incapacitating condition existed before, and at the time of, a dependent child's 21st birthday, a dependent child 21 or 22 years old in student status does not have eligibility related to mental or physical incapacity as described in Chapter 3, B.2.d.(3)(b) of this Regulation.

d. Disenrollment because of no eligible dependents. When an active duty member ceases to have any eligible dependents, the member must disenroll.

e. Option to disenroll as a result of a change in active duty station. When an active duty member transfers with enrolled family members to a duty station where space-available dental care is readily available at the local military clinic, the member may elect within 90 days of the transfer to disenroll from the plan. If the member is later transferred to a duty station where dental care is not available in the local military clinic, the member may re-enroll his or her dependents in the plan.

f. Option to disenroll after an initial two-year enrollment. When an active duty member's enrollment of his or her dependents has been in effect for a continuous period of two years, the member may disenroll his or her dependents at any time. Subsequently, the member may enroll his or her dependents for another minimum period of two years.

6. Eligibility determination and enrollment

a. Eligibility determination and enrollment responsibility of Uniformed Services. Determination of a person's eligibility and processing of enrollment in the Active Duty Dependents Dental Benefit Plan is the responsibility of the active duty member's Uniformed Service. For the purpose of program integrity, the appropriate Uniformed Service shall, upon request of the Director, OCHAMPUS, review the eligibility of a specific

person when there is reason to question the eligibility status. In such cases, a report on the result of the review and any action taken will be submitted to the Director, OCHAMPUS, or a designee.

b. Procedures for determination of eligibility. Uniformed Services identification cards do not distinguish eligibility for the Active Duty Dependents Dental Plan. Procedures for the determination of eligibility are identified in Chapter 3, F.2. of this Regulation, except that Uniformed Services identification cards do not provide evidence of eligibility for the dental plan.

7. Evidence of eligibility required. Eligibility and enrollment in the Active Duty Dependents Dental Plan will be verified through the DEERS (DoD 1341.1-M, "Defense Enrollment Eligibility Reporting System (DEERS) Program Manual," May 1982).

a. Acceptable evidence of eligibility and enrollment. Eligibility information established and maintained in the DEERS files is the only acceptable evidence of eligibility.

b. Responsibility for obtaining evidence of eligibility. It is the responsibility of the active duty member, or Active Duty Dependent Dental Plan beneficiary, parent, or legal representative, when appropriate, to enroll with a Uniformed Service authorized representative and provide adequate evidence for entry into the DEERS file to establish eligibility for the Active Duty Dependents Dental Plan, and to ensure that all changes in status that may affect enrollment and eligibility are reported immediately to the appropriate Uniformed Service for action. Ineligibility for benefits is presumed in the absence of prescribed enrollment and eligibility evidence in the DEERS file.

8. Continuation of eligibility for dependents of service members who die on active duty. Eligible dependents of service members who die on for after October 1, 1993, while on active duty for a period of more than 30 days and who are enrolled in the dental benefits plan on the date of the death of the member shall be eligible for continued enrollment in the dental benefits plan for up to one year from the date of the service member's death.

D. PREMIUM SHARING

1. General. Active duty members enrolling their dependents in the Active Duty Dependents Dental Plan shall be required to pay a share of the premium cost for their dependents.

2. Premium classifications. Premium classifications are established by the Secretary of Defense, or designee, and provide for a minimum of two classifications, single and family.

3. Premium amounts. The premium amounts to be paid for the Active Duty Dependents Dental plan are established by the Secretary of Defense or designee.

4. Proportion of member's premium share. The proportion of premium share to be paid by the member is established by the Secretary of Defense or designee, at not more than 40 percent of the total premium.

5. Pay deduction. The member's premium share shall be deducted from the basic pay of the member.

E. PLAN BENEFITS

1. General

a. Scope of benefits. The Active Duty Dependents Dental Benefit Plan provides coverage for diagnostic and preventive services, sealants, restorative services, endodontics, periodontics, prosthodontics, orthodontics and oral surgery to eligible, enrolled dependents of active duty members as set forth in Section C. of this Chapter.

b. Authority to act for the plan. The authority to make benefit determinations and authorize plan payments under the Active Duty Dependents Dental Plan rests primarily with the insurance, service plan, or prepayment dental plan contractor, subject to compliance with federal law and regulation and government contract provisions. The Director, OCHAMPUS, or designee, provides required benefit policy decisions resulting from changes in federal law and regulation and appeal decisions. No other persons or agents (such as dentists or Uniformed Services health benefits advisors) have such authority.

c. Right to information. As a condition precedent to the provision of benefits hereunder, the Director, OCHAMPUS, or designee, shall be entitled to receive information from an authorized provider or other person, institution, or organization (including a local, state, or U.S. Government agency) providing services or supplies to the beneficiary for which claims for benefits are submitted. While establishing enrollment and eligibility, benefits, and benefit utilization and performance reporting information standards; the government has not established and does not maintain a system of records and information for the Dependents Dental Plan. By contract, the government audits the adequacy and accuracy of the dental contractor's system of records and requires access to information and records to meet program accountabilities. Such information and records may relate to attendance, testing, monitoring, examination, or diagnosis of dental disease or conditions; or treatment rendered; or services and supplies furnished to a beneficiary; and shall be necessary for the accurate and efficient administration and payment of benefits under this plan. Before a determination will be made on a claim of benefits, a beneficiary or active duty member must provide particular additional information relevant to the requested determination, when necessary. Failure to provide the requested information may result in denial of the claim. The recipient of such information shall in every case hold such records confidential except when:

(1) Disclosure of such information is necessary to the determination by a provider or the Plan contractor of beneficiary enrollment or eligibility for coverage of specific services;

(2) Disclosure of such information is authorized specifically by the beneficiary;

(3) Disclosure is necessary to permit authorized governmental officials to investigate and prosecute criminal actions; or

(4) Disclosure constitutes a standard and acceptable business practice commonly used among dental insurers which is consistent with the principle of preserving confidentiality of personal information and detailed clinical data. For example, the release of utilization information for the purpose of determining eligibility for certain services, such as the number of dental prophylaxis procedures performed for a beneficiary, is authorized.

(5) Disclosure by the Director, OCHAMPUS, or designee, is for the purpose of determining the applicability of, and implementing the provisions of, other dental benefits coverage or entitlement.

NOTE: Release by the recipient of the information under the confidentiality exceptions identified in E.1.c. is authorized without consent or notice to any beneficiary or sponsor, to any person, organization, government agency, provider, or other entity.

d. Dental insurance policy, prepayment, or dental service plan contract. The Director, OCHAMPUS, or designee, shall develop a standard insurance policy, prepayment agreement, or dental service plan contract designating OCHAMPUS as the policyholder or purchaser. The policy shall be in the form customarily employed by the dental plan insurer, subject to its compliance with federal law and the provisions of this Regulation.

e. Dental benefits brochure

(1) Content. The Director, OCHAMPUS, or designee shall establish a dental benefits brochure explaining the benefits of the plan in common lay terminology. The brochure shall include the limitations and exclusions and other benefit determination rules for administering the benefits in accordance with the law and this part. The brochure shall include the rules for adjudication and payment of claims, appealable issues, and appeal procedures in sufficient detail to serve as a common basis for interpretation and understanding of the rules by providers, beneficiaries, claims examiners, correspondence specialists, employees and representatives of other government bodies, health benefits advisors, and other interested parties. Any conflict which may occur between the dental benefits brochure and law or regulation shall be resolved in favor of law and regulation.

(2) Distribution. The dental benefits brochure shall be printed and distributed with the assistance of the Uniformed Services health benefits advisors, major personnel centers at Uniformed Services installations, and authorized providers of care to all active duty members enrolling their dependents.

f. Utilization review and quality assurance. Claims submitted for benefits under the Active Duty Dependents Dental Plan are subject to review by the Director, OCHAMPUS or designee for quality of care and appropriate utilization. The Director, OCHAMPUS or designee is responsible for appropriate utilization review and quality assurance standards, norms, and criteria consistent with the level of benefits.

g. Alternative course of treatment policy. The Director, OCHAMPUS or designee may establish, in accordance with generally accepted dental benefit practices, an alternative course of treatment policy which provides reimbursement in instances where the dentist and beneficiary select a more expensive service, procedure, or course of treatment than is customarily provided. The benefit policy must meet the following conditions:

(1) The service, procedure, or course of treatment must be consistent with sound professional standards of dental practice for the dental condition concerned.

(2) The service, procedure, or course of treatment must be a generally accepted alternative for a service or procedure covered by this plan for the dental condition.

(3) Payment for the alternative service or procedure may not exceed the lower of the prevailing limits for the alternative procedure, the prevailing limits or scheduled allowance for the otherwise authorized benefit procedure for which the alternative is substituted, or the actual charge for the alternative procedure.

2. Benefits

a. Diagnostic and preventive services. Benefits may be extended for those dental services described as oral examination, diagnostic, and preventive services defined as traditional prophylaxis (i.e., scaling deposits from teeth, polishing teeth, and topical application of fluoride to teeth) when performed directly by dentists or dental hygienists as authorized under Section F. of this Chapter. These services are defined (subject to the dental plan's exclusions, limitations, and benefit determination rules approved by OCHAMPUS) using the American Dental Association's Code on Dental Procedures and Nomenclature as listed in the Current Dental Terminology manual to include the following categories of services:

(1) Diagnostic services

(a) Clinical Oral examinations

(b) Radiographs

(c) Tests and laboratory examinations

(2) Preventive services

(a) Dental prophylaxis

(b) Topical fluoride treatment (office procedure)

(c) Sealants

(d) Space maintenance (passive appliances)

b. Adjunctive general services (Services "By Report"). The following categories of services are authorized when performed directly by dentists or dental hygienists only in unusual circumstances requiring justification of exceptional conditions directly related to otherwise authorized procedures. Use of the procedures may not result in the fragmentation of services normally included in a single procedure. These services are defined (subject to the dental plan's exclusions, limitations, and benefit determination rules as adopted by OCHAMPUS) using the American Dental Association's Code on Dental Procedures and Nomenclature as listed in the Current Dental Terminology manual to include the following categories of service:

(1) Emergency oral examinations

(2) Palliative emergency treatment of dental pain

(3) Professional consultation

(4) Professional visits

(5) Drugs

(6) Post-surgical complications

c. Restorative. Benefits may be extended for basic restorative services when performed directly by dentists or dental hygienists, or under orders and supervision by dentists, as authorized under Section F. of this Chapter. These services are defined (subject to the dental plan's exclusions, limitations, and benefit determination rules as adopted by OCHAMPUS) using the American Dental Association's Code on Dental Procedures and Nomenclature as listed in the Current Dental Terminology manual to include the following categories of services:

(1) Restorative Services

(a) Amalgam restorations

- (b) Silicate restorations
- (c) Resin restorations
- (d) Prefabricated crowns
- (e) Pin retention

(2) Other restorative services

- (a) Diagnostic casts
- (b) Onlay restoration - metallic
- (c) Crowns

d. Endodontic services. Benefits may be extended for those dental services involved in treatment of diseases and injuries affecting the dental pulp, tooth root, and periapical tissue when performed directly by dentists as authorized under Section F. of this Chapter. These services are defined (subject to the dental plan's exclusions, limitations, and benefit determination rules as adopted by OCHAMPUS) using the American Dental Association's Code on Dental Procedures and Nomenclature as listed in the Current Dental Terminology manual to include the following categories of services:

- (1) Pulp capping - indirect
- (2) Pulpotomy
- (3) Root canal therapy
- (4) Periapical services
- (5) Hemisection

e. Periodontic services. Benefits may be extended for those dental services involved in prevention and treatment of diseases affecting the supporting structures of the teeth to include periodontal prophylaxis, gingivectomy or gingivoplasty, gingival curettage, etc., when performed directly by dentists as authorized under Section F. of this Chapter. These services are defined (subject to the dental plan's exclusions, limitations, and benefit determination rules as adopted by OCHAMPUS) using the American Dental Association's Code on Dental Procedures and Nomenclature as listed in the Current Dental Terminology manual to include the following categories of services:

- (1) Surgical services
- (2) Periodontal scaling and root planing

(3) Unscheduled dressing change

f. Prosthodontic services. Benefits may be extended for those dental services involved in fabrication, insertion, adjustment, relinement, and repair of artificial teeth and associated tissues to include removable complete and partial dentures, fixed crowns and bridges when performed directly by dentists as authorized under Section F. of this Chapter. These services are defined (subject to the dental plan's exclusions, limitations, and benefit determination rules as adopted by OCHAMPUS) using the American Dental Association's Code on Dental Procedures and Nomenclature as listed in the Current Dental Terminology manual to include the following categories of services:

(1) Prosthodontics (removable)

- (a) Complete/partial dentures
- (b) Adjustments to removable prosthesis
- (c) Repairs to complete/partial dentures
- (d) Denture rebase procedures
- (e) Denture reline procedures
- (f) Interim complete/partial dentures
- (g) Tissue conditioning

(2) Prosthodontics (fixed)

- (a) Bridge pontics
- (b) Retainers (by report)
- (c) Bridge retainers-crowns
- (d) Other fixed prosthetic services

g. Orthodontic services. Benefits may be extended for the supervision, guidance, and correction of growing or mature dentofacial structures, including those conditions that require movement of teeth or correction of malrelationships and malformations through the use of orthodontic procedures and devices when performed directly by dentists as authorized under Section F. of this Chapter to include in-process orthodontics. Coverage of in-process orthodontics is limited to services rendered on or after the date of enrollment in the expanded dependents dental plan. These services are defined (subject to the dental plan's exclusions, limitations, and benefit determination rules as adopted by OCHAMPUS) using

- (1) Minor treatment for tooth guidance
- (2) Minor treatment to control harmful habits
- (3) Interceptive orthodontic treatment
- (4) Comprehensive orthodontic treatment - transitional dentition
- (5) Comprehensive orthodontic treatment - permanent dentition
- (6) Treatment of the atypical or extended skeletal case
- (7) Post-treatment stabilization

NOTE: Coverage of in-process orthodontics is limited to services rendered on or after the date of enrollment in the expanded dependents dental plan.

h. Oral surgery services. Benefits may be extended for basic surgical procedure of the extraction, reimplantation, stabilization and repositioning of teeth, alveoloplasties, incision and drainage of abscesses, suturing of wounds, biopsies, etc., when performed directly by dentists as authorized under Section F. of this Chapter. These services are defined (subject to the dental plan's exclusions, limitations, and benefit determination rules as adopted by OCHAMPUS) using the American Dental Association's Code on Dental Procedures and Nomenclature as listed in the Current Dental Terminology manual to include the following categories of services:

- (1) Extractions
- (2) Surgical extractions
- (3) Other surgical procedures
- (4) Alveoloplasty - surgical preparation of ridge for denture tissue
- (5) Surgical incision and drainage of abscess - intraoral soft tissue
- (6) Repair of traumatic wounds
- (7) Complicated suturing
- (8) Excision of pericoronal gingiva

i. Exclusion of adjunctive dental care. Under limited circumstances, benefits are available for dental services and supplies under CHAMPUS when the dental care is medically necessary in the treatment of an

otherwise covered medical (not dental) condition, is an integral part of the treatment of such medical condition, and is essential to the control of the primary medical condition; or is required in preparation for, or as the result of, dental trauma which may be or is caused by medically necessary treatment of an injury or disease (iatrogenic). These benefits are excluded under the Active Duty Dependents Dental Plan. For further information on adjunctive dental care benefits under CHAMPUS, see Chapter 4, Section E.10. of this Regulation.

j. Exclusion of benefit services performed in military dental care facilities. Except for emergency treatment, dental care provided outside the United States, and services incidental to noncovered services, dependents enrolled in the Active Duty Dependents Dental Plan may not obtain those services which are benefits of the Plan in military dental care facilities. Enrolled dependents may continue to obtain noncovered services from military dental care facilities subject to the provisions for space available care.

k. Benefit limitations and exclusions. The Director, OCHAMPUS or designee may establish such exclusions and limitations as are consistent with those established by dental insurance and prepayment plans to control utilization and quality of care for the services and items covered by this dental plan.

