

CHAPTER 6

AUTHORIZED PROVIDERS

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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** incorporate 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. Submission 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 All., 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 All., 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.) I

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:

(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. Psychiatric partial hospitalization programs must be **either** a distinct **part of** an otherwise authorized institutional provider or a freestanding program. The treatment program must be under the general direction of a psychiatrist employed by the partial hospitalization program 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. CHAMPUS reimbursement is limited to programs complying with all requirements of Chapter 4, paragraph B.10. In addition, in order for a partial hospitalization program (PHP) to be authorized, the PHP shall comply with the following requirements:

(1) The PHP shall comply with the CHAMPUS Standards for Partial Hospitalization Programs and Facilities, as promulgated by the Director, **OCHAMPUS.**

(2) The PHP shall be specifically accredited by and remain in substantial compliance with standards issued by **the** Joint Commission on Accreditation of **Healthcare** Organizations under the Mental Health Manual (formerly the Consolidated Standards). NOTE : A one-time grace period is being allowed not to exceed October 1, 1994 for this provision only **if** the provider is already accredited under the **JCAHO** hospital standards. The provider must agree not to accept any new admissions for CHAMPUS patients for care beyond October 1, 1994, if accreditation and substantial compliance with the Mental Health Manual standards have not been obtained by that date.

(3) The PHP shall be licensed as a partial hospitalization program to provide PHP services within the applicable jurisdiction in which it operates.

(4) The PHP shall accept the **CHAMPUS-allowable** partial hospitalization program rate, as provided in Chapter 14, paragraph A.2.i., as payment in full for services provided.

(5) The PHP shall 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.

(6) The PHP must be fully operational and treating patients for a period of at least six months (with at least 30 percent minimum patient census) before an application for approval may **be** submitted. The PHP shall not be considered a CHAMPUS-authorized provider nor may any CHAMPUS benefits **be** paid to the facility for any services provided **prior** to the date the facility is approved by the Director, OCHAMPUS, or designee.

(7) All mental health services must be provided by a CHAMPUS-authorized mental health provider. [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.] All **other** program services shall **be** provided by trained, licensed staff.

(8) The PHP **shall** 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 mental health provider.

(9) The PHP must have a written agreement with at least one **backup** CHAMPUS-authorized hospital which specifies that the hospital will accept any and **all** CHAMPUS beneficiaries transferred for emergency **mental health** or medical/surgical care. The PHP must have a written emergency transport agreement with at least one ambulance company which specifies the estimated transport time to each backup hospital.

(10) The PHP shall enter into a participation agreement with the Director, **OCHAMPUS**, which shall include but which shall not be limited to the following provisions:

(a) The PHP agrees not to bill the beneficiary for services in excess of the cost-share or services for which payment is disallowed for failure to comply with requirements for preauthorization or concurrent care review.

(b) The PHP agrees not to bill the beneficiary for services excluded on the basis of Chapter 4, paragraphs G.1. (not medically necessary), G.3. (inappropriate **level** of care) or G.7. (custodial care), unless the beneficiary has agreed in writing to pay for the care, knowing the specific care in question **had** been determined **noncovered** by CHAMPUS. (A general statement signed at **admission** as to financial liability does not fulfill this requirement. )

c. INDIVIDUAL PROFESSIONAL PROVIDERS OF CARE

1. General. Individual professional providers of care are those providers who bill for their services on a tee-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.

(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

(cl) 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, CHAMPUS, 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 7

CLAIMS SUBMISSION, REVIEW, AND PAYMENT

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b. Physician or other authorized individual professional provider. A physician or other authorized individual professional provider is **liable** for any signature submitted on his or her behalf. Further, a facsimile signature is not acceptable unless such facsimile signature is on file with, and has been authorized specifically by, the CHAMPUS fiscal intermediary serving the state where the physician or other authorized individual professional provider practices.

c. Hospital or other authorized institutional provider. The provider signature on a claim form for institutional services must be **that** of an authorized representative of the hospital or other authorized institutional provider, whose signature is on file with-and approved by the appropriate **CHAMPUS** fiscal intermediary.

D. 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 paragraph D.2., of this Chapter, 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 this deadline waives all rights to benefits for such services or supplies.

1. Claims returned for additional information. When a claim is submitted initially within the claim filing time limit, but is returned in whole or in part **for** additional information to be considered for benefits, the returned claim, **along** with the requested information must be resubmitted and received by the appropriate CHAMPUS contractor no later than the later of: (1) one year after the services are provided; or (2) 90 days from the date the claim was returned to the provider or beneficiary.

2. Exception to claims filing deadline. The Director, **OCHAMPUS**, or a designee, may grant exceptions to the claims filing deadline requirements.

a. Types of exception

(1) Retroactive eligibility. Retroactive CHAMPUS eligibility determinations.

(2) Administrative error. Administrative error (that is, **misrepresentation**, mistake, or other accountable action) of an officer or employee of **OCHAMPUS** (including **OCHAMPUSEUR**) or a CHAMPUS fiscal intermediary, performing functions under CHAMPUS and acting within the scope of that official's authority.

(3) Mental incompetency. **Mental** incompetency of the beneficiary or guardian or sponsor, in the case of a minor child (which includes inability to communicate, even if it is the result of a physical disability).

(4) Provider billings. Direct billings by participating providers.

(5) Delays by other health insurance. When not attributable to the beneficiary, delays in adjudication by other health insurance companies when double coverage coordination is required before the CHAMPUS benefit determination.

b. Request for exception to claims filing deadline. Beneficiaries who wish to request an exception to the claims filing deadline may submit such a request to the CHAMPUS fiscal intermediary having jurisdiction over the location in which the service was rendered, or as otherwise designated by the Director, OCHAMPUS.

(1) Such requests for an exception must include a complete explanation of the circumstances of the late filing, together with all available documentation supporting the request, and the specific claim denied for late filing.

(2) Each request for an exception to the claims filing deadline is reviewed individually and considered on its own merits.

E. Other waiver authority. The Director, OCHAMPUS may waive the claims filing deadline in other circumstances in which the Director determines that the waiver is necessary in order to ensure adequate access for CHAMPUS beneficiaries to health care services.

1. Continuing care. Except for claims subject to the CHAMPUS DRG-based payment system, whenever medical services and supplies are being rendered on a continuing basis, an appropriate claim or claims should be submitted every 30 days (monthly) whether submitted directly by the beneficiary or sponsor or by the provider on behalf of the beneficiary. Such claims may be submitted more frequently if the beneficiary or provider so elects. The Director, OCHAMPUS, or a designee, also may require more frequent claims submission based on dollars. Examples of care that may be rendered on a continuing basis are outpatient physical therapy, private duty (special) nursing, or inpatient stays. 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.

2. Inpatient mental health services. Under most circumstances, the 60-day inpatient mental health limit applies to the first 60 days of care paid in a calendar year. The patient will be notified when the first 30 days of inpatient mental health benefits have been paid. The beneficiary is responsible for assuring that all claims for care are submitted sequentially and on a regular basis. Once payment has been made for care determined to be medically appropriate and a program benefit, the decision will not be reopened solely on the basis that previous inpatient mental health care had been rendered but not yet billed during the same calendar year by a different provider.

3. Claims involving the services of marriage and family counselors, pastoral counselors, and mental health counselors. CHAMPUS requires that certified marriage and family therapists, pastoral counselors, and mental health counselors make a written report to the referring physician concerning the CHAMPUS beneficiary's progress. Therefore, each claim for reimbursement for services of marriage and family counselors, pastoral counselors, and mental health counselors must include certification to the effect that a written communication has been made or will be made to the referring physician at the end of treatment, or more frequently, as required by the referring physician.