3. Beneficiary or sponsor liability

a. Diagnostic and preventive services. Enrolled dependents of active duty members or their sponsors are responsible for the payment of only those amounts which are for services rendered by nonparticipating providers of care which exceed the equivalent of the statewide or regional prevailing fee levels as established by the insurer, except in the case of sealants where the dependents or their sponsors will also be responsible for payment of 20 percent of the insurer's determined allowable amount. Where the dental plan is unable to identify a participating provider of care within 35 miles of the dependent's place of residence with appointment availability within 21 calendar days, the dental plan will reimburse the dependent, or sponsor, or the nonparticipating provider selected by the dependent within 35 miles of the dependent's place of residence at the level of the provider's usual fees less 20 percent of the insurer's allowable amount for sealants.

b. Restorative services. Enrolled dependents of active duty members or their sponsors are responsible for payment of 20 percent of the amounts determined by the insurer for services rendered by participating providers of care, or 20 percent of these amounts plus any remainder of the charges made by nonparticipating providers of care, except in the case of crowns and casts where the dependents or their sponsors will be responsible for payment of 50 percent of the insurer's determined allowable amount. Where the dental plan is unable to identify a participating provider of care within 35 miles of the dependent's place of residence with appointment availability within 21 calendar days, dependents or their sponsors are

responsible for payment of 20 percent (50 percent in the case of crowns and casts) of the charges made by nonparticipating providers located within 35 miles of the dependent's place of residence.

c. Endodontic, periodontic, and oral surgery services. Enrolled dependents of active duty members or their sponsors are responsible for payment of 40 percent of the amounts determined by the insurer for services rendered by participating providers of care, or 40 percent of these amounts plus any remainder of the charges made by nonparticipating providers of care. Where the dental plan is unable to identify a participating provider of care within 35 miles of the dependent's place of residence with appointment availability within 21 calendar days, dependents or their sponsors are responsible for payment of 40 percent of the charges made by nonparticipating providers located within 35 miles of the dependent's place of residence.

d. Prosthodontic and orthodontic services. Enrolled dependents of active duty members or their sponsors are responsible for payment of 50 percent of the amounts determined by the insurer for services rendered by participating providers of care, or 50 percent of these amounts plus any remainder of the charges made by nonparticipating providers of care. Where the dental plan is unable to identify a participating provider of care within 35 miles of the dependent's place of residence with appointment availability within 21 calendar days, dependents or their sponsors are responsible for payment of 50 percent of the charges made by nonparticipating providers located within 35 miles of the dependent's place of residence.

e. Adjunctive general services (Services "By Report"). The beneficiary or sponsor liability is dependent on the particular service provided. Emergency oral examinations and palliative emergency treatment of dental pain are paid in full except for those amounts for services rendered by nonparticipating providers of care which exceed the equivalent of the statewide or regional prevailing fee levels as established by the insurer which are the responsibility of the enrolled dependents or their sponsors. Enrolled dependents or their sponsors are responsible for payment of 20 percent of the amounts determined by the insurer for professional consultations/visits and postsurgical services and 50 percent for covered medications when provided by participating providers of care, or these percentage payments plus any remaining amounts in excess of the prevailing charge limits established by the insurer for services rendered by nonparticipating providers, subject to the exceptions for dependent lack of access to participating providers as provided in paragraphs E.3.a. through E.3.d. of this Chapter. The contracting dental insurer may recognize a "by report" condition by providing additional allowance to the primary covered procedure instead of recognizing or permitting a distinct billing for the "by report" service.

f. Amounts over the dental insurer's established allowance for charges. It is the responsibility of the dental plan insurer to determine allowable charges for the procedures identified as benefits of this plan.

All benefits of the plan are based on the insurer's determination of the allowable charges, subject to the exceptions for lack of access to participating providers as provided in paragraphs E.3.a. through E.3.d. of this Chapter.

g. Maximum coverage amounts. Enrolled dependents of active duty members are subject to an annual maximum coverage amount for non-orthodontic dental benefits and a lifetime maximum coverage amount for orthodontia as established by the Secretary of Defense or designee.

F. AUTHORIZED PROVIDERS

1. General. This section sets forth general policies and procedures that are the basis for the Active Duty Dependents Dental Plan cost sharing of dental services and supplies provided by or under the direct supervision or prescription by dentists, and by dental hygienists, within the scope of their licensure.

a. Listing of provider does not guarantee payment of benefits. The fact that a type of provider is listed in this section is not to be construed to mean that the Active Duty Dependents Dental Plan will pay automatically a claim for services or supplies provided by such a provider. The Director, OCHAMPUS or designee also must determine if the patient is an eligible beneficiary, whether the services or supplies billed are authorized and medically necessary, and whether any of the authorized exclusions of otherwise qualified providers presented in this section apply.

b. Conflict of interest. See Chapter 9, D. of this Regulation.

c. Fraudulent practices or procedures. See Chapter 9, C. of this Regulation.

d. Utilization review and quality assurance. Services and supplies furnished by providers of care shall be subject to utilization review and quality assurance standards, norms, and criteria established by the dental plan. Utilization review and quality assurance assessments shall be performed by the dental plan consistent with the nature and level of benefits of the plan, and shall include analysis of the data and findings by the dental plan insurer from other dental accounts.

e. Provider required. In order to be considered benefits, all services and supplies shall be rendered by, prescribed by, or furnished at the direction of, or on the order of an Active Duty Dependents Dental Plan authorized provider practicing within the scope of his or her license.

f. Participating provider. An authorized provider may elect to participate and accept the fee or charge determinations as established and made known to the provider by the dental plan insurer. The fee or charge determinations are binding upon the provider in accordance with the dental

plan insurer's procedures for participation. The authorized provider may not participate on a claim-by-claim basis. The participating provider must agree to accept, within one day of a request for appointment, beneficiaries in need of emergency palliative treatment. Payment to the participating provider is based on the lower of the actual charge or the insurer's determination of the allowable charge. Payment is made directly to the participating provider, and the participating provider may only charge the beneficiary the percent cost-share of the insurer's allowable charge for those benefit categories as specified in paragraphs E.3.a. through E.3.e. of this Chapter, in addition to the charges for any services not authorized as benefits.

g. Nonparticipating provider. An authorized provider may elect for all beneficiaries not to participate and request the beneficiary or sponsor to pay any amount of the provider's billed charge in excess of the dental plan insurer's determination of allowable charges. Neither the government nor the dental plan insurer shall have any responsibility for any amounts over the allowable charges as determined by the dental plan insurer, except where the dental plan insurer is unable to identify a participating provider of care within 35 miles of the dependent's place of residence with appointment availability within 21 calendar days. In such instances of the nonavailability of a participating provider, the nonparticipating provider located within 35 miles of the dependent's place of residence shall be paid his or her usual fees, less the percent cost-share as specified in paragraphs E.3.a. through E.3.e. of this Chapter.

(1) Assignment. A nonparticipating provider may accept assignment of claims for beneficiaries certifying their willingness to make such assignment by filing the claims completed with the assistance of the beneficiary or sponsor for direct payment by the dental plan insurer to the provider.

(2) Nonassignment. A nonparticipating provider for all beneficiaries may request the beneficiary or sponsor to file the claim directly with the dental plan insurer, making arrangements with the beneficiary or sponsor for direct payment by the beneficiary or sponsor.

2. Dentists. Subject to standards of participation provisions of this part, the following are authorized providers of care:

a. Doctors of Dental Surgery (D.D.S.) having a degree from an accredited school of dentistry, licensed to practice dentistry by a state board of dental examiners, and practicing within the scope of their licenses, whether in individual, group, or clinic practice settings.

b. Doctors of Dental Medicine (D.M.D.) having a degree from an accredited school of dentistry, licensed to practice dentistry by a state board of dental examiners, and practicing within the scope of their licenses, whether in individual, group, or clinic practice settings.

3. Dental hygienists. Subject to state licensure laws and standards of participation provisions of this part, dental hygienists having either an associate degree, certificate, or baccalaureate degree from an accredited school of dental hygiene, licensed to practice dental hygiene by a state board, and practicing within the scope of their licenses, whether in individual, group, or clinic practice settings.

NOTE: Dental hygienists may independently bill and receive payment only in a few states where state licensure laws authorize them as independent providers of care. In nearly all states at the present time, the dental hygienist performs services under the supervision of a dentist and the Dependents Dental Plan will pay for such services in these states only when supervised and billed by a dentist.

4. Alternative delivery systems

a. General. Alternative delivery systems may be established by the Director, OCHAMPUS or designee as authorized providers. Only dentists and dental hygienists shall be authorized to provide or direct the provision of authorized services and supplies in an approved alternative delivery system.

b. Defined. An alternative delivery system may be any approved arrangement for a preferred provider organization, capitation plan, dental health maintenance or clinic organization, or other contracted arrangement which is approved by OCHAMPUS in accordance with requirements and guidelines.

c. Elective or exclusive arrangement. Alternative delivery systems may be established by contract or other arrangement on either an elective or exclusive basis for beneficiary selection of participating and authorized providers in accordance with contractual requirements and guidelines.

d. Provider election of participation. Otherwise authorized providers must be provided with the opportunity of applying for participation in an alternative delivery system and of achieving participation status based on reasonable criteria for timeliness of application, quality of care, cost containment, geographic location, patient availability, and acceptance of reimbursement allowances.

e. Limitation on authorized providers. Where exclusive alternative delivery systems are established, only providers participating in the alternative delivery system are authorized providers of care. In such instances, the dental plan shall continue to pay beneficiary claims for services rendered by otherwise authorized providers in accordance with established rules for reimbursement of nonparticipating providers where the beneficiary has established a patient relationship with the nonparticipating provider prior to the dental plan's proposal to subcontract with the alternative delivery system.

f. Charge agreements. Where the alternative delivery system employs a discounted fee-for-service reimbursement methodology or schedule of charges or rates which includes all or most dental services and procedures recognized by the American Dental Association, Council on Dental Care Programs "Code on Dental Procedures and Nomenclature," the discounts or schedule of charges or rates for all dental services and procedures shall be extended by its participating providers to beneficiaries of the Active Duty Dependents Dental Plan as an incentive for beneficiary participation in the alternative delivery system.

5. Billing practices. The Director, OCHAMPUS, or designee, approves the dental plan's procedures governing the itemization and completion of claims for services rendered by authorized providers to enrolled beneficiaries of the Active Duty Dependents Dental Plan consistent with the insurer's existing procedures for completion and submittal of dental claims for its other dental plans and accounts.

6. Reimbursement of authorized providers. The Director, OCHAMPUS or designee, approves the dental plan methodology for reimbursement of services rendered by authorized providers consistent with law, regulation, and contract provisions, and the benefits of the Active Duty Dependents Dental Plan. The following general requirements for the methodology shall be met, subject to modifications and exceptions approved by the Director, OCHAMPUS or a designee.

a. Nonparticipating providers (or the dependents or sponsors for unassigned claims) shall be reimbursed at the equivalent of not less than the 50th percentile of prevailing charges made for similar services in the same locality (region) or state, or the provider's actual charge, whichever is lower; less any cost-share amount due for authorized services, except where the dental plan insurer is unable to identify a participating provider of care within 35 miles of the dependent's place of residence with appointment availability within 21 calendar days. In such instances of the nonavailability of a participating provider, the nonparticipating provider located within 35 miles of the dependent's place of residence shall be paid his or her usual fees, less the cost-share for the authorized services.

b. Participating providers shall be reimbursed at the equivalent of a percentile of prevailing charges sufficiently above the 50th percentile of prevailing charges made for similar services in the same locality (region) or state as to constitute a significant financial incentive for participation, or the provider's actual charge, whichever is lower; less any cost-share amount due for authorized services.

G. BENEFIT PAYMENT

1. General. Active Duty Dependent Dental Plan benefit payments are made either directly to the provider or to the beneficiary or sponsor, depending on the manner in which the claim is submitted or the terms of the subcontract of an alternative delivery system with the dental plan insurer.

2. Benefit payments made to a participating provider. When the authorized provider has elected to participate in accordance with the arrangement and procedures established by the dental plan insurer, payment is made based on the lower of the actual charge or the insurer's determination of the allowable charge. Payment is made directly to the participating provider as payment in full, less the percent cost-share of the insurer's allowable charge as specified in paragraphs E.3.a. through E.3.e. of this Chapter.

3. Benefit payments made to a nonparticipating provider. When the authorized provider has elected not to participate in accordance with the arrangement and procedures established by the dental plan, payment is made by the insurer based on the lower of the actual charge or the insurer's determination of the allowable charge. The beneficiary is responsible for payment of a percent cost-share of the insurer's allowable charge as specified in paragraphs E.3.a. through E.3.e. of this Chapter. Where the dental plan is unable to identify a participating provider of care within 35 miles of the dependent's place of residence with appointment availability within 21 calendar days, dependents or their sponsors are responsible for payment of a percent cost-share of the charges made by nonparticipating providers located within 35 miles of the dependent's place of residence as specified in paragraphs E.3.a. through E.3.d. of this Chapter.

a. Assigned claims are claims submitted directly by the nonparticipating provider and are paid directly to the provider.

b. Nonassigned claims are claims submitted by the beneficiary, provider, or sponsor and are paid directly to the claimant.

4. Dental Explanation of Benefits (DEOB). An explanation of benefits is sent to the beneficiary or sponsor and provides the following information:

- a. Name and address of the beneficiary.
- b. Social Security Account Number (SSAN) of the sponsor.
- c. Name and address of the provider.
- d. Services or supplies covered by the claim for which the DEOB applies.
- e. Dates the services or supplies were provided.
- f. Amount billed; allowable charge; and amount of payment.
- g. To whom payment, if any, was made.
- h. Reasons for any denial.

i. Recourse available to beneficiary for review of claim decision (refer to section H. of this Chapter).

5. Fraud

a. Federal laws. 18 U.S.C. 287 and 1001 provide for criminal penalties for submitting knowingly or making any false, fictitious, or fraudulent statement or claim in any matter within the jurisdiction of any department or agency of the United States. Examples of fraud include situations in which ineligible persons not enrolled in the Active Duty Dependents Dental Plan obtain care and file claims for benefits under the name and identification of an enrolled beneficiary; or when providers submit claims for services and supplies not rendered to enrolled beneficiaries; or when a participating provider bills the beneficiary for amounts over the dental plan insurer's determination of allowable charges; or fails to collect the specified patient copayment amount.

b. Suspected fraud. Any person, including the dental plan insurer, who becomes aware of a suspected fraud shall report the circumstances in writing, together with copies of any available documents pertaining thereto, to the Director, OCHAMPUS, or a designee, who shall initiate an official investigation of the case.

H. APPEAL AND HEARING PROCEDURES

1. General. This section sets forth the policies and procedures for appealing decisions made by the dental plan adversely affecting the rights and liabilities of beneficiaries, participating providers, and providers denied the status of authorized provider under the Active Duty Dependents Dental Plan. An appeal under the Active Duty Dependents Dental Plan is an administrative review of program determinations made under the provisions of law and regulation. An appeal cannot challenge the propriety, equity, or legality of any provision of law and regulation.

a. Initial determination

(1) Notice of initial determination and right to appeal

(a) The dental plan contractor shall mail notices of initial determinations to the Active Duty Dependents Dental Plan beneficiary at the last known address. For beneficiaries who are under 18 years of age or who are incompetent, a notice issued to the parent or guardian constitutes notice to the beneficiary.

(b) The dental plan contractor shall notify providers of an initial determination on a claim only if the providers participated in the claim or accepted assignment.

(c) Notice of an initial determination on a claim by the dental plan contractor shall be made in the contractor's explanation of benefits (beneficiary) or with the summary of payment (provider).

(d) Each notice of an initial determination on a request for benefit authorization, a request by a provider for approval as an authorized provider, or a decision to disqualify or exclude a provider as an authorized provider under the Active Duty Dependents Dental Plan shall state the reason for the determination and the underlying facts supporting the determination.

(e) In any case when the initial determination is adverse to the beneficiary or participating provider or to the provider seeking approval as an authorized provider, the notice shall include a statement of the beneficiary's or provider's right to appeal the determination. The procedure for filing the appeal also shall be explained.

(2) Effect of initial determination. The initial determination is final, unless appealed in accordance with this section or unless the initial determination is reopened by OCHAMPUS or the dental plan contractor.

b. Participation in an appeal. Participation in an appeal is limited to any party to the initial determination, including OCHAMPUS, the dental plan contractor, and authorized representatives of the parties. Any party to the initial determination, except OCHAMPUS and the dental plan contractor, may appeal an adverse determination. The appealing party is the party who actually files the appeal.

(1) Parties to the initial determination. For purposes of these appeal and hearing procedures, the following are not parties to an initial determination and are not entitled to administrative review under this section.

(a) A provider disqualified or excluded as an authorized provider under the Active Duty Dependents Dental Plan based on a determination under another Federal or federally funded program is not a party to the OCHAMPUS action and may not appeal under this section.

(b) A sponsor or parent of a beneficiary under 18 years of age or guardian of an incompetent beneficiary is not a party to the initial determination and may not serve as the appealing party, although such persons may represent the appealing party in an appeal.

(c) A third party other than the dental plan contractor, such as an insurance company, is not a party to the initial determination and is not entitled to appeal, even though it may have an indirect interest in the initial determination.

(d) A nonparticipating provider is not a party to the initial determination and may not appeal.

(2) Representative. Any party to the initial determination may appoint a representative to act on behalf of the party in connection with an appeal. Generally, the parent of a minor beneficiary and the legally appointed guardian of an incompetent beneficiary shall be presumed to have been appointed representative without specific designation by the beneficiary.

(a) The representative shall have the same authority as the party to the appeal, and notice given to the representative shall constitute notice required to be given to the party under this part.

(b) To avoid possible conflicts of interest, an officer or employee of the United States, such as an employee or member of a Uniformed Service, including an employee or staff member of a Uniformed Service legal office, or a CHAMPUS advisor, subject to the exceptions in 18 U.S.C. 205, is not eligible to serve as a representative. An exception usually is made for an employee or member of a Uniformed Service who represents an immediate family member. In addition, the Director, OCHAMPUS, or designee, may appoint an officer or employee of the United States as the OCHAMPUS representative at a hearing.

c. Burden of proof. The burden of proof is on the appealing party to establish affirmatively by substantial evidence the appealing party's entitlement under law and this Regulation to the authorization of the Active Duty Dependents Dental Plan benefits or approval as an authorized provider. Any cost or fee associated with the production or submission of information in support of an appeal may not be paid by OCHAMPUS.

d. Late filing. If a request for reconsideration, formal review, or hearing is filed after the time permitted in this section, written notice shall be issued denying the request. Late filing may be permitted only if the appealing party reasonably can demonstrate to the satisfaction of the dental plan contractor, or the Director, OCHAMPUS, or designee, that timely filing of the request was not feasible due to extraordinary circumstances over which the appealing party had no practical control. Each request for an exception to the filing requirement will be considered on its own merits.

e. Appealable issue. An appealable issue is required in order for an adverse determination to be appealed under the provisions of this section. Examples of issues that are not appealable under this section include:

(1) A dispute regarding a requirement of the law or regulation.