F. PREAUTHORIZATION

When specifically required in other chapters of this Regulation, pre-authorization requires the following:

1. Preauthorization must be granted before benefits can be extended. In those situations requiring preauthorization, the request for such pre-authorization shall be submitted and approved before benefits may be extended, except as provided in Chapter 4, subsection All. If a claim for services or supplies is submitted without the required preauthorization, no benefits shall be paid, unless the Director, OCHAMPUS, or a designee, has granted an exception to the requirement for preauthorization.

a. Specifically preauthorized services. An approved preauthorization specifies the exact services or supplies for which authorization is being given. In a preauthorization situation, benefits cannot be extended for services or supplies provided beyond the specific authorization.

b. Time limit on preauthorization. Approved preauthorizations are valid for specific periods of time, appropriate for the circumstances presented and specified at the time the preauthorization is approved. In general, preauthorizations are valid for 30 days. If the preauthorized service or supplies are not obtained or commenced within the specified time limit, a new preauthorization is required before benefits may be extended.

2. Treatment plan, management plan. Each preauthorization request shall be accompanied by a proposed medical treatment plan (for inpatient stays under the Basic Program) or management plan (for services under the PFTH) which shall include generally a diagnosis; a detailed summary of complete history and physical; a detailed statement of the problem; the proposed type and extent of treatment or therapy; the proposed treatment modality, including anticipated length of time the proposed modality will be required; any available test results; consultant's reports; and the prognosis. When the preauthorization request involves transfer from a hospital to another inpatient facility, medical records related to the inpatient stay also must be provided.

3. Durable equipment. Requests for preauthorization to purchase durable equipment under the PFTH must list all items of durable equipment previously authorized under the PFTH and state whether the current item of equipment is the initial purchase or a replacement. If it is a replacement item, the date the initial item was purchased also shall be provided.

4. Claims for services and supplies that have been preauthorized. **When-** ever a claim is submitted for benefits under CHAMPUS involving preauthorized services and supplies, the date of the approved preauthorization must be indicated **on** the claim form **and** a copy of the written preauthorization must be attached **to** the appropriate CHAMPUS claim.

G. CLAIMS REVIEW

It is the responsibility of the CHAMPUS fiscal intermediary (or **OCHAMPUS**, including **OCHAMPUSEUR**) to review each CHAMPUS claim submitted for benefit consideration **to** ensure compliance with all applicable definitions, conditions, limitations, or exclusions specified or enumerated in this Regulation. It is also required that before any CHAMPUS benefits may be extended, claims for medical services and supplies will **be** subject to utilization review and quality assurance standards, norms, and criteria issued by the Director, OCHAMPUS, or a designee (see paragraph **A.1.e.** of Chapter 14 for review standards for **claims** subject to the CHAMPUS **DRG-based** payment system).

H. BENEFIT PAYMENTS

CHAMPUS benefit payments are made either directly to the beneficiary or sponsor or to the provider, depending on the manner in which the CHAMPUS claim is submitted.

1. Benefit payments made to beneficiary or sponsor. When the CHAMPUS beneficiary or sponsor signs **and** submits a specific claim form directly to the appropriate CHAMPUS fiscal intermediary (or **OCHAMPUS**, including **OCHAMPUSEUR**), any CHAMPUS benefit payments due as a result of that specific claim submission will **be** made in the name **of**, and mailed to, the beneficiary or sponsor. In such circumstances, the beneficiary or sponsor is responsible to the provider for any amounts billed.

2. Benefit payments made to participating provider. When the authorized provider elects **to** participate by signing a **CHAMPUS** claim form, indicating participation in the appropriate space on the claim form, and submitting a specific claim on behalf of the beneficiary to the appropriate CHAMPUS fiscal intermediary, any CHAMPUS benefit payments due as a result of that claim submission will **be** made in the name of and mailed to the participating provider. Thus, by signing the claim form, the authorized provider agrees to abide by the CHAMPUS-determined allowable charge or cost, whether or not lower than the amount billed. Therefore, the beneficiary or sponsor is responsible only for any required deductible amount and any cost-sharing portion of the CHAMPUS-determined allowable charge or cost as may be required under the terms and conditions set forth **in** Chapters 4 and 5 of this Regulation.