(2) The amount of the dental plan contractor-determined allowable charge since the methodology constitutes a limitation on benefits under the provisions of this part.

(3) Certain other issues on the basis that the authority for the initial determination is not vested in OCHAMPUS. Such issues include but are not limited to the following examples:

(a) Determination of a person's eligibility as an enrolled beneficiary in the Active Duty Dependents Dental Plan is the responsibility of the appropriate Uniformed Service. Although OCHAMPUS and the dental plan contractor must make determinations concerning a beneficiary's enrollment, ultimate responsibility for resolving a beneficiary's eligibility and enrollment rests with the Uniformed Services. Accordingly, a disputed question of fact concerning a beneficiary's enrollment or eligibility will not be considered an appealable issue under the provisions of this section, but shall be resolved in accordance with Section C of this Chapter.

(b) The decision to disqualify or exclude a provider because of a determination against that provider under another Federal or federally funded program is not an initial determination that is appealable under this section. The provider is limited to exhausting administrative appeal rights offered under the Federal or federally funded program that made the initial determination. However, a determination to disqualify or exclude a provider because of abuse or fraudulent practices or procedures under the Active Duty Dependents Dental Plan is an initial determination that is appealable under this section.

f. Amount in dispute. An amount in dispute is required for an adverse determination to be appealed under the provisions of this section, except as set forth in the following.

(1) The amount in dispute is calculated as the amount of money the dental plan contractor would pay if the services and supplies involved in dispute were determined to be authorized benefits of the Active Duty Dependents Dental Plan. Examples of amounts of money that are excluded by this section from payments for authorized benefits include, but are not limited to:

(a) Amounts in excess of the dental plan contractor-determined allowable charge.

(b) The beneficiary's cost-share amounts for restorative services.

(c) Amounts that the beneficiary, or parent, guardian, or other responsible person has no legal obligation to pay.

(2) There is no requirement for an amount in dispute when the appealable issue involves a denial of a provider's request for approval as an authorized provider or the determination to disqualify or exclude a provider as an authorized provider.

(3) Individual claims may be combined to meet the required amount in dispute if all of the following exist:

(a) The claims involve the same beneficiary.

(b) The claims involve the same issue.

(c) At least one of the claims so combined has had a reconsideration decision issued by the dental plan contractor.

NOTE: A request for administrative review under this appeal process which involves a dispute regarding a requirement of law or regulation (paragraph 1.e.(1) of this section) or does not involve a sufficient amount in dispute (paragraph 1.f. of this section) may not be rejected at the reconsideration level of appeal. However, an appeal shall involve an appealable issue and sufficient amount in dispute under these subsections to be granted a formal review or hearing.

g. Levels of appeal. The sequence and procedures of an Active Duty Dependents Dental Plan appeal are contained in the following.

(1) Reconsideration by the dental plan contractor.

(2) Formal review by OCHAMPUS.

(3) Hearing.

2. Reconsideration. Any party to the initial determination made by the dental plan contractor may request a reconsideration.

a. Requesting a reconsideration

(1) Written request required. The request must be in writing, shall state the specific matter in dispute, and shall include a copy of the notice of initial determination made by the dental plan contractor, such as the explanation of benefits.

(2) Where to file. The request shall be submitted to the dental plan contractor's office as designated in the notice of initial determination.

(3) Allowed time to file. The request must be mailed within 90 days after the date of the notice of initial determination.

(4) Official filing date. A request for a reconsideration shall be deemed filed on the date it is mailed and postmarked. If the request does not have a postmark, it shall be deemed filed on the date received by the dental plan contractor.

b. The reconsideration process. The purpose of the reconsideration is to determine whether the initial determination was made in accordance with law, regulation, policies, and guidelines in effect at the time the care was provided or requested or at the time the provider requested

approval as an authorized provider. The reconsideration is performed by a member of the dental plan contractor's staff who was not involved in making the initial determination and is a thorough and independent review of the case. The reconsideration is based on the information submitted that led to the initial determination, plus any additional information that the appealing party may submit or the dental plan contractor may obtain.

c. Timeliness of reconsideration determination. The dental plan contractor normally shall issue its reconsideration determination no later than 60 days from the date of its receipt of the request for reconsideration.

d. Notice of reconsideration determination. The dental plan contractor shall issue a written notice of the reconsideration determination to the appealing party at his or her last known address. The notice of the reconsideration determination must contain the following elements:

- (1) A statement of the issue or issues under appeal.
- (2) The provisions of law, regulation, policies, and guidelines that apply to the issue or issues under appeal.
- (3) A discussion of the original and additional information that is relevant to the issue or issues under appeal.
- (4) Whether the reconsideration upholds the initial determination or reverses it, in whole or in part, and the rationale for the action.
- (5) A statement of the right to appeal further in any case when the reconsideration determination is less than fully favorable to the appealing party and the amount in dispute is \$50 or more.

e. Effect of reconsideration determination. The reconsideration determination is final if either of the following exist:

- (1) The amount in dispute is less than \$50.
- (2) Appeal rights have been offered, but a request for formal review is not received by OCHAMPUS within 60 days of the date of the notice of the reconsideration determination.

3. Formal review. Any party to the initial determination may request a formal review by OCHAMPUS if the party is dissatisfied with the reconsideration determination and the reconsideration determination is not final under the provisions of paragraph 2.e. of this section. Any party to the initial determination made by OCHAMPUS may request a formal review by OCHAMPUS if the party is dissatisfied with the initial determination.

a. Requesting a formal review

(1) Written request required. The request must be in writing, shall state the specific matter in dispute, shall include copies of the written determination (notice of reconsideration determination) being appealed, and shall include any additional information or documents not submitted previously.

(2) Where to file. The request shall be submitted to the Chief, Appeals and Hearings, OCHAMPUS, Aurora, Colorado 80045-6900.

(3) Allowed time to file. The request shall be mailed within 60 days after the date of the notice of the reconsideration determination being appealed.

(4) Official filing date. A request for a formal review shall be deemed filed on the date it is mailed and postmarked. If the request does not have a postmark, it shall be deemed filed on the date received by OCHAMPUS.

b. The formal review process. The purpose of the formal review is to determine whether the initial determination or reconsideration determination was made in accordance with law, regulation, policies, and guidelines in effect at the time the care was provided or requested, at the time the provider requested approval as an authorized provider, or at the time of the action by OCHAMPUS to disqualify or exclude a provider. The formal review is performed by the Chief, Appeals and Hearings, OCHAMPUS, or a designee, and is a thorough review of the case. The formal review determination shall be based on the information upon which the initial determination or reconsideration determination was based and any additional information the appealing party or the dental plan contractor may submit or OCHAMPUS may obtain.

c. Timeliness of formal review determination. The Chief, Appeals and Hearings, OCHAMPUS, or a designee, normally shall issue the formal review determination no later than 90 days from the date of receipt of the request for formal review by the OCHAMPUS.

d. Notice of formal review determination. The Chief, Appeals and Hearings, OCHAMPUS, or a designee, shall issue a written notice of the formal review determination to the appealing party at his or her last known address. The notice of the formal review determination must contain the following elements:

(1) A statement of the issue or issues under appeal.

(2) The provisions of law, regulation, policies, and guidelines that apply to the issue or issues under appeal.

(3) A discussion of the original and additional information that is relevant to the issue or issues under appeal.

(4) Whether the formal review upholds the prior determination or determinations or reverses the prior determination or determinations in whole or in part and the rationale for the action.

(5) A statement of the right to request a hearing in any case when the formal review determination is less than fully favorable, the issue is appealable, and the amount in dispute is \$300 or more.

e. Effect of formal review determination. The formal review determination is final if one or more of the following exist:

(1) The issue is not appealable. (See paragraph 1.e. of this section.)

(2) The amount in dispute is less than \$300. (See paragraph 1.f. of this section.)

(3) Appeal rights have been offered, but a request for hearing is not received by OCHAMPUS within 60 days of the date of the notice of the formal review determination.

4. Hearing. Any party to the initial determination may request a hearing if the party is dissatisfied with the formal review determination and the formal review determination is not final under the provisions of paragraph 3.e. of this section.

a. Requesting a hearing

(1) Written request required. The request shall be in writing, state the specific matter in dispute, include a copy of the formal review determination, and include any additional information or documents not submitted previously.

(2) Where to file. The request shall be submitted to the Chief, Appeals and Hearings, OCHAMPUS, Aurora, Colorado 80045-6900.

(3) Allowed time to file. The request shall be mailed within 60 days after the date of the notice of the formal review determination being appealed.

(4) Official filing date. A request for hearing shall be deemed filed on the date it is mailed and postmarked. If a request for hearing does not have a postmark, it shall be deemed filed on the date received by OCHAMPUS.

b. The hearing process. The hearing shall be conducted as a nonadversary, administrative proceeding to determine the facts of the case and to allow the appealing party the opportunity personally to present the case before an impartial hearing officer. The hearing is a forum in which facts

relevant to the case are presented and evaluated in relation to applicable law, regulation, policies, and guidelines in effect at the time the care was provided or requested, or at the time the provider requested approval as an authorized provider.

c. Timeliness of hearing

(1) Except as otherwise provided in this section, within 60 days following receipt of a request for hearing, the Director, OCHAMPUS, or a designee, normally will appoint a hearing officer to hear the appeal. Copies of all records in the possession of OCHAMPUS that are pertinent to the matter to be heard or that formed the basis of the formal review determination shall be provided to the hearing officer and, upon request, to the appealing party.

(2) The hearing officer, except as otherwise provided in this section, normally shall have 60 days from the date of written notice of assignment to review the file, schedule and hold the hearing, and issue a recommended decision to the Director, OCHAMPUS, or designee.

(3) The Director, OCHAMPUS, or designee, may delay the case assignment to the hearing officer if additional information is needed that cannot be obtained and included in the record within the time period specified above. The appealing party will be notified in writing of the delay resulting from the request for additional information. The Director, OCHAMPUS, or a designee, in such circumstances, will assign the case to a hearing officer within 30 days of receipt of all such additional information or within 60 days of receipt of the request for hearing, whichever shall occur last.

(4) The hearing officer may delay submitting the recommended decision if, at the close of the hearing, any party to the hearing requests that the record remain open for submission of additional information. In such circumstances, the hearing officer will have 30 days following receipt of all such additional information including comments from the other parties to the hearing concerning the additional information to submit the recommended decision to the Director, OCHAMPUS, or a designee.

d. Representation at a hearing. Any party to the hearing may appoint a representative to act on behalf of the party at the hearing, unless such person currently is disqualified or suspended from acting in another Federal administrative proceeding, or unless otherwise prohibited by law, this part, or any other DoD regulation (see paragraph 1 of this section). A hearing officer may refuse to allow any person to represent a party at the hearing when such person engages in unethical, disruptive, or contemptuous conduct, or intentionally fails to comply with proper instructions or requests of the hearing officer or the provisions of this part. The representative shall have the same authority as the appealing party, and notice given to the representative shall constitute notice required to be given to the appealing party.

e. Consolidation of proceedings. The Director, OCHAMPUS, or a designee, may consolidate any number of proceedings for hearing when the facts and circumstances are similar and no substantial right of an appealing party will be prejudiced.

f. Authority of the hearing officer. The hearing officer, in exercising the authority to conduct a hearing under this part, will be bound by 10 U.S.C., Chapter 55 and this part. The hearing officer in addressing substantive, appealable issues shall be bound by the dental benefits brochure, policies, procedures, and other guidelines issued by the ASD(HA), or a designee, or by the Director, OCHAMPUS, or a designee, in effect for the period in which the matter in dispute arose. A hearing officer may not establish or amend the dental benefits brochure, policy, procedures, instructions, or guidelines. However, the hearing officer may recommend reconsideration of the policy, procedures, instructions or guidelines by the ASD(HA), or a designee, when the final decision is issued in the case.

g. Disqualification of hearing officer. A hearing officer voluntarily shall disqualify himself or herself and withdraw from any proceeding in which the hearing officer cannot give fair or impartial hearing, or in which there is a conflict of interest. A party to the hearing may request the disqualification of a hearing officer by filing a statement detailing the reasons the party believes that a fair and impartial hearing cannot be given or that a conflict of interest exists. Such request immediately shall be sent by the appealing party or the hearing officer to the Director, OCHAMPUS, or a designee, who shall investigate the allegations and advise the complaining party of the decision in writing. A copy of such decision also shall be mailed to all other parties to the hearing. If the Director, OCHAMPUS, or a designee, reassigns the case to another hearing officer, no investigation shall be required.

h. Notice and scheduling of hearing. The hearing officer shall issue by certified mail, when practicable, a written notice to the parties to the hearing of the time and place for the hearing. Such notice shall be mailed at least 15 days before the scheduled date of the hearing. The notice shall contain sufficient information about the hearing procedure, including the party's right to representation, to allow for effective preparation. The notice also shall advise the appealing party of the right to request a copy of the record before the hearing. Additionally, the notice shall advise the appealing party of his or her responsibility to furnish the hearing officer, no later than 7 days before the scheduled date of the hearing, a list of all witnesses who will testify and a copy of all additional information to be presented at the hearing. The time and place of the hearing shall be determined by the hearing officer, who shall select a reasonable time and location mutually convenient to the appealing party and OCHAMPUS.

i. Dismissal of request for hearing

(1) By application of appealing party. A request for hearing may be dismissed by the Director, OCHAMPUS, or a designee, at any time before the mailing of the final decision, upon the application of the appealing party. A request for dismissal must be in writing and filed with the Chief,

appeals and Hearings, OCHAMPUS, or the hearing officer. When dismissal is requested, the formal review determination in the case shall be deemed final, unless the dismissal is vacated in accordance with subparagraph (5) below.

(2) By stipulation of the parties to the hearing. A request for a hearing may be dismissed by the Director, OCHAMPUS, or a designee, at any time before the mailing of notice of the final decision under a stipulation agreement between the appealing party and OCHAMPUS. When dismissal is entered under a stipulation, the formal review decision shall be deemed final, unless the dismissal is vacated in accordance with subparagraph (5) below.

(3) By abandonment. The Director, OCHAMPUS, or a designee, may dismiss a request for hearing upon abandonment by the appealing party.

(a) An appealing party shall be deemed to have abandoned a request for hearing, other than when personal appearance is waived in accordance with paragraph 4.k.(13), below, if neither the appealing party nor an appointed representative appears at the time and place fixed for the hearing and if, within 10 days after the mailing of a notice by certified mail to the appealing party by the hearing officer to show cause, such party does not show good and sufficient cause for such failure to appear and failure to notify the hearing officer before the time fixed for hearing that an appearance could not be made.

(b) An appealing party shall be deemed to have abandoned a request for hearing if, before assignment of the case to the hearing officer, OCHAMPUS is unable to locate either the appealing party or an appointed representative.

(c) An appealing party shall be deemed to have abandoned a request for hearing if the appealing party fails to prosecute the appeal. Failure to prosecute the appeal includes, but is not limited to, an appealing party's failure to provide information reasonably requested by OCHAMPUS or the hearing officer for consideration in the appeal.

(d) If the Director, OCHAMPUS, or a designee, dismisses the request for hearing because of abandonment, the formal review determination in the case shall be deemed to be final, unless the dismissal is vacated in accordance with paragraph 4.i.(5) below.

(4) For cause. The Director, OCHAMPUS, or a designee, may dismiss for cause a request for hearing either entirely or as to any stated issue. If the Director, OCHAMPUS, or a designee, dismisses a hearing request for cause, the formal review determination in the case shall be deemed to be final, unless the dismissal is vacated in accordance with paragraph 4.i.(5) below. A dismissal for cause may be issued under any of the following circumstances:

(a) When the appealing party requesting the hearing is not a proper party under paragraph 1.b.(1), above, or does not otherwise have a right to participate in a hearing.

(b) When the appealing party who filed the hearing request dies, and there is no information before the Director, OCHAMPUS, or a designee, showing that a party to the initial determination who is not an appealing party may be prejudiced by the formal review determination.

(c) When the issue is not appealable (See paragraph 1.e. of this section.)

(d) When the amount in dispute is less than \$300 (See paragraph 1.f. of this section.)

(e) When all appealable issues have been resolved in favor of the appealing party.

(5) Vacation of dismissal. Dismissal of a request for hearing may be vacated by the Director, OCHAMPUS, or a designee, upon written request of the appealing party, if the request is received within 6 months of the date of the notice of dismissal mailed to the last known address of the party requesting the hearing.

j. Preparation for hearing

(1) Prehearing statement of contentions. The hearing officer may on reasonable notice, require a party to the hearing to submit a written statement of contentions and reasons. The written statement shall be provided to all parties to the hearing before the hearing takes place.

(2) Agency records

(a) Hearing officer. A hearing officer may ask OCHAMPUS to produce, for inspection, any records or relevant portions of records when they are needed to decide the issues in any proceeding before the hearing officer or to assist an appealing party in preparing for the proceeding.

(b) Appealing party. A request to a hearing officer by an appealing party for disclosure or inspection of OCHAMPUS or the dental plan contractor records shall be in writing and shall state clearly what information and records are required.

(3) Witnesses and evidence. All parties to a hearing are responsible for producing, at each party's expense, meaning without reimbursement of payment by OCHAMPUS, witnesses and other evidence in their own behalf, and for furnishing copies of any such documentary evidence to the hearing officer and other party or parties to the hearing. The Department of Defense is not authorized to subpoena witnesses or records. The hearing

officer may issue invitations and requests to individuals to appear and testify without cost to the Government, so that the full facts in the case may be presented.

(4) Interrogatories and depositions. A hearing officer may arrange to take interrogatories and depositions, recognizing that the Department of Defense does not have subpoena authority. The expense shall be assessed to the requesting party, with copies furnished to the hearing officer and other party or parties to the hearing.

k. Conduct of hearing

(1) Right to open hearing. Because of the personal nature of the matters to be considered, hearings normally shall be closed to the public. However, the appealing party may request an open hearing. If this occurs, the hearing shall be open, except when protection of other legitimate Government purposes dictates closing certain portions of the hearing.

(2) Right to examine parties to the hearing and their witnesses. Each party to the hearing shall have the right to produce and examine witnesses, to introduce exhibits, to question opposing witnesses on any matter relevant to the issue even though the matter was not covered in the direct examination, to impeach any witness regardless of which party to the hearing first called the witness to testify, and to rebut any evidence presented. Except for those witnesses employed by OCHAMPUS at the time of the hearing or records in the possession of OCHAMPUS, a party to a hearing shall be responsible, that is to say no payment or reimbursement shall be made by CHAMPUS for the cost or fee associated with producing witnesses or other evidence in the party's own behalf, or for furnishing copies of documentary evidence to the hearing officer and other party or parties to the hearing.

(3) Burden of proof. The burden of proof is on the appealing party affirmatively to establish by substantial evidence the appealing party's entitlement under law and this Regulation to the authorization of Active Duty Dependents Dental Plan benefits or approval as an authorized provider. Any part of the cost or fee associated with producing or submitting in support of an appeal may not be paid by OCHAMPUS.

(4) Taking of evidence. The hearing officer shall control the taking of evidence in a manner best suited to ascertain the facts and safeguard the rights of the parties to the hearing. Before taking evidence, the hearing officer shall identify and state the issues in dispute on the record and the order in which evidence will be received.

(5) Questioning and admission of evidence. A hearing officer may question any witness and shall admit any relevant evidence. Evidence that is irrelevant or unduly repetitious shall be excluded.

(6) Relevant evidence. Any relevant evidence shall be admitted, unless unduly repetitious, if it is the type of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the existence of any common law or statutory rule that might make improper the admission of such evidence over objection in civil or criminal actions.

(7) Active Duty Dependents Dental Plan determination first. The basis of the Active Duty Dependents Dental Plan determinations shall be presented to the hearing officer first. The appealing party shall then be given the opportunity to establish affirmatively why this determination is held to be in error.

(8) Testimony. Testimony shall be taken only on oath, affirmation, or penalty of perjury.

(9) Oral argument and briefs. At the request of any party to the hearing made before the close of the hearing, the hearing officer shall grant oral argument. If written argument is requested, it shall be granted, and the parties to the hearing shall be advised as to the time and manner within which such argument is to be filed. The hearing officer may require any party to the hearing to submit written memoranda pertaining to any or all issues raised in the hearing.

(10) Continuance of hearing. A hearing officer may continue a hearing to another time or place on his or her own motion or, upon showing of good cause, at the request of any party. Written notice of the time and place of the continued hearing, except as otherwise provided here, shall be in accordance with this part. When a continuance is ordered during a hearing, oral notice of the time and place of the continued hearing may be given to each party to the hearing who is present at the hearing.

(11) Continuance for additional evidence. If the hearing officer determines, after a hearing has begun, that additional evidence is necessary for the proper determination of the case, the following procedures may be invoked:

(a) Continue hearing. The hearing may be continued to a later date in accordance with paragraph 4.k.(10) of this section.

(b) Closed hearing. The hearing may be closed, but the record held open in order to permit the introduction of additional evidence. Any evidence submitted after the close of the hearing shall be made available to all parties to the hearing, and all parties to the hearing shall have the opportunity for comment. The hearing officer may reopen the hearing if any portion of the additional evidence makes further hearing desirable. Notice thereof shall be given in accordance with paragraph 4.h. of this section.

(12) Transcript of hearing. A verbatim taped record of the hearing shall be made and shall become a permanent part of the record. Upon request, the appealing party shall be furnished a duplicate copy of the

tape. A typed transcript of the testimony will be made only when determined to be necessary by OCHAMPUS. If a typed transcript is made, the appealing party shall be furnished a copy without charge. Corrections shall be allowed in the typed transcript by the hearing officer solely for the purpose of conforming the transcript to the actual testimony.

(13) Waiver of right to appear and present evidence. If all parties waive their right to appear before the hearing officer for presenting evidence and contentions personally or by representation, it will not be necessary for the hearing officer to give notice of, or to conduct a formal hearing. A waiver of the right to appear must be in writing and filed with the hearing officer or the Chief, Appeals and Hearings, OCHAMPUS. Such waiver may be withdrawn by the party by written notice received by the hearing officer or Chief, Appeals and Hearings, no later than 7 days before the scheduled hearing or the mailing of notice of the final decision, whichever occurs first. For purposes of this section, failure of a party to appear personally or by representation after filing written notice of waiver, will not be cause for finding of abandonment and the hearing officer shall make the recommended decision on the basis of all evidence of record.

(14) Recommended decision. At the conclusion of the hearing and after the record has been closed, the matter shall be taken under consideration by the hearing officer. Within the time frames previously set forth in this section, the hearing officer shall submit to the Director, OCHAMPUS, or a designee, a written recommended decision containing a statement of findings and a statement of reasons based on the evidence adduced at the hearing and otherwise included in the hearing record.

(a) Statement of findings. A statement of findings is a clear and concise statement of fact evidenced in the record or conclusions that readily can be deduced from the evidence of record. Each finding must be supported by substantial evidence that is defined as such evidence as a reasonable mind can accept as adequate to support a conclusion.

(b) Statement of reasons. A reason is a clear and concise statement of law, regulation, policies, or guidelines relating to the statement of findings that provides the basis for the recommended decision.

5. Final decision

a. Director, OCHAMPUS. The recommended decision shall be reviewed by the Director, OCHAMPUS, or a designee, who shall adopt or reject the recommended decision or refer the recommended decision for review by the Assistant Secretary of Defense (Health Affairs). The Director, OCHAMPUS, or designee, normally will take action with regard to the recommended decision within 90 days of receipt of the recommended decision or receipt of the revised recommended decision following a remand order to the Hearing Officer.

(1) Final action. If the Director, OCHAMPUS, or a designee, concurs in the recommended decision, no further agency action is required and the recommended decision, as adopted by the Director, OCHAMPUS, is the final

agency decision in the appeal. In the case of rejection, the Director, OCHAMPUS, or a designee, shall state the reason for disagreement with the recommended decision and the underlying facts supporting such disagreement. In these circumstances, the Director, OCHAMPUS, or a designee, may have a final decision prepared based on the record, or may remand the matter to the Hearing Officer for appropriate action. In the latter instance, the Hearing Officer shall take appropriate action and submit a new recommended decision within 60 days of receipt of the remand order. The decision by the Director, OCHAMPUS, or a designee, concerning a case arising under the procedures of this section, shall be the final agency decision and the final decision shall be sent by certified mail to the appealing party or parties. A final agency decision under this paragraph 5.a. will not be relied on, used, or cited as precedent by the Department of Defense or the dental plan contractor in the administration of the Active Duty Dependents Dental Plan.

(2) Referral for review by ASD(HA). The Director, OCHAMPUS, or a designee, may refer a hearing case to the Assistant Secretary of Defense (Health Affairs) when the hearing involves the resolution of policy and issuance of a final decision which may be relied on, used, or cited as precedent in the administration of the Active Duty Dependents Dental Plan. In such a circumstance, the Director, OCHAMPUS, or a designee, shall forward the recommended decision, together with the recommendation of the Director, OCHAMPUS, or a designee, regarding disposition of the hearing case.

b. ASD(HA). The ASD(HA), or a designee, after reviewing a case arising under the procedures of this section may issue a final decision based on the record in the hearing case or remand the case to the Director, OCHAMPUS, or a designee, for appropriate action. A decision issued by the ASD(HA), or a designee, shall be the final agency decision in the appeal and a copy of the final decision shall be sent by certified mail to the appealing party or parties. A final decision of the ASD(HA), or a designee, issued under this paragraph 5.b. may be relied on, used, or cited as precedent in the administration of the Active Duty Dependents Dental Plan.

CHAPTER 14
PROVIDER REIMBURSEMENT METHODS

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CHAPTER 14
PROVIDER REIMBURSEMENT METHODS

A. HOSPITALS

The CHAMPUS-determined allowable cost for reimbursement of a hospital shall be determined on the basis of one of the following methodologies.

1. CHAMPUS Diagnosis Related Group(DRG)-based payment system. Under the CHAMPUS DRG-based payment system, payment for the operating costs of inpatient hospital services furnished by hospitals subject to the system is made on the basis of prospectively-determined rates and applied on a per discharge basis using DRGs. Payments under this system will include a differentiation for urban (using large urban and other urban areas) and rural hospitals and an adjustment for area wage differences and indirect medical education costs. Additional payments will be made for capital costs, direct medical education costs, and outlier cases.

a. General.

(1) DRGs used. The CHAMPUS DRG-based payment system will use the same DRGs used in the most recently available grouper for the Medicare Prospective Payment System, except as necessary to recognize distinct characteristics of CHAMPUS beneficiaries and as described in instructions issued by the Director, OCHAMPUS.

(2) Assignment of discharges to DRGs.

(a) The classification of a particular discharge shall be based on the patient's age, sex, principal diagnosis (that is, the diagnosis established, after study, to be chiefly responsible for causing the patient's admission to the hospital), secondary diagnoses, procedures performed and discharge status. In addition, for neonatal cases (other than normal newborns) the classification shall also account for birthweight, surgery and the presence of multiple, major and other neonatal problems, and shall incorporate annual updates to these classification features.

(b) Each discharge shall be assigned to only one DRG regardless of the number of conditions treated or services furnished during the patient's stay.

(3) Basis of payment.

(a) Hospital billing. Under the CHAMPUS DRG-based payment system, hospitals are required to submit claims (including itemized charges) in accordance with Chapter 7, paragraph B. The CHAMPUS fiscal intermediary will assign the appropriate DRG to the claim based on the information contained on the claim. Any request from a hospital for reclassification of a claim to a higher weighted DRG must be submitted, within 60 days from the date of the initial payment, in a manner prescribed by the Director, OCHAMPUS.

(b) Payment on a per discharge basis. Under the CHAMPUS DRG-based payment system, hospitals are paid a predetermined amount per discharge for inpatient hospital services furnished to CHAMPUS beneficiaries.

(c) Claims priced as of date of admission. Except for interim claims submitted for qualifying outlier cases, all claims reimbursed under the CHAMPUS DRG-based payment system are to be priced as of the date of admission, regardless of when the claim is submitted.

(d) Payment in full. The DRG-based amount paid for inpatient hospital services is the total CHAMPUS payment for the inpatient operating costs (as described in subparagraph A.1.a.(3)(e)) incurred in furnishing services covered by the CHAMPUS. The full prospective payment amount is payable for each stay during which there is at least one covered day of care, except as provided in subparagraph A.1.c.(5)(a)1a.

(e) Inpatient operating costs. The CHAMPUS DRG-based payment system provides a payment amount for inpatient operating costs, including:

1 Operating costs for routine services; such as the costs of room, board, and routine nursing services;

2 Operating costs for ancillary services, such as hospital radiology and laboratory services (other than physicians' services) furnished to hospital inpatients;

3 Special care unit operating costs; and

4 Malpractice insurance costs related to services furnished to inpatients.

(f) Discharges and transfers.

1 Discharges. A hospital inpatient is discharged when:

a The patient is formally released from the hospital (release of the patient to another hospital as described in subparagraph 2 of this subparagraph, or a leave of absence from the hospital, will not be recognized as a discharge for the purpose of determining payment under the CHAMPUS DRG-based payment system);

b The patient dies in the hospital; or

c The patient is transferred from the care of a hospital included under the CHAMPUS DRG-based payment system to a hospital or unit that is excluded from the prospective payment system.

2 Transfers. Except as provided under subparagraph A.1.a.(3)(f)1, a discharge of a hospital inpatient is not counted for purposes of the CHAMPUS DRG-based payment system when the patient is transferred:

a From one inpatient area or unit of the hospital to another area or unit of the same hospital;

b From the care of a hospital included under the CHAMPUS DRG-based payment system to the care of another hospital paid under this system;

c From the care of a hospital included under the CHAMPUS DRG-based payment system to the care of another hospital that is excluded from the CHAMPUS DRG-based payment system because of participation in a statewide cost control program which is exempt from the CHAMPUS DRG-based payment system under subparagraph A.1.b.(1) of this chapter; or

d From the care of a hospital included under the CHAMPUS DRG-based payment system to the care of a uniformed services treatment facility.

3 Payment in full to the discharging hospital.
The hospital discharging an inpatient shall be paid in full under the CHAMPUS DRG-based payment system.

4 Payment to a hospital transferring an inpatient to another hospital. If a hospital subject to the CHAMPUS DRG-based payment system transfers an inpatient to another such hospital, the transferring hospital shall be paid a per diem rate (except that in neonatal cases, other than normal newborns, the hospital will be paid at 125 percent of that per diem rate), as determined under instructions issued by OCHAMPUS, for each day of the patient's stay in that hospital, not to exceed the DRG-based payment that would have been paid if the patient had been discharged to another setting. However, if a discharge is classified into DRG No. 456 (Burns, transferred to another acute care facility) or DRG 601 (neonate, transferred less than or equal to 4 days old), the transferring hospital shall be paid in full.

5 Additional payments to transferring hospitals.
A transferring hospital may qualify for an additional payment for extraordinary cases that meet the criteria for long-stay or cost outliers.

(4) DRG system updates. The CHAMPUS DRG-based payment system is modeled on the Medicare Prospective Payment System (PPS) and uses annually updated items and numbers from the Medicare PPS as provided for in this Part and in instructions issued by the Director, OCHAMPUS. The effective date of these items and numbers shall correspond to that under the Medicare PPS except where distinctions are made in this chapter.

b. Applicability of the DRG system.

(1) Areas affected. The CHAMPUS DRG-based payment system shall apply to hospitals' services in the fifty states, the District of Columbia, and Puerto Rico, except that any state which has implemented a separate DRG-based payment system or similar payment system in order to control costs and is exempt from the Medicare Prospective Payment System may be exempt from the CHAMPUS DRG-based payment system if it requests exemption in writing, and provided payment under such system does not exceed payment which would otherwise be made under the CHAMPUS DRG-based payment system.

(2) Services subject to the DRG-based payment system. All normally covered inpatient hospital services furnished to CHAMPUS beneficiaries by hospitals are subject to the CHAMPUS DRG-based payment system.

(3) Services exempt from the DRG-based payment system. The following hospital services, even when provided in a hospital subject to the CHAMPUS DRG-based payment system, are exempt from the CHAMPUS DRG-based payment system. The services in subparagraphs A.1.b.(3)(a) through (d) and (g) through (i) shall be reimbursed under the procedures in subsection A.3. of this chapter, and the services in subparagraphs A.1.b.(3)(e) and (f) shall be reimbursed under the procedures in section G. of this chapter.

(a) Services provided by hospitals exempt from the DRG-based payment system.

(b) All services related to kidney acquisition by Renal Transplantation Centers.

(c) All services related to a heart transplantation which would otherwise be paid under DRG 103.

(d) All services related to liver transplantation when the transplant is performed in a CHAMPUS-authorized liver transplantation center.

(e) All professional services provided by hospital-based physicians.

(f) All services provided by nurse anesthetists.

(g) All services related to discharges involving pediatric bone marrow transplants (patient under 18 at admission).

(h) All services related to discharges involving children who have been determined to be HIV seropositive (patient under 18 at admission).

(i) All services related to discharges involving pediatric cystic fibrosis (patient under 18 at admission).

(j) For admissions occurring on or after October 1, 1990, the costs of blood clotting factor for hemophilia inpatients. An additional payment shall be made to a hospital for each unit of blood clotting factor furnished to a CHAMPUS inpatient who is hemophiliac in accordance with the amounts established under the Medicare Prospective Payment System (42 CFR 412.115).

(4) Hospitals subject to the CHAMPUS DRG-based payment system. All hospitals within the fifty states, the District of Columbia, and Puerto Rico which are certified to provide services to CHAMPUS beneficiaries are subject to the DRG-based payment system except for the following hospitals or hospital units which are exempt.

(a) Psychiatric hospitals. A psychiatric hospital which is exempt from the Medicare Prospective Payment System is also exempt from the CHAMPUS DRG-based payment system. In order for a psychiatric hospital which does not participate in Medicare to be exempt from the CHAMPUS DRG-based payment system, it must meet the same criteria (as determined by the Director, OCHAMPUS, or a designee) as required for exemption from the Medicare Prospective Payment System as contained in Section 412.23 of Title 42 CFR.

(b) Rehabilitation hospitals. A rehabilitation hospital which is exempt from the Medicare Prospective Payment System is also exempt from the CHAMPUS DRG-based payment system. In order for a rehabilitation hospital which does not participate in Medicare to be exempt from the CHAMPUS DRG-based payment system, it must meet the same criteria (as determined by the Director, OCHAMPUS, or a designee) as required for exemption from the Medicare Prospective Payment System as contained in Section 412.23 of Title 42 CFR.

(c) Psychiatric and rehabilitation units (distinct parts). A psychiatric or rehabilitation unit which is exempt from the Medicare prospective payment system is also exempt from the CHAMPUS DRG-based payment system. In order for a distinct unit which does not participate in Medicare to be exempt from the CHAMPUS DRG-based payment system, it must meet the same criteria (as determined by the Director, OCHAMPUS, or a designee) as required for exemption from the Medicare Prospective Payment System as contained in Section 412.23 of Title 42 CFR.