3. **CEOB** . When a CHAMPUS claim is adjudicated, a **CEOB** is sent to the beneficiary or sponsor. A copy **of** the **CEOB** also is sent to the provider if the claim was submitted on a participating basis. The **CEOB** form provides, at a minimum, the following information:

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**. I

(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;

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.

**RESERVED**

14-18c

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G. 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'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.

#### H. 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.

#### I. 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 A1. 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.

J. 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.

K. 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.

CHAPTER 15

QUALITY AND UTILIZATION PEER REVIEW ORGANIZATION PROGRAM

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CHAPTER 15  
QUALITY AND UTILIZATION REVIEW PEER REVIEW ORGANIZATION PROGRAM

A. GENERAL

1. Purpose. The purpose of this chapter is to establish rules and procedures for the CHAMPUS Quality and Utilization Review Peer Review Organization program.

2. Applicability of program. All claims submitted for health services under CHAMPUS are subject to review for quality of care and appropriate utilization. The Director, OCHAMPUS shall establish generally accepted standards, norms and criteria as are necessary for this program of utilization and quality review. These standards, norms and criteria shall include, but not be limited to, need for inpatient admission or inpatient or outpatient service, length of inpatient stay, intensity of care, appropriateness of treatment, and level of institutional care required. The Director, OCHAMPUS may issue implementing instructions, procedures and guidelines for retrospective, concurrent and prospective review.

3. Contractor implementation. The CHAMPUS Quality and Utilization Review Peer Review Organization program may be implemented through contracts administered by the Director, OCHAMPUS. These contractors may include contractors that have exclusive functions in the area of utilization and quality review, fiscal intermediary contractors (which perform these functions along with a broad range of administrative services), and managed care contractors (which perform a range of functions concerning management of the delivery and financing of health care services under CHAMPUS). Regardless of the contractors involved, utilization and quality review activities follow the same standards, rules and procedures set forth in this chapter, unless otherwise specifically provided in this chapter or elsewhere in this Regulation.

4. Medical issues affected. The CHAMPUS Quality and Utilization Review Peer Review Organization program is distinguishable in purpose and impact from other activities relating to the administration and management of CHAMPUS in that the Peer Review Organization program is concerned primarily with medical judgments regarding the quality and appropriateness of health care services. Issues regarding such matters as benefit limitations are similar, but, if not determined on the basis of medical judgments, are governed by CHAMPUS rules and procedures other than those provided in this chapter. (See, for example, Chapter 7 regarding claims submission, review and payment.) Based on this

purpose, a major attribute of the Peer Review Organization program is that medical judgments are made by (directly or pursuant to guidelines and subject to direct review) reviewers who are peers of the health care providers providing the services under review.

5. Provider responsibilities. -Because of the dominance of medical **judgements in the quality and utilization review program, principal** responsibility for complying with program rules and procedures rests with health care providers. For this reason, there are limitations, set forth in this chapter and in paragraph H, Chapter 4, on the extent to which beneficiaries may be held financially liable for health care services not provided **in** conformity with rules and procedures of the quality and utilization review program concerning medical necessity of care.

6. Medicare rules used as model. The CHAMPUS Quality and Utilization Review Peer Review Organization program, based on specific statutory authority, follows many of the quality and utilization review requirements and procedures in effect for the Medicare Peer Review Organization program, subject to adaptations appropriate for the **CHAMPUS** program.

B. OBJECTIVES AND GENERAL REQUIREMENTS OF REVIEW SYSTEM.

1. In general. Broadly, the program of quality and utilization 'review has as its objective to review the quality, completeness and adequacy of care provided, as well as its necessity, appropriateness and reasonableness.