(d) Long-term hospitals. A long-term hospital which is exempt from the Medicare prospective payment system is also exempt from the CHAMPUS DRG-based payment system. In order for a long-term hospital which does not participate in Medicare to be exempt from the CHAMPUS DRG-based payment system, it must have an average length of inpatient stay greater than 25 days:

1 As computed by dividing the number of total inpatient days (less leave or pass days) by the total number of discharges for the hospital's most recent fiscal year; or

2 As computed by the same method for the immediately preceding six-month period, if a change in the hospital's average length of stay is indicated.

(e) Sole community hospitals. Any hospital which has qualified for special treatment under the Medicare prospective payment system as a sole community hospital and has not given up that classification is exempt from the CHAMPUS DRG-based payment system. (See Subpart G of 42 CFR Part 412.)

(f) Christian Science sanitoriums. All Christian Science sanitoriums (as defined in paragraph B.4.h. of Chapter 6) are exempt from the CHAMPUS DRG-based payment system.

(g) Cancer hospitals. Any hospital which qualifies as a cancer hospital under the Medicare standards and has elected to be exempt from the Medicare prospective payment system is exempt from the CHAMPUS DRG-based payment system. (See 42 CFR Section 412.94.)

(h) Hospitals outside the 50 states, the District of Columbia, and Puerto Rico. A hospital is excluded from the CHAMPUS DRG-based payment system if it is not located in one of the fifty States, the District of Columbia, or Puerto Rico.

(5) Hospitals which do not participate in Medicare. It is not required that a hospital be a Medicare-participating provider in order to be an authorized CHAMPUS provider. However, any hospital which is subject to the CHAMPUS DRG-based payment system and which otherwise meets CHAMPUS requirements but which is not a Medicare-participating provider (having completed a form HCFA-1514, Hospital Request for Certification in the Medicare/Medicaid Program and a form HCFA-1561, Health Insurance Benefit Agreement) must complete a participation agreement with OCHAMPUS. By completing the participation agreement, the hospital agrees to participate on all CHAMPUS inpatient claims and to accept the CHAMPUS-determined allowable amount as payment in full for these claims. Any hospital which does not participate in Medicare and does not complete a participation agreement with OCHAMPUS will not be authorized to provide services to CHAMPUS beneficiaries.

(6) Substance Use Disorder Rehabilitation facilities. With admissions on or after July 1, 1995, substance use disorder rehabilitation facilities, authorized under chapter 6, section B.4.n., are subject to the DRG-based payment system.

c. Determination of payment amounts. The actual payment for an individual claim under the CHAMPUS DRG-based payment system is calculated by multiplying the appropriate adjusted standardized amount (adjusted to account for area wage differences using the wage indexes used in the Medicare program) by a weighting factor specific to each DRG.

(1) Calculation of DRG Weights.

(a) Grouping of charges. All discharge records in the database shall be grouped by DRG.

(b) Remove DRGs 469 and 470. Records from DRGs 469 and 470 shall be removed from the database.

(c) Indirect medical education standardization. To standardize the charges for the cost effects of indirect medical education factors, each teaching hospital's charges will be divided by 1.0 plus the following ratio on a hospital-specific basis:

$$1.43 \times \left[\left\{ 1.0 + \frac{\text{number of interns + residents}}{\text{number of beds}} \right\}^{.5795} - 1.0 \right]$$

(d) Wage level standardization. To standardize the charge records for area wage differences, each charge record will be divided into labor-related and nonlabor-related portions, and the labor-related portion shall be divided by the most recently available Medicare wage index for the area. The labor-related and nonlabor-related portions will then be added together.

(e) Elimination of statistical outliers. All unusually high or low charges shall be removed from the database.

(f) Calculation of DRG average charge. After the standardization for indirect medical education, and area wage differences, an average charge for each DRG shall be computed by summing charges in a DRG and dividing that sum by the number of records in the DRG.

(g) Calculation of national average charge per discharge. A national average charge per discharge shall be calculated by summing all charges and dividing that sum by the total number of records from all DRG categories.

(h) DRG relative weights. DRG relative weights shall be calculated for each DRG category by dividing each DRG average charge by the national average charge.

(2) Empty and low-volume DRGs. The Medicare weight shall be used for any DRG with less than ten (10) occurrences in the CHAMPUS database. The short-stay thresholds shall be set at one day for these DRGs and the long-stay thresholds shall be set at the FY 87 Medicare thresholds.

(3) Updating DRG weights. The CHAMPUS DRG weights shall be updated or adjusted as follows:

(a) DRG weights shall be recalculated annually using CHAMPUS charge data and the methodology described in subparagraph A.1.c.(1) of this chapter.

(b) When a new DRG is created, CHAMPUS will, if practical, calculate a weight for it using an appropriate charge sample (if available) and the methodology described in subparagraph A.1.c.(1) of this chapter.

(c) In the case of any other change under Medicare to an existing DRG weight (such as in connection with technology changes), CHAMPUS shall adjust its weight for that DRG in a manner comparable to the change made by Medicare.

(4) Calculation of the adjusted standardized amounts. The following procedures shall be followed in calculating the CHAMPUS adjusted standardized amounts.

(a) Differentiate large urban, other urban, and rural charges. All charges in the database shall be sorted into large urban, other urban, and rural groups (using the same definitions for these categories used in the Medicare program). The following procedures will be applied to each group.

(b) Indirect medical education standardization. To standardize the charges for the cost effects of indirect medical education factors, each teaching hospital's charges will be divided by 1.0 plus the following ratio on a hospital-specific basis:

$$1.43 \times \left[\left\{ 1.0 + \frac{\text{number of interns + residents}}{\text{number of beds}} \right\}^{.5795} - 1.0 \right]$$

(c) Wage level standardization. To standardize the charge records for area wage differences, each charge record will be divided into labor-related and nonlabor-related portions, and the labor-related portion shall be divided by the most recently available Medicare wage index for the area. The labor-related and nonlabor-related portions will then be added together.

(d) Apply the cost to charge ratio. Each charge is to be reduced to a representative cost by using the Medicare cost to charge ratio. This amount shall be increased by 1 percentage point in order to reimburse hospitals for bad debt expenses attributable to CHAMPUS beneficiaries.

(e) Preliminary base year standardized amount. A preliminary base year standardized amount shall be calculated by summing all costs in the database applicable to the large urban, other urban, or rural group and dividing by the total number of discharges in the respective group.

(f) Update for inflation. The preliminary base year standardized amounts shall be updated using an annual update factor equal to 1.07 to produce fiscal year 1988 preliminary standardized amounts. Thereafter, any development of a new standardized amount will use an inflation factor equal to the hospital market basket index used by the Health Care Financing Administration in their Prospective Payment System.

(g) The preliminary standardized amounts, updated for inflation, shall be divided by a system standardization factor so that total DRG outlays, given the database distribution across hospitals and diagnoses, are equal to the total charges reduced to costs.

(h) Labor and nonlabor portions of the adjusted standardized amounts. The adjusted standardized amounts shall be divided into labor and nonlabor portions in accordance with the Medicare division of labor and nonlabor portions.

(5) Adjustments to the DRG-based payment amounts. The following adjustments to the DRG-based amounts (the weight multiplied by the adjusted standardized amount) will be made.

(a) Outliers. The DRG-based payment to a hospital shall be adjusted for atypical cases. These outliers are those cases that have either an unusually short length-of-stay or extremely long length-of-stay or that involve extraordinarily high costs when compared to most discharges classified in the same DRG. Cases which qualify as both a length-of-stay outlier and a cost outlier shall be paid at the rate which results in the greater payment.

1 Length-of-stay outliers. Length-of-stay outliers shall be identified and paid by the fiscal intermediary when the claims are processed.

a Short-stay outliers. Any discharge with a length-of-stay (LOS) less than 1.94 standard deviations from the DRG's geometric LOS shall be classified as a short-stay outlier. Short-stay outliers shall be reimbursed at 200 percent of the per diem rate for the DRG for each covered day of the hospital stay, not to exceed the DRG amount. The per diem rate shall equal the DRG amount divided by the geometric mean length-of-stay for the DRG.

b Long-stay outliers. Any discharge (except for neonatal services and services in children's hospitals) which has a length-of-stay (LOS) exceeding a threshold established in accordance with the criteria used for the Medicare Prospective Payment System as contained in 42 CFR 412.82 shall be classified as a long-stay outlier. Any discharge for neonatal services or for services in a children's hospital which has a LOS exceeding the lesser of 1.94 standard deviations or 17 days from the DRG's geometric mean LOS also shall be classified as a long-stay outlier. Long-stay outliers shall be reimbursed the DRG-based amount plus a percentage (as established for the Medicare Prospective Payment System) of the per diem rate for the DRG for each covered day of care beyond the long-stay outlier threshold. The per diem rate shall equal the DRG amount divided by the geometric mean LOS for the DRG.

2 Cost outliers. Additional payment for cost outliers shall be made only upon request by the hospital.

a Cost outliers except those in children's hospitals or for neonatal services. Any discharge which has standardized costs that exceed a threshold established in accordance with the criteria used for the Medicare Prospective Payment System as contained in 42 CFR 412.84 shall qualify as a cost outlier. The standardized costs shall be calculated by multiplying the total charges by the factor described in subparagraph A.1.c.(4)(d) and adjusting this amount for indirect medical education costs. Cost outliers shall be reimbursed the DRG-based amount plus a percentage (as established for the Medicare Prospective Payment System) of all costs exceeding the threshold.

b Cost outliers in children's hospitals and for neonatal services. Any discharge for services in a children's hospital or for neonatal services which has standardized costs that exceed a threshold of the greater of two times the DRG-based amount or \$13,500 shall qualify as a cost outlier. The standardized costs shall be calculated by multiplying the total charges by the factor described in subparagraph A.1.c.(4)(d) (adjusted to include average capital and direct medical education costs) and adjusting this amount for indirect medical education costs. Cost outliers for services in children's hospitals and for neonatal services shall be reimbursed the DRG-based amount plus a percentage (as established for the Medicare Prospective Payment System) of all costs exceeding the threshold.

c Cost outliers for burn cases. All cost outliers for DRGs related to burn cases shall be reimbursed the DRG-based amount plus a percentage (as established for the Medicare Prospective Payment System) of all costs exceeding the threshold. The standardized costs and thresholds for these cases shall be calculated in accordance with subparagraph A.1.c.(5)(a)2 a and subparagraph A.1.c.(5)(a)2 b.

(b) Wage Adjustment. CHAMPUS will adjust the labor portion of the standardized amounts according to the hospital's area wage index.

(c) Indirect Medical Education Adjustment. The wage adjusted DRG payment will also be multiplied by 1.0 plus the hospital's indirect medical education ratio.

(d) Children's Hospital Differential. With respect to claims from children's hospitals, the appropriate adjusted standardized amount shall also be adjusted by a children's hospital differential.

1 Qualifying children's hospitals. Hospitals qualifying for the children's hospital differential are hospitals that are exempt from the Medicare Prospective Payment System, or, in the case of hospitals that do not participate in Medicare, that meet the same criteria (as determined by the Director, OCHAMPUS, or a designee) as required for exemption from the Medicare Prospective Payment System as contained in 42 CFR 412.23.

2 Calculation of differential. The differential shall be equal to the difference between a specially calculated children's hospital adjusted standardized amount and the adjusted standardized amount for fiscal year 1988. The specially calculated children's hospital adjusted standardized amount shall be calculated in the same manner as set forth in subparagraph A.1.c.(4), except that:

a The base period shall be fiscal year 1988 and shall represent total estimated charges for discharges that occurred during fiscal year 1988.

b No cost to charge ratio shall be applied.

c Capital costs and direct medical education costs will be included in the calculation.

d The factor used to update the database for inflation to produce the fiscal year 1988 base period amount shall be the applicable Medicare inpatient hospital market basket rate.

3 Transition rule. Until March 1, 1992, separate differentials shall be used for each higher volume children's hospital (individually) and for all other children's hospitals (in the aggregate). For this purpose, a higher volume hospital is a hospital that had 50 or more CHAMPUS discharges in fiscal year 1988.

4 Hold harmless provision. At such time as the weights initially assigned to neonatal DRGs are recalibrated based on sufficient volume of CHAMPUS claims records, children's hospital differentials shall be recalculated and appropriate retrospective and prospective adjustments shall be made. To the extent practicable, the recalculation shall also include reestimated values of other factors (including but not limited to direct education and capital costs and indirect education factors) for which more accurate data became available.

5 No update for inflation. The children's hospital differential, calculated (and later recalculated under the hold harmless provision) for the base period of fiscal year 1988, shall not be updated for subsequent fiscal years.

6 Administrative corrections. In connection with determinations pursuant to subparagraph A.1.c.(5)(d)3 of this chapter, any children's hospital that believes OCHAMPUS erroneously failed to classify the hospital as a high volume hospital or incorrectly calculated (in the case of a high volume hospital) the hospital's differential may obtain administrative corrections by submitting appropriate documentation to the Director, OCHAMPUS (or designee).

(6) Updating the adjusted standardized amounts. Beginning in FY 1989, the adjusted standardized amounts will be updated by the Medicare annual update factor, unless the adjusted standardized amounts are recalculated.

(7) Annual Cost Pass-Throughs.

(a) Capital costs. When requested in writing by a hospital, CHAMPUS shall reimburse the hospital its share of actual capital costs as reported annually to the CHAMPUS fiscal intermediary. Payment for capital costs shall be made annually based on the ratio of CHAMPUS inpatient days for those beneficiaries subject to the CHAMPUS DRG-based payment system to total inpatient days applied to the hospital's total allowable capital costs. Reductions in payments for capital costs which are required under Medicare shall also be applied to payments for capital costs under CHAMPUS.

1 Costs included as capital costs. Allowable capital costs are those specified in Medicare Regulation Section 413.130, as modified by Section 412.72.

2 Services, facilities, or supplies provided by supplying organizations. If services, facilities, or supplies are provided to the hospital by a supplying organization related to the hospital within the meaning of Medicare Regulation Section 413.17, then the hospital must include in its capital-related costs, the capital-related costs of the supplying organization. However, if the supplying organization is not related to the provider within the meaning of 413.17, no part of the charge to the provider may be considered a capital-related cost unless the services, facilities, or supplies are capital-related in nature and:

a The capital-related equipment is leased or rented by the provider;

b The capital-related equipment is located on the provider's premises; and

c The capital-related portion of the charge is separately specified in the charge to the provider.

(b) Direct medical education costs. When requested in writing by a hospital, CHAMPUS shall reimburse the hospital its actual direct medical education costs as reported annually to the CHAMPUS fiscal intermediary. Such teaching costs must be for a teaching program approved under Medicare Regulation Section 413.85. Payment for direct medical education costs shall be made annually based on the ratio of CHAMPUS inpatient days for those beneficiaries subject to the CHAMPUS DRG-based payment system to total inpatient days applied to the hospital's total allowable direct medical education costs. Allowable direct medical education costs are those specified in Medicare Regulation Section 413.85.

(c) Information necessary for payment of capital and direct medical education costs. All hospitals subject to the CHAMPUS DRG-based payment system, except for children's hospitals, may be reimbursed for allowed capital and direct medical education costs by submitting a request to the CHAMPUS contractor. Such request shall cover the one-year period corresponding to the hospital's Medicare cost-reporting period. The first such request may cover a period of less than a full year--from the effective date of the CHAMPUS DRG-based payment system to the end of the hospital's Medicare cost-reporting period. All costs reported to the CHAMPUS contractor must correspond to the costs reported on the hospital's Medicare cost report. In the case of children's hospitals that request reimbursement under this clause for capital and/or direct medical education costs, the hospital must submit appropriate base period cost information, as determined by the Director, OCHAMPUS (or designee). (If these costs change as a result of a subsequent audit by Medicare, the revised costs are to be reported to

the hospital's CHAMPUS contractor within 30 days of the date the hospital is notified of the change.) The request must be signed by the hospital official responsible for verifying the amounts and shall contain the following information.

- 1 The hospital's name.
- 2 The hospital's address.
- 3 The hospital's CHAMPUS provider number.
- 4 The hospital's Medicare provider number.
- 5 The period covered--this must correspond to the hospital's Medicare cost-reporting period.
- 6 Total inpatient days provided to all patients in units subject to DRG-based payment.
- 7 Total allowed CHAMPUS inpatient days provided in units subject to DRG-based payment.
- 8 Total allowable capital costs.
- 9 Total allowable direct medical education costs.
- 10 Total full-time equivalents for:
 - a Residents.
 - b Interns
- 11 Total inpatient beds as of the end of the cost-reporting period. If this has changed during the reporting period, an explanation of the change must be provided.
- 12 Title of official signing the report.
- 13 Reporting date.
- 14 The report shall contain a certification statement that any changes to the items in subparagraphs 6, 7, 8, 9, or 10, which are a result of an audit of the hospital's Medicare cost-report, shall be reported to CHAMPUS within thirty (30) days of the date the hospital is notified of the change.

2. CHAMPUS mental health per diem payment system. The CHAMPUS mental health per diem payment system shall be used to reimburse for inpatient mental health hospital care in specialty psychiatric hospitals and units. Payment is made on the basis of prospectively determined rates and paid on a

per diem basis. The system uses two sets of per diems. One set of per diems applies to hospitals and units that have a relatively higher number of CHAMPUS discharges. For these hospitals and units, the system uses hospital-specific per diem rates. The other set of per diems applies to hospitals and units with a relatively lower number of CHAMPUS discharges. For these hospitals and units, the system uses regional per diems, and further provides for adjustments for area wage differences and indirect medical education costs and additional pass-through payments for direct medical education costs.

a. Applicability of the mental health per diem payment system.

(1) Hospitals and units covered. The CHAMPUS mental health per diem payment system applies to services covered (see subparagraph A.2.a.(2) below) that are provided in Medicare prospective payment system (PPS) exempt psychiatric specialty hospitals and all Medicare PPS exempt psychiatric specialty units of other hospitals. In addition, any psychiatric hospital that does not participate in Medicare, or any other hospital that has a psychiatric specialty unit that has not been so designated for exemption from the Medicare prospective payment system because the hospital does not participate in Medicare, may be designated as a psychiatric hospital or psychiatric specialty unit for purposes of the CHAMPUS mental health per diem payment system upon demonstrating that it meets the same criteria (as determined by the Director, OCHAMPUS) as required for the Medicare exemption. The CHAMPUS mental health per diem payment system does not apply to mental health services provided in other hospitals.

(2) Services covered. Unless specifically exempted, all covered hospitals' and units' inpatient claims which are classified into a mental health DRG (DRG categories 425-432, but not DRG 424) or an alcohol/drug abuse DRG (DRG categories 433-437) shall be subject to the mental health per diem payment system.

b. Hospital-specific per diems for higher volume hospitals and units. This paragraph describes the per diem payment amounts for hospitals and units with a higher volume of CHAMPUS discharges.

(1) Per diem amount.

(a) A hospital-specific per diem amount shall be calculated for each hospital and unit with a higher volume of CHAMPUS discharges. The base period per diem amount shall be equal to the hospital's average daily charge in the base period. The base period amount, however, may not exceed the cap described in subparagraph A.2.b.(2), below. The base period amount shall be updated in accord with paragraph A.2.d. of this chapter.

(b) In states that have implemented a payment system in connection with which hospitals in that state have been exempted from the CHAMPUS DRG-based payment system pursuant to paragraph A.1.b.(1) of this chapter, psychiatric hospitals and units may have per diem amounts established based on the payment system applicable to such hospitals and units in the state. The per diem amount, however, may not exceed the cap amount applicable to other higher volume hospitals.

(2) Cap.

(a) As it affects payment for care provided to patients prior to April 6, 1995, the base period per diem amount may not exceed the 80th percentile of the average daily charge weighted for all discharges throughout the United States from all higher volume hospitals.

(b) Applicable to payments for care provided to patients on or after April 6, 1995, the base period per diem amount may not exceed the 70th percentile of the average daily charge weighted for all discharges throughout the United States from all higher volume hospitals. For this purpose, base year charges shall be deemed to be charges during the period of July 1, 1991 to June 30, 1992, adjusted to correspond to base year (FY1988) charges by the percentage change in average daily charges for all higher volume hospitals and units between the period of July 1, 1991 to June 30, 1992 and the base year.

(3) Review of per diem amount. Any hospital or unit which believes OCHAMPUS calculated a hospital-specific per diem which differs by more than \$5.00 from that calculated by the hospital or unit may apply to the Director, OCHAMPUS, or a designee, for a recalculation. The burden of proof shall be on the hospital.

c. Regional per diems for lower volume hospitals and units. This paragraph describes the per diem amounts for hospitals and units with a lower volume of CHAMPUS discharges.

(1) Per diem amounts. Hospitals and units with a lower volume of CHAMPUS patients shall be paid on the basis of a regional per diem amount, adjusted for area wages and indirect medical education. Base period regional per diems shall be calculated based upon all CHAMPUS lower volume hospitals' claims paid during the base period. Each regional per diem amount shall be the quotient of all covered charges divided by all covered days of care, reported on all CHAMPUS claims from lower volume hospitals in the region paid during the base period, after having standardized for indirect medical education costs and area wage indexes and subtracted direct medical education costs. Regional per diem amounts are adjusted in accordance with subparagraph A.2.c.(3), below. Additional pass-through payments to lower volume hospitals are made in accordance with subparagraph A.2.c.(4), below. The regions shall be the same as the federal census regions.

(2) Review of per diem amount. Any hospital that believes the regional per diem amount applicable to that hospital has been erroneously calculated by OCHAMPUS by more than \$5.00 may submit to the Director, OCHAMPUS, or a designee, evidence supporting a different regional per diem. The burden of proof shall be on the hospital.

(3) Adjustments to regional per diems. Two adjustments shall be made to the regional per diem rates.

(a) Area wage index. The same area wage indexes used for the CHAMPUS DRG-based payment system (see subparagraph A.1.c.(5)(b) of this chapter) shall be applied to the wage portion of the applicable regional per diem rate for each day of the admission. The wage portion shall be the same as that used for the CHAMPUS DRG-based payment system.

(b) Indirect medical education. The indirect medical education adjustment factors shall be calculated for teaching hospitals in the same manner as is used in the CHAMPUS DRG-based payment system (see subparagraph A.1.c.(5)(c) of this chapter) and applied to the applicable regional per diem rate for each day of the admission.

(4) Annual cost pass-through for direct medical education. In addition to payments made to lower volume hospitals under paragraph A.2.c., CHAMPUS shall annually reimburse hospitals for actual direct medical education costs associated with services to CHAMPUS beneficiaries. This reimbursement shall be done pursuant to the same procedures as are applicable to the CHAMPUS DRG-based payment system (see subparagraph A.1.c.(7) of this chapter).

d. Base period and update factors.

(1) Base period. The base period for calculating the hospital-specific and regional per diems, as described in paragraphs A.2.b. and c. above, is federal fiscal year 1988. Base period calculations shall be based on actual claims paid during the period July 1, 1987 through May 31, 1988, trended forward to represent the 12-month period ending September 30, 1988 on the basis of the Medicare inpatient hospital market basket rate.

(2) Alternative hospital-specific data base. Upon application of a higher volume hospital or unit to the Director, OCHAMPUS, or a designee, the hospital or unit may have its hospital-specific base period calculations based on claims with a date of discharge (rather than date of payment) between July 1, 1987 through May 31, 1988 if it has generally experienced unusual delays in claims payments and if the use of such an alternative data base would result in a difference in the per diem amount of at least \$5.00. For this purpose, the unusual delays means that the hospital's or unit's average time period between date of discharge and date of payment is more than two standard deviations longer than the national average.

(3) Update factors.

(a) The hospital-specific per diems and the regional per diems calculated for the base period pursuant to paragraph A.2.b. of this chapter shall remain in effect for federal fiscal year 1989; there will be no additional update for fiscal year 1989.

(b) Except as provided in paragraph A.2.d.(3)(c) of this chapter, for subsequent federal fiscal years, each per diem shall be updated by the Medicare update factor for hospitals and units exempt from the Medicare prospective payment system.

(c) As an exception to the update required by paragraph A.2.d.(3)(b) of this chapter, all per diems in effect at the end of fiscal year 1995 shall remain in effect, with no additional update, throughout fiscal years 1996 and 1997. For fiscal year 1998 and thereafter, the per diems in effect at the end of fiscal year 1997 will be updated in accordance with paragraph A.2.d.(3)(b).

(d) Hospitals and units with hospital-specific rates will be notified of their respective rates prior to the beginning of each Federal fiscal year. New hospitals shall be notified at such time as the hospital rate is determined. The actual amounts of each regional per diem that will apply in any Federal fiscal year shall be published in the Federal Register at approximately the start of that fiscal year.

e. Higher volume hospitals. This paragraph describes the classification of and other provisions pertinent to hospitals with a higher volume of CHAMPUS patients.

(1) In general. Any hospital or unit that had an annual rate of 25 or more CHAMPUS discharges of CHAMPUS patients during the period July 1, 1987 through May 31, 1988 shall be considered a higher volume hospital during federal fiscal year 1989 and all subsequent fiscal years. All other hospitals and units covered by the CHAMPUS mental health per diem payment system shall be considered lower volume hospitals.

(2) Hospitals that subsequently become higher volume hospitals. In any federal fiscal year in which a hospital, including a new hospital (see subparagraph A.2.e.(3) below), not previously classified as a higher volume hospital has 25 or more CHAMPUS discharges, that hospital shall be considered to be a higher volume hospital during the next federal fiscal year and all subsequent fiscal years. The hospital specific per diem amount shall be calculated in accordance with the provisions of paragraph A.2.b. of this chapter, except that the base period average daily charge shall be deemed to be the hospital's average daily charge in the year in which the hospital had 25 or more discharges, adjusted by the percentage change in average daily charges for all higher volume hospitals and units between the year in which the hospital had 25 or more CHAMPUS discharges and the base period. The base period amount, however, may not exceed the cap described in subparagraph A.2.b.(2) of this chapter.

(3) Special retrospective payment provision for new hospitals. For purposes of this subparagraph, a new hospital is a hospital that qualifies for the Medicare exemption from the rate of increase ceiling applicable to new hospitals which are PPS-exempt psychiatric hospitals. Any new hospital that becomes a higher volume hospital, in addition to qualifying prospectively as a higher volume hospital for purposes of subparagraph A.2.e.(2) above, may additionally, upon application to the Director, OCHAMPUS, receive a retrospective adjustment. The retrospective adjustment shall be calculated so that the hospital receives the same government share payments it would have received had it been designated a higher volume hospital for the federal fiscal year in which it first had 25 or more CHAMPUS discharges and the preceding fiscal year (if it had any CHAMPUS patients during the preceding fiscal year). Such new hospitals must agree not to bill CHAMPUS beneficiaries for any additional costs beyond that determined initially.

(4) Review of classification. Any hospital or unit which OCHAMPUS erroneously fails to classify as a higher volume hospital may apply to the Director, OCHAMPUS, or a designee, for such a classification. The hospital shall have the burden of proof.

f. Payment for hospital based professional services. Lower volume hospitals and units may not bill separately for hospital based professional mental health services; payment for those services is included in the per diems. Higher volume hospitals and units, whether they billed CHAMPUS separately for hospital based professional mental health services or included those services in the hospital's billing to CHAMPUS, shall continue the practice in effect during the period July 1, 1987 to May 31, 1988 (or other data base period used for calculating the hospital's or unit's per diem), except that any such hospital or unit may change its prior practice (and obtain an appropriate revision in its per diem) by providing to OCHAMPUS notice in accordance with procedures established by the Director, OCHAMPUS, or a designee.

g. Leave days. CHAMPUS shall not pay for days where the patient is absent on leave from the specialty psychiatric hospital or unit. The hospital must identify these days when claiming reimbursement. CHAMPUS shall not count a patient's leave of absence as a discharge in determining whether a facility should be classified as a higher volume hospital pursuant to paragraph A.2.e. of this chapter.

h. Exemptions from the CHAMPUS mental health per diem payment system. The following providers and procedures are exempt from the CHAMPUS mental health per diem payment system.

(1) Non-specialty providers. Providers of inpatient care which are not either psychiatric hospitals or psychiatric specialty units as described in subparagraph A.2.a.(1) of this chapter are exempt from the CHAMPUS mental health per diem payment system. Such providers should refer to subsection A.1. of this chapter for provisions pertinent to the CHAMPUS DRG-based payment system.

(2) DRG 424. Admissions for operating room procedures involving a principal diagnosis of mental illness (services which group into DRG 424) are exempt from the per diem payment system. They will be reimbursed pursuant to the provisions of subsection A.3. of this chapter.

(3) Non-mental health services. Admissions for non-mental health procedures in specialty psychiatric hospitals and units are exempt from the per diem payment system. They will be reimbursed pursuant to the provisions of subsection A.3. of this chapter.

(4) Sole community hospitals. Any hospital which has qualified for special treatment under the Medicare prospective payment system as a sole community hospital and has not given up that classification is exempt.

(5) Hospitals outside the U.S. A hospital is exempt if it is not located in one of the 50 states, the District of Columbia or Puerto Rico.

i. Per diem payment for psychiatric and substance use disorder rehabilitation partial hospitalization services.

(1) In general. Psychiatric and substance use disorder rehabilitation partial hospitalization services authorized by chapter 4, sections B.10. and E.4. and provided by institutional providers authorized under chapter 6, sections B.4.1. and B.4.n. are reimbursed on the basis of prospectively determined, all-inclusive per diem rates. The per diem payment amount must be accepted as payment in full for all institutional services provided, including board, routine nursing services, ancillary services (includes art, music, dance, occupational and other such therapies), psychological testing and assessments, overhead and any other services for which the customary practice among similar providers is included as part of the institutional charges.

(2) Services which may be billed separately. The following services are not considered as included within the per diem payment amount and may be separately billed when provided by an authorized independent professional provider:

(a) Psychotherapy sessions not included. Professional services provided by an authorized professional provider (who is not employed by or under contract with the partial hospitalization program) for purposes of providing clinical patient care to a patient in the partial hospitalization program are not included in the per diem rate. They may be separately billed. Professional mental health benefits are limited to a maximum of one session (60 minutes individual, 90 minutes family, etc.) per authorized treatment day not to exceed five sessions in any calendar week.

(b) Non-mental health related medical services.

Those services not normally included in the evaluation and assessment of a partial hospitalization program, non-mental health related medical services, may be separately billed when provided by an authorized independent professional provider. This includes ambulance services when medically necessary for emergency transport.

(3) Per diem rate. For any full day partial hospitalization program (minimum of 6 hours), the maximum per diem payment amount is 40 percent of the average inpatient per diem amount per case established under the CHAMPUS mental health per diem reimbursement system for both high and low volume psychiatric hospitals and units (as defined in chapter 14, section A.2.) for the fiscal year. A partial hospitalization program of less than 6 hours (with a minimum of three hours) will be paid a per diem rate of 75 percent of the rate for a full-day program.

(4) Other requirements. No payment is due for leave days, for days in which treatment is not provided, or for days in which the duration of the program services was less than three hours.

3. Billed charges and set rates. The allowable costs for authorized care in all hospitals not subject to the CHAMPUS DRG-based payment system or the CHAMPUS mental health per diem payment system shall be determined on the basis of billed charges or set rates. Under this procedure the allowable costs may not exceed the lower of:

a. The actual charge for such service made to the general public;
or

b. The allowed charge applicable to the policyholders or subscribers of the CHAMPUS fiscal intermediary for comparable services under comparable circumstances, when extended to CHAMPUS beneficiaries by consent or agreement; or

c. The allowed charge applicable to the citizens of the community or state as established by local or state regulatory authority, excluding title XIX of the Social Security Act or other welfare program, when extended to CHAMPUS beneficiaries by consent or agreement.

4. CHAMPUS discount rates. The CHAMPUS-determined allowable cost for authorized care in any hospital may be based on discount rates established under section I. of this chapter.

B. SKILLED NURSING FACILITIES (SNFs)

The CHAMPUS-determined allowable cost for reimbursement of a SNF shall be determined on the same basis as for hospitals which are not subject to the CHAMPUS DRG-based payment system.

C. REIMBURSEMENT FOR OTHER THAN HOSPITALS AND SNFs

The Director, OCHAMPUS, or a designee, shall establish such other methods of determining allowable cost or charge reimbursement for those institutions, other than hospitals and SNFs, as may be required.

D. Payment of Institutional facility costs for ambulatory surgery.

1. In general. CHAMPUS pays institutional facility costs for ambulatory surgery on the basis of prospectively determined amounts, as provided in this paragraph. This payment method is similar to that used by the Medicare program for ambulatory surgery. This paragraph applies to payment for institutional charges for ambulatory surgery provided in hospitals and freestanding ambulatory surgical centers. It does not apply to professional services. A list of ambulatory surgery procedures subject to the payment method set forth in this paragraph shall be published periodically by the Director OCHAMPUS. Payment to freestanding ambulatory surgery centers is limited to these procedures.

2. Payment in full. The payment provided for under this paragraph is the payment in full for services covered by this paragraph. Facilities may not charge beneficiaries for amounts, if any, in excess of the payment amounts determined pursuant to this paragraph.

3. Calculation of standard payment rates. Standard payment rates are calculated for groups of procedures under the following steps:

a. Step 1: calculate a median standardized cost for each procedure. For each ambulatory surgery procedure, a median standardized cost will be calculated on the basis of all ambulatory surgery charges nationally under CHAMPUS during a recent one-year base period. The steps in this calculation include standardizing for local labor costs by reference to the same wage index and labor/non-labor-related cost ratio as applies to the facility under Medicare, applying a cost-to-charge ratio, calculating a median cost for each procedure, and updating to the year for which the payment rates will be in effect by the Consumer Price Index-Urban. In applying a cost-to-charge ratio, the Medicare cost-to-charge ratio for freestanding ambulatory surgery centers (FASCs) will be used for all charges from FASCs, and the Medicare cost-to-charge ratio for hospital outpatient settings will be used for all charges from hospitals.

b. Step 2: grouping procedures. Procedures will then be placed into one of ten groups by their median per procedure cost, starting with \$0 to \$299 for group 1 and ending with \$1000 to \$1299 for group 9 and \$1300 and above for group 10, with groups 2 through 8 set on the basis of \$100 fixed intervals.

c. Step 3: adjustments to groups. The Director, OCHAMPUS may make adjustments to the groupings resulting from step 2 to account for any ambulatory surgery procedures for which there were insufficient data to allow a grouping or to correct for any anomalies resulting from data or statistical factors or other special factors that fairness requires be specially recognized. In making any such adjustments, the Director may take into consideration the placing of particular procedures in the ambulatory surgery groups under Medicare.

d. Step 4: standard payment amount per group. The standard payment amount per group will be the volume weighted median per procedure cost for the procedures in that group.

e. Step 5: actual payments. Actual payment for a procedure will be the standard payment amount for the group which covers that procedure, adjusted for local labor costs by reference to the same labor/non-labor-related cost ratio and hospital wage index as used for ambulatory surgery centers by Medicare.

4. Multiple procedures. In cases in which authorized multiple procedures are performed during the same operative session, payment shall be based on 100 percent of the payment amount for the procedure with the highest ambulatory surgery payment amount, plus, for each other procedure performed during the session, 50 percent of its payment amount.

5. Annual updates. The standard payment amounts will be updated annually by the same update factor as is used in the Medicare annual updates for ambulatory surgery center payments.

6. Recalculation of rates. The Director, OCHAMPUS, may periodically recalculate standard payment rates for ambulatory surgery using the steps set forth in paragraph D.3., of this Chapter.

E. REIMBURSEMENT OF BIRTHING CENTERS

1. Reimbursement for maternity care and childbirth services furnished by an authorized birthing center shall be limited to the lower of the CHAMPUS established all-inclusive rate or the center's most-favored all-inclusive rate.

2. The all-inclusive rate shall include the following to the extent that they are usually associated with a normal pregnancy and childbirth: laboratory studies, prenatal management, labor management, delivery, post-partum management, newborn care, birth assistant, certified nurse-midwife professional services, physician professional services, and the use of the facility.

3. The CHAMPUS established all-inclusive rate is equal to the sum of the CHAMPUS area prevailing professional charge for total obstetrical care for a normal pregnancy and delivery and the sum of the average CHAMPUS allowable institutional charges for supplies, laboratory, and delivery room

for a hospital inpatient normal delivery. The CHAMPUS established all-inclusive rate areas will coincide with those established for prevailing professional charges and will be updated concurrently with the CHAMPUS area prevailing professional charge database.

4. Extraordinary maternity care services, when otherwise authorized, may be reimbursed at the lesser of the billed charge or the CHAMPUS allowable charge.

5. Reimbursement for an incomplete course of care will be limited to claims for professional services and tests where the beneficiary has been screened but rejected for admission into the birthing center program, or where the woman has been admitted but is discharged from the birthing center program prior to delivery, adjudicated as individual professional services and items.

6. The beneficiary's share of the total reimbursement to a birthing center is limited to the cost-share amount plus the amount billed for non-covered services and supplies.

F. REIMBURSEMENT OF RESIDENTIAL TREATMENT CENTERS

The CHAMPUS rate is the per diem rate that CHAMPUS will authorize for all mental health services rendered to a patient and the patient's family as part of the total treatment plan submitted by a CHAMPUS-approved RTC, and approved by the Director, OCHAMPUS, or designee.

1. The all-inclusive per diem rate for RTCs operating or participating in CHAMPUS during the base period of July 1, 1987, through June 30, 1988, will be the lowest of the following conditions:

a. The CHAMPUS rate paid to the RTC for all-inclusive services as of June 30, 1988, adjusted by the Consumer Price Index - Urban (CPI-U) for medical care as determined applicable by the Director, OCHAMPUS, or designee; or

b. The per diem rate accepted by the RTC from any other agency or organization (public or private) that is high enough to cover one-third of the total patient days during the 12-month period ending June 30, 1988, adjusted by the CPI-U; or

NOTE: The per diem rate accepted by the RTC from any other agency or organization includes the rates accepted from entities such as Government contractors in CHAMPUS demonstration projects.

c. An OCHAMPUS determined capped per diem amount not to exceed the 80th percentile of all established CHAMPUS RTC rates nationally, weighted by total CHAMPUS days provided at each rate during the base period discussed in F.1. above.

2. The all-inclusive per diem rates for RTCs which began operation after June 30, 1988, or began operation before July 1, 1988, but had less than 6 months of operation by June 30, 1988, will be calculated based on the lower of the per diem rate accepted by the RTC that is high enough to cover one-third of the total patient days during its first 6 to 12 consecutive months of operation, or the OCHAMPUS determined capped amount. Rates for RTCs beginning operation prior to July 1, 1988, will be adjusted by an appropriate CPI-U inflation factor for the period ending June 30, 1988. A period of less than 12 months will be used only when the RTC has been in operation for less than 12 months. Once a full 12 months is available, the rate will be recalculated.

3. For care on or after April 6, 1995, the per diem amount may not exceed a cap of the 70th percentile of all established Federal fiscal year 1994 RTC rates nationally, weighted by total CHAMPUS days provided at each rate during the first half of Federal fiscal year 1994, and updated to FY95. For Federal fiscal years 1996 and 1997, the cap shall remain unchanged. For Federal fiscal years after fiscal year 1997, the cap shall be adjusted by the Medicare update factor for hospitals and units exempt from the Medicare prospective payment system.

4. All educational costs, whether they include routine education or special education costs, are excluded from reimbursement except when appropriate education is not available from, or not payable by, a cognizant public entity.

a. The RTC shall exclude educational costs from its daily costs.

b. The RTC's accounting system must be adequate to assure CHAMPUS is not billed for educational costs.

c. The RTC may request payment of educational costs on an individual case basis from the Director, OCHAMPUS, or designee, when appropriate education is not available from, or not payable by, a cognizant public entity. To qualify for reimbursement of educational costs in individual cases, the RTC shall comply with the application procedures established by the Director, OCHAMPUS, or designee, including, but not limited to, the following:

(1) As part of its admission procedures, the RTC must counsel and assist the beneficiary and the beneficiary's family in the necessary procedures for assuring their rights to a free and appropriate public education.

(2) The RTC must document any reasons why an individual beneficiary cannot attend public educational facilities and, in such a case, why alternative educational arrangements have not been provided by the cognizant public entity.

(3) If reimbursement of educational costs is approved for an individual beneficiary by the Director, OCHAMPUS, or designee, such educational costs shall be shown separately from the RTC's daily costs on the CHAMPUS claim. The amount paid shall not exceed the RTC's most-favorable rate to any other patient, agency, or organization for special or general educational services whichever is appropriate.

(4) If the RTC fails to request CHAMPUS approval of the educational costs on an individual case, the RTC agrees not to bill the beneficiary or the beneficiary's family for any amounts disallowed by CHAMPUS. Requests for payment of educational costs must be referred to the Director, OCHAMPUS, or designee for review and a determination of the applicability of CHAMPUS benefits.

5. Subject to the applicable RTC cap, adjustments to the RTC rates may be made annually.

a. For Federal fiscal years through 1995, the adjustment shall be based on the Consumer Price Index-Urban (CPI-U) for medical care as determined applicable by the Director, OCHAMPUS.

b. For purposes of rates for Federal fiscal years 1996 and 1997:

(1) For any RTC whose 1995 rate was at or above the thirtieth percentile of all established Federal fiscal year 1995 RTC rates normally, weighted by total CHAMPUS days provided at each rate during the first half of Federal fiscal year 1994, that rate shall remain in effect, with no additional update, throughout fiscal years 1996 and 1997; and

(2) For any RTC whose 1995 rate was below the 30th percentile level determined under paragraph F.5.b.(1) of this chapter, the rate shall be adjusted by the lesser of: the CPI-U for medical care, or the amount that brings the rate up to that 30th percentile level.

c. For subsequent Federal fiscal years after fiscal year 1997, RTC rates shall be updated by the Medicare update factor for hospitals and units exempt from the Medicare prospective payment system.

6. For care provided on or after July 1, 1995, CHAMPUS will not pay for days in which the patient is absent on leave from the RTC. The RTC must identify these days when claiming reimbursement.

G. Reimbursement of hospice programs. Hospice care will be reimbursed at one of four predetermined national CHAMPUS rates based on the type and intensity of services furnished to the beneficiary. A single rate is applicable for each day of care except for continuous home care where payment is based on the number of hours of care furnished during a 24-hour period. These rates will be adjusted for regional differences in wages using wage indices for hospice care.

1. National hospice rates. CHAMPUS will use the national hospice rates for reimbursement of each of the following levels of care provided by or under arrangement with a CHAMPUS approved hospice program:

a. Routine home care. The hospice will be paid the routine home care rate for each day the patient is at home, under the care of the hospice, and not receiving continuous home care. This rate is paid without regard to the volume or intensity of routine home care services provided on any given day.

b. Continuous home care. The hospice will be paid the continuous home care rate when continuous home care is provided. The continuous home care rate is divided by 24 hours in order to arrive at an hourly rate.

(1) A minimum of 8 hours of care must be provided within a 24-hour day starting and ending at midnight.

(2) More than half of the total actual hours being billed for each 24-hour period must be provided by either a registered or licensed practical nurse.

(3) Homemaker and home health aide services may be provided to supplement the nursing care to enable the beneficiary to remain at home.

(4) For every hour or part of an hour of continuous care furnished, the hourly rate will be reimbursed to the hospice up to 24 hours a day.

c. Inpatient respite care. The hospice will be paid at the inpatient respite care rate for each day on which the beneficiary is in an approved inpatient facility and is receiving respite care.

(1) Payment for respite care may be made for a maximum of 5 days at a time, including the date of admission but not counting the date of discharge. The necessity and frequency of respite care will be determined by the hospice interdisciplinary group with input from the patient's attending physician and the hospice's medical director.

(2) Payment for the sixth and any subsequent days is to be made at the routine home care rate.

d. General inpatient care. Payment at the inpatient rate will be made when general inpatient care is provided for pain control or acute or chronic symptom management which cannot be managed in other settings. None of the other fixed payment rates (i.e., routine home care) will be applicable for a day on which the patient receives general inpatient care except on the date of discharge.

e. Date of discharge. For the day of discharge from an inpatient unit, the appropriate home care rate is to be paid unless the patient dies as an inpatient. When the patient is discharged deceased, the inpatient rate (general or respite) is to be paid for the discharge date.

2. Use of Medicare rates. CHAMPUS will use the most current Medicare rates to reimburse hospice programs for services provided to CHAMPUS beneficiaries. It is CHAMPUS' intent to adopt changes in the Medicare reimbursement methodology as they occur; e.g., Medicare's adoption of an updated, more accurate wage index.

3. Physician reimbursement. Payment is dependent on the physician's relationship with both the beneficiary and the hospice program.

a. Physicians employed by, or contracted with, the hospice.

(1) Administrative and supervisory activities (i.e., establishment, review and updating of plans of care, supervising care and services, and establishing governing policies) are included in the adjusted national payment rate.

(2) Direct patient care services are paid in addition to the adjusted national payment rate.

(a) Physician services will be reimbursed an amount equivalent to 100 percent of the CHAMPUS' allowable charge; i.e., there will be no cost-sharing and/or deductibles for hospice physician services.

(b) Physician payments will be counted toward the hospice cap limitation.

b. Independent attending physician. Patient care services rendered by an independent attending physician (a physician who is not considered employed by or under contract with the hospice) are not part of the hospice benefit.

(1) Attending physician may bill in his/her own right.

(2) Services will be subject to the appropriate allowable charge methodology.

(3) Reimbursement is not counted toward the hospice cap limitation.

(4) Services provided by an independent attending physician must be coordinated with any direct care services provided by hospice physicians.

(5) The hospice must notify the CHAMPUS contractor of the name of the physician whenever the attending physician is not a hospice employee.

c. Voluntary physician services. No payment will be allowed for physician services furnished voluntarily (both physicians employed by, and under contract with, the hospice and independent attending physicians). Physicians may not discriminate against CHAMPUS beneficiaries; e.g., designate all services rendered to non-CHAMPUS patients as volunteer and at the same time bill for CHAMPUS patients.

4. Unrelated medical treatment. Any covered CHAMPUS services not related to the treatment of the terminal condition for which hospice care was elected will be paid in accordance with standard reimbursement methodologies; i.e., payment for these services will be subject to standard deductible and cost-sharing provisions under the CHAMPUS. A determination must be made whether or not services provided are related to the individual's terminal illness. Many illnesses may occur when an individual is terminally ill which are brought on by the underlying condition of the patient. For example, it is not unusual for a terminally ill patient to develop pneumonia or some other illness as a result of his or her weakened condition. Similarly, the setting of bones after fractures occur in a bone cancer patient would be treatment of a related condition. Thus, if the treatment or control of an upper respiratory tract infection is due to the weakened state of the terminal patient, it will be considered a related condition, and as such, will be included in the hospice daily rates.

5. Cap amount. Each CHAMPUS-approved hospice program will be subject to a cap on aggregate CHAMPUS payments from November 1 through October 31 of each year, hereafter known as "the cap period."

a. The cap amount will be adjusted annually by the percent of increase or decrease in the medical expenditure category of the Consumer Price Index for all urban consumers (CPI-U).

b. The aggregate cap amount (i.e., the statutory cap amount times the number of CHAMPUS beneficiaries electing hospice care during the cap period) will be compared with total actual CHAMPUS payments made during the same cap period.

c. Payments in excess of the cap amount must be refunded by the hospice program. The adjusted cap amount will be obtained from the Health Care Financing Administration (HCFA) prior to the end of each cap period.

d. Calculation of the cap amount for a hospice which has not participated in the program for an entire cap year (November 1 through October 31) will be based on a period of at least 12 months but no more than 23 months. For example, the first cap period for a hospice entering the program on October 1, 1994, would run from October 1, 1994 through October 31, 1995. Similarly, the first cap period for hospice providers entering the program after November 1, 1993 but before November 1, 1994 would end October 31, 1995.

6. Inpatient limitation. During the 12-month period beginning November 1 of each year and ending October 31, the aggregate number of inpatient days, both for general inpatient care and respite care, may not exceed 20 percent of the aggregate total number of days of hospice care provided to all CHAMPUS beneficiaries during the same period.

a. If the number of days of inpatient care furnished to CHAMPUS beneficiaries exceeds 20 percent of the total days of hospice care to CHAMPUS beneficiaries, the total payment for inpatient care is determined as follows:

(1) Calculate the ratio of the maximum number of allowable inpatient days to the actual number of inpatient care days furnished by the hospice to Medicare patients.

(2) Multiply this ratio by the total reimbursement for inpatient care made by the CHAMPUS contractor.

(3) Multiply the number of actual inpatient days in excess of the limitation by the routine home care rate.

(4) Add the amounts calculated in paragraphs G.6.a.(2) and (3) of this section.

b. Compare the total payment for inpatient care calculated in paragraph G.6.a.(4) above to actual payments made to the hospice for inpatient care during the cap period.

c. Payments in excess of the inpatient limitation must be refunded by the hospice program.

7. Hospice reporting responsibilities. The hospice is responsible for reporting the following data within 30 days after the end of the cap period:

a. Total reimbursement received and receivable for services furnished CHAMPUS beneficiaries during the cap period, including physician's services not of an administrative or general supervisory nature.

b. Total reimbursement received and receivable for general inpatient care and inpatient respite care furnished to CHAMPUS beneficiaries during the cap period.

c. Total number of inpatient days furnished to CHAMPUS hospice patients (both general inpatient and inpatient respite days) during the cap period.

d. Total number of CHAMPUS hospice days (both inpatient and home care) during the cap period.

e. Total number of beneficiaries electing hospice care. The following rules must be adhered to by the hospice in determining the number of CHAMPUS beneficiaries who have elected hospice care during the period:

(1) The beneficiary must not have been counted previously in either another hospice's cap or another reporting year.

(2) The beneficiary must file an initial election statement during the period beginning September 28 of the previous cap year through September 27 of the current cap year in order to be counted as an electing CHAMPUS beneficiary during the current cap year.

(3) Once a beneficiary has been included in the calculation of a hospice cap amount, he or she may not be included in the cap for that hospice again, even if the number of covered days in a subsequent reporting period exceeds that of the period where the beneficiary was included.

(4) There will be proportional application of the cap amount when a beneficiary elects to receive hospice benefits from two or more different CHAMPUS-certified hospices. A calculation must be made to determine the percentage of the patient's length of stay in each hospice relative to the total length of hospice stay.

8. Reconsideration of cap amount and inpatient limit. A hospice dissatisfied with the contractor's calculation and application of its cap amount and/or inpatient limitation may request and obtain a contractor review if the amount of program reimbursement in controversy -- with respect to matters which the hospice has a right to review -- is at least \$1000. The administrative review by the contractor of the calculation and application of the cap amount and inpatient limitation is the only administrative review available. These calculations are not subject to the appeal procedures set forth in Chapter 10. The methods and standards for calculation of the hospice payment rates established by CHAMPUS, as well as questions as to the validity of the applicable law, regulations or CHAMPUS decisions, are not subject to administrative review, including the appeal procedures of Chapter 10.

9. Beneficiary cost-sharing. There are no deductibles under the CHAMPUS hospice benefit. CHAMPUS pays the full cost of all covered services for the terminal illness, except for small cost-share amounts which may be collected by the individual hospice for outpatient drugs and biologicals and inpatient respite care.

a. The patient is responsible for 5 percent of the cost of outpatient drugs or \$5 toward each prescription, whichever is less. Additionally, the cost of prescription drugs (drugs or biologicals) may not exceed that which a prudent buyer would pay in similar circumstances; that is, a buyer who refuses to pay more than the going price for an item or service and also seeks to economize by minimizing costs.

b. For inpatient respite care, the cost-share for each respite care day is equal to 5 percent of the amount CHAMPUS has estimated to be the cost of respite care, after adjusting the national rate for local wage differences.

c. The amount of the individual cost-share liability for respite care during a hospice cost-share period may not exceed the Medicare inpatient hospital deductible applicable for the year in which the hospice cost-share period began. The individual hospice cost-share period begins on the first day an election is in effect for the beneficiary and ends with the close of the first period of 14 consecutive days on each of which an election is not in effect for the beneficiary.

H. REIMBURSEMENT OF INDIVIDUAL HEALTH-CARE PROFESSIONALS AND OTHER
NON-INSTITUTIONAL HEALTH-CARE PROVIDERS

The CHAMPUS-determined reasonable charge (the amount allowed by CHAMPUS) for the service of an individual health-care professional or other non-institutional health-care provider (even if employed by or under contract to an institutional provider) shall be determined by one of the following methodologies, that is, whichever is in effect in the specific geographic location at the time covered services and supplies are provided to a CHAMPUS beneficiary.

1. Allowable charge method.

a. Introduction

(1) In general. The allowable charge method is the preferred and primary method for reimbursement of individual health care professionals and other non-institutional health care providers (covered by 10 U.S.C. 1079(h)(1)). The allowable charge for authorized care shall be the lower of the billed charge or the local CHAMPUS Maximum Allowable Charge (CMAC) level.

(2) CHAMPUS Maximum Allowable Charge. Beginning in calendar year 1992, prevailing charge levels and appropriate charge levels will be calculated on a national level. There will then be calculated a national CHAMPUS Maximum Allowable Charge (CMAC) level for each procedure, which shall be the lesser of the national prevailing charge level or the national appropriate charge level. The national CMAC will then be adjusted for localities in accordance with paragraph G.1.d., of this Chapter.

(3) Differential for Participating Providers. Beginning in calendar year 1994, there shall be a differential in national and local CMACs based on whether the provider is a participating provider or a nonparticipating provider. The differential shall be calculated so that the CMAC for the nonparticipating providers is 95 percent of the CMAC for the participating providers. To assure the effectiveness of the several phase-in and waiver provisions set forth in paragraphs G.1.c., and G.1.d., of this Chapter, beginning in calendar year 1994, there will first be calculated the national and local CMACs for nonparticipating providers. For purposes of this calculation, the identification of overpriced procedures called for in paragraph G.1.C.a., of this Chapter and the calculation of appropriate charge levels for such overpriced procedures called for in paragraph G.1.D.(2), of this Chapter shall use as the Medicare fee component of the comparisons and calculations the fee level applicable to Medicare nonparticipating providers, which is 95 percent of the basic fee level. After nonparticipating provider local CMACs are calculated (including consideration of special phase-in rules and waiver rules in paragraph G.1.d., of this Chapter) participating provider local CMACs will be calculated so that nonparticipating provider local CMACs are 95 percent of participating provider local CMACs. (For more information on the Participating Provider Program, see Chapter 6.A.8).

(4) Limits on balance billing by nonparticipating providers. Nonparticipating providers may not balance bill a beneficiary an amount which exceeds the applicable balance billing limit. The balance billing limit shall be the same percentage as the Medicare limiting charge percentage for nonparticipating physicians. The balance billing limit may be waived by the Director, OCHAMPUS on a case-by-case basis if requested by the CHAMPUS beneficiary (or sponsor) involved. A decision by the Director to waive or not waive the limit in any particular case is not subject to the appeal and hearing procedures of Chapter 10., of this regulation.

b. Prevailing charge level.

(1) Beginning in calendar year 1992, the prevailing charge level shall be calculated on a national basis.

(2) The national prevailing charge level referred to in paragraph G.1.b.(1) of this section is the level that does not exceed the amount equivalent to the 80th percentile of billed charges made for similar services during the base period. The 80th percentile of charges shall be determined on the basis of statistical data and methodology acceptable to the Director, OCHAMPUS (or a designee).

(3) For purposes of paragraph G.1.b.(2) of this section, the base period shall be a period of 12 calendar months and shall be adjusted once a year, unless the Director, OCHAMPUS determines that a different period for adjustment is appropriate and publishes a notice to that effect in the Federal Register.

c. Appropriate charge level. Beginning in calendar year 1992, the appropriate charge level for each procedure is the product of the two-step process set forth in paragraphs G.1.(c)(1) and (2) of this Chapter. This process involves comparing the prior year's CMAC with the fully phased in Medicare fee. For years after the Medicare fee has been fully phased in, the comparison shall be to the current Medicare fee. For any particular procedure for which comparable Medicare fee and CHAMPUS data are unavailable, but for which alternative data are available that the Director, OCHAMPUS (or designee) determines provide a reasonable approximation of relative value or price, the comparison may be based on such alternative data.

(1) Step 1: procedures classified. All procedures are classified into one of three categories, as follows:

(a) Overpriced procedures. These are the procedures for which the prior year's national CMAC exceeds the Medicare fee.

(b) Other procedures. These are procedures subject to the allowable charge method that are not included in either the overpriced procedures group or the underpriced procedures group.

(c) Underpriced procedures. These are the procedures for which the prior year's national CMAC is less than the Medicare fee.

(2) Step 2: calculating appropriate charge levels. For each year, appropriate charge levels will be calculated by adjusting the prior year's CMAC as follows:

(a) For overpriced procedures, the appropriate charge level for each procedure shall be the prior year's CMAC, reduced by the lesser of: the percentage by which it exceeds the Medicare fee or fifteen percent.

(b) For other procedures, the appropriate charge level for each procedure shall be the same as the prior year's CMAC.

(c) For underpriced procedures, the appropriate charge level for each procedure shall be the prior year's CMAC, increased by the lesser of: the percentage by which it is exceeded by the Medicare fee or the Medicare Economic Index.

c. Special rule for cases in which the CHAMPUS appropriate charge was prematurely reduced. In any case in which a recalculation of the Medicare fee results in a Medicare rate higher than the CHAMPUS appropriate charge for a procedure that had been considered an overpriced procedure, the reduction in the CHAMPUS appropriate charge shall be restored up to the level of the recalculated Medicare rate.

d. Calculating CHAMPUS Maximum Allowable Charge levels for localities.

(1) In general. The national CHAMPUS Maximum Allowable Charge level for each procedure will be adjusted for localities using the same (or similar) geographical areas and the same geographic adjustment factors as are used for determining allowable charges under Medicare.

(2) Special locality-based phase-in provision.

(a) In general. Beginning with the recalculation of CMACs for calendar year 1993, the CMAC in a locality will not be less than 72.25 percent of the maximum charge level in effect for that locality on December 31, 1991. For recalculations of CMACs for calendar years after 1993, the CMAC in a locality will not be less than 85 percent of the CMAC in effect for that locality at the end of the prior calendar year.

(b) Exception. The special locality-based phase-in provision established by Section G.1.d.(2)(a) of this Chapter shall not be applicable in the case of any procedure code for which there were not CHAMPUS claims in the locality accounting for at least 50 services.

(3) Special locality-based waivers of reductions to assure adequate access to care. Beginning with the recalculation of CMACs for calendar year 1993, in the case of any procedure classified as an overpriced procedure pursuant to section G.1.c.(1)(a) of this Chapter, a reduction in the CMAC in a locality below the level in effect at the end of the previous calendar year that would otherwise occur pursuant to sections G.1.c., and G.1.d., of this Chapter may be waived pursuant to this section G.1.c.(3).

(a) Waiver based on balance billing rates. Except as provided in section G.1.d.(3)(b) of this Chapter such a reduction will be waived if there has been excessive balance billing in the locality for the procedure involved. For this purpose, the extent of balance billing will be determined based on a review of all services under the procedure code involved in the prior year (or most recent period for which data are available). If the number of services for which balance billing was not required was less than 60 percent of all services provided, the Director will determine that there was an excessive balance billing with respect to that procedure in that locality and will waive the reduction in the CMAC that would otherwise occur. A decision by the Director to waive or not to waive the reduction is not subject to the appeal and hearing procedures of Chapter 10 of this regulation.

(b) Exception. As an exception to section G.1.d.(3)(a) of this Chapter, the waiver required by that section shall not be applicable in the case of any procedure code for which there were not CHAMPUS claims in the locality accounting for at least 50 services. A waiver may, however, be granted in such cases pursuant to section G.1.d.(3)(c) of this Chapter.

(c) Waiver based on other evidence that adequate access to care would be impaired. The Director, OCHAMPUS may waive a reduction that would otherwise occur (or restore a reduction that was already taken) if the Director determines that available evidence shows that the reduction would impair adequate access. For this purpose, such evidence may include consideration of the number of providers in the locality who provide the affected services, the number of such providers who are CHAMPUS Participating Providers, the number of CHAMPUS beneficiaries in the area, and other relevant factors. Providers or beneficiaries in a locality may submit to the Director, OCHAMPUS a petition, together with appropriate documentation regarding relevant factors, for a determination that adequate access would be impaired. The Director, OCHAMPUS will consider and respond to all such petitions. Petitions may be filed at any time. Any petition received by the date which is 120 days prior to the implementation of a recalculation of CMACs will be assured of consideration prior that implementation. The Director, OCHAMPUS may establish procedures for handling petitions. A decision by the Director to waive or not to waive a reduction is not subject to the appeal and hearing procedures of Chapter 10 of this regulation.

e. Special rules for 1991.

(1) Prevailing charge levels for care provided on or after January 1, 1991, and before the 1992 prevailing charge levels take effect shall be the same as those in effect on December 31, 1990, except that prevailing charge levels for care provided on or after October 7, 1991 shall be those established pursuant to this paragraph G.1.e. of this section.

(2) Appropriate charge levels will be established for each locality for which a prevailing charge level was in effect immediately prior to October 7, 1991. For each procedure, the appropriate charge level shall be the prevailing charge level in effect immediately prior to October 7, 1991, adjusted as provided in G.1.e.(2)(a) through (c) of this section.

(a) For each overpriced procedure, the level shall be reduced by fifteen percent. For this purpose, overpriced procedures are the procedures determined by the Physician Payment Review Commission to be overvalued pursuant to the process established under the Medicare program, other procedures considered overvalued in the Medicare program (for which Congress directed reductions in Medicare allowable levels for 1991), radiology procedures and pathology procedures.

(b) For each other procedure, the level shall remain unchanged. For this purpose, other procedures are procedures which are not overpriced procedures or primary care procedures.

(c) For each primary care procedure, the level shall be adjusted by the MEI, as the MEI is applied to Medicare prevailing charge levels. For this purpose, primary care procedures include maternity care and delivery services and well baby care services.

f. Special transition rule for 1992.

(1) For purposes of calculating the national appropriate charge levels for 1992, the prior year's appropriate charge level for each service will be considered to be the level that does not exceed the amount equivalent to the 80th percentile of billed charges made for similar services during the base period of July 1, 1986 to June 30, 1987 (determined as under paragraph G.1.b.(2) of this section), adjusted to calendar year 1991 based on the adjustments made for maximum CHAMPUS prevailing charge levels through 1990 and the application of paragraph G.1.e. of this section for 1991.

(2) The adjustment to calendar year 1991 of the product of paragraph G.1.f.(1) of this section shall be as follows:

(a) For procedures other than those described in paragraph G.1.f.(2)(b) of this section, the adjustment to 1991 shall be on the same basis as that provided under paragraph G.1.e. of this section.

(b) For any procedure that was considered an overpriced procedure for purposes of the 1991 prevailing charge levels under paragraph G.1.e. of this section for which the resulting 1991 prevailing charge level was less than 150 percent of the Medicare converted relative value unit, the adjustment to 1991 for purposes of the special transition rule for 1992 shall be as if the procedure had been treated under paragraph G.1.e.(2)(b) of this section for purposes of the 1991 prevailing charge level.

g. Adjustments and procedural rules.

(1) The Director, OCHAMPUS may make adjustments to the appropriate charge levels calculated pursuant to paragraphs G.1.c. and G.1.e. of this section to correct any anomalies resulting from data or statistical factors, significant differences between Medicare-relevant information and CHAMPUS-relevant considerations or other special factors that fairness requires be specially recognized. However, no such adjustment may result in reducing an appropriate charge level.

(2) The Director, OCHAMPUS will issue procedural instructions for administration of the allowable charge method.

h. Clinical laboratory services. The allowable charge for clinical diagnostic laboratory test services shall be calculated in the same manner as allowable charges for other individual health care providers are calculated pursuant to paragraphs G.1.a. through G.1.d. of this Chapter, with the following exceptions and clarifications.

(1) The calculation of national prevailing charge levels, national appropriate charge levels and national CMACs for laboratory services shall begin in calendar year 1993. For purposes of the 1993 calculation, the prior year year's national appropriate charge level or national prevailing charge level shall be the level that does not exceed the amount equivalent to the 80th percentile of billed charges made for similar services during the period July 1, 1991, through June 30, 1992 (referred to in this paragraph G.1.h. of this Chapter as the "base period").

(2) For purposes of comparison to Medicare allowable payment amounts pursuant to paragraph G.1.c. of this Chapter, the Medicare national laboratory payment limitation amounts shall be used.

(3) For purposes of establishing laboratory service local CMACs pursuant to paragraph G.1.d. of this Chapter, the adjustment factor shall equal the ratio of the local average charge (standardized for the distribution clinical laboratory services) to the national average charge for all clinical laboratory services during the base period.

(4) For purposes of a special locality-based phase-in provision similar to that established by paragraph G.1.d.(2) of this Chapter, the CMAC in a locality will not be less than 85 percent of the maximum charge level in effect for that locality during the base period.

i. The allowable charge for physician assistant services other than assistant-at-surgery may not exceed 85 percent of the allowable charge for a comparable service rendered by a physician performing the service in a similar location. For cases in which the physician assistant and the physician perform component services of a procedure other than assistant-at-surgery (e.g., home, office or hospital visit), the combined allowable charge for the procedure may not exceed the allowable charge for the procedure rendered by a physician alone. The allowable charge for physician assistant services performed as an assistant-at-surgery may not exceed 65 percent of the allowable charge for a physician serving as an assistant surgeon when authorized as CHAMPUS benefits in accordance with the provisions of Chapter 4 C.3.c. of this Part. Physician assistant services must be billed through the employing physician who must be an authorized CHAMPUS provider.

j. A charge that exceeds the CHAMPUS Maximum Allowable charge can be determined to be allowable only when unusual circumstances or medical complications justify the higher charge. The allowable charge may not exceed the billed charge under any circumstances.

2. All-inclusive rate. Claims from individual health-care professional providers for services rendered to CHAMPUS beneficiaries residing in an RTC that is either being reimbursed on an all-inclusive per diem rate, or is billing an all-inclusive per diem rate, shall be denied; with the exception of independent health-care professionals providing geographically distant family therapy to a family member residing a minimum of 250 miles from the RTC or covered medical services related to a nonmental health condition rendered outside the RTC. Reimbursement for individual professional services is included in the rate paid the institutional provider.

3. Alternative method. The Director, OCHAMPUS, or a designee, may, subject to the approval of the ASD(HA), establish an alternative method of reimbursement designed to produce reasonable control over health care costs and to ensure a high level of acceptance of the CHAMPUS-determined charge by the individual health-care professionals or other noninstitutional health-care providers furnishing services and supplies to CHAMPUS beneficiaries. Alternative methods may not result in reimbursement greater than the allowable charge method above.

I. REIMBURSEMENT UNDER THE MILITARY-CIVILIAN HEALTH SERVICES PARTNERSHIP PROGRAM

The Military-Civilian Health Services Partnership Program, as authorized by Section 1096, Chapter 55, Title 10, provides for the sharing of staff, equipment, and resources between the civilian and military health care system in order to achieve more effective, efficient, or economical health care for authorized beneficiaries. Military treatment facility commanders, based upon the authority provided by their respective Surgeons General of the military departments, are responsible for entering into individual partnership agreements only when they have determined specifically that use of the Partnership Program is more economical overall to the Government than referring the need for health care services to the civilian community under the normal operation of the CHAMPUS Program. (See Section P. of Chapter 1, for general requirements of the Partnership Program.)

1. Reimbursement of institutional health care providers. Reimbursement of institutional health care providers under the Partnership Program shall be on the same basis as non-Partnership providers.

2. Reimbursement of individual health-care professionals and other non-institutional health care providers. Reimbursement of individual health care professional and other non-institutional health care providers shall be on the same basis as non-Partnership providers as detailed in Section G. of this chapter.

J. ACCOMMODATION OF DISCOUNTS UNDER PROVIDER REIMBURSEMENT METHODS

1. General rule. The Director, OCHAMPUS (or designee) has authority to reimburse a provider at an amount below the amount usually paid pursuant to this chapter when, under a program approved by the Director, the provider has agreed to the lower amount.

2. Special applications. The following are examples of applications of the general rule; they are not all inclusive.

a. In the case of individual health care professionals and other noninstitutional providers, if the discounted fee is below the provider's normal billed charge and the prevailing charge level (see section G. of this chapter), the discounted fee shall be the provider's actual billed charge and the CHAMPUS allowable charge.

b. In the case of institutional providers normally paid on the basis of a pre-set amount (such as DRG-based amount under subsection A.1. of this chapter or per-diem amount under subsection A.2. of this chapter), if the discount rate is lower than the pre-set rate, the discounted rate shall be the CHAMPUS-determined allowable cost. This is an exception to the usual rule that the pre-set rate is paid regardless of the institutional provider's billed charges or other factors.

3. Procedures.

a. This section only applies when both the provider and the Director have agreed to the discounted payment rate. The Director's agreement may be in the context of approval of a program that allows for such discounts.

b. The Director of OCHAMPUS may establish uniform terms, conditions and limitations for this payment method in order to avoid administrative complexity.

K. OUTSIDE THE UNITED STATES

The Director, OCHAMPUS, or a designee, shall determine the appropriate reimbursement method or methods to be used in the extension of CHAMPUS benefits for otherwise covered medical services or supplies provided by hospitals or other institutional providers, physicians or other individual professional providers, or other providers outside the United States.

L. IMPLEMENTING INSTRUCTIONS

The Director, OCHAMPUS, or a designee, shall issue CHAMPUS policies, instructions, procedures, and guidelines, as may be necessary to implement the intent of this chapter.