2. Payment exclusion for services provided contrary to utilization and quality standards,

a. In any case in which **health** care services are provided in a manner determined to be contrary to quality or necessity standards established under the quality and utilization review program, payment may be wholly or partially excluded.

b. In any case in which payment is excluded pursuant to paragraph **B.2.a.** of this chapter, the patient (or the patient's family) may not be billed for the excluded services.

c. Limited exceptions **and** other special provisions pertaining to the requirements established **in** paragraphs **B.2.a.** and **b. of** this chapter, are set forth in Chapter 4, paragraph H.

3. Review of services covered by DRG-based payment system. Application of these objectives in the context of hospital services covered **by** the DRG-based payment system **also** includes a validation of diagnosis and procedural information that determines CHAMPUS reimbursement, and a review of the necessity and appropriateness of care for which 'payment is sought on an **outlier** basis .

4. Preauthorization and other utilization review procedures.

a. In general. All health care services for which payment is sought under CHAMPUS are subject to review for appropriateness of utilization. The

procedures for this review may be prospective (before the care is provided), concurrent (while the care is in process), or retrospective (after the care has been provided). Regardless of the procedures of this utilization review, the same generally accepted standards, norms and criteria for evaluating the necessity, appropriateness and reasonableness of the care involved shall **apply**. The Director, **OCHAMPUS** shall establish procedures for conducting reviews, **including** identification of **types** of health care services for which preauthorization or concurrent review shall **be** required. Preauthorization or concurrent review may **be** required for any categories of health care services. Except where required by law, the categories of health care services for which preauthorization **or** concurrent review is required may vary in different geographical locations **or** for different types of providers.

b. Preauthorization procedures. With respect to categories of health care (inpatient or outpatient) for which preauthorization is required, the following procedures shall apply:

(1) The requirement for preauthorization shall **be** widely publicized to beneficiaries and providers.

(2) All requests for preauthorization shall be responded to in writing. Notification of approval or denial shall **be** sent to the beneficiary. Approvals shall specify the health care services and supplies approved and identify any special limits or further requirements applicable to the particular case.

(3) An approved preauthorization shall state the number of days, appropriate for the type of care involved, for which it is valid. In general, preauthorizations **will** be valid for 30 days. If the services or supplies are **not** obtained within the number of days specified, a new preauthorization request is required.

c. Payment reduction for noncompliance with required utilization review procedures.

(1) Paragraph **B.4.c.** of this chapter applies **to** any case in which:

(a) A provider was required to obtain preauthorization **or** **continued stay (in connection with required concurrent review procedures)** approval.

(b) The provider failed to obtain the necessary approval:  
and

(c) The health care services have not been disallowed on the basis of necessity, appropriateness **or** reasonableness.

In such a case, reimbursement **will be** reduced, unless such reduction is waived based on special circumstances.

(2) In a case described in paragraph B.4.c.(1) of this chapter, reimbursement will be reduced, unless such reduction is waived based on special circumstances. The amount of this reduction shall be ten percent of the amount otherwise allowable for services for which preauthorization (including preauthorization for continued stays in connection with concurrent review requirements) approval should have been obtained, but was not obtained. In the case of hospital admissions reimbursed under the DRG-based payment system, the reduction shall be taken against the percentage (between zero and 100 percent) of the total reimbursement equal to the number of days of care provided without preauthorization approval, divided by the total length of stay for the admission. In the case of institutional payments based on per diem payments, the reduction shall be taken only against the days of care provided without preauthorization approval. For care for which payment is on a per service basis, the reduction shall be taken only against the amount that relates to the services provided without preauthorization approval. Unless otherwise specifically provided under procedures issued by the Director, OCHAMPUS, the effective date of any preauthorization approval shall be the date on which a properly submitted request was received by the review organization designated for that purpose.

(3) The payment reduction set forth in paragraph B.4.c.(2) of this chapter may be waived by the Director. OCHAMPUS when the provider could not reasonably have been expected to know of the preauthorization requirement or some other special circumstance justifies the waiver.

(1.) Services for which payment is disallowed under paragraph B.4.c. of this chapter may not be billed to the patient (or the patient's family).

c. HOSPITAL COOPERATION

All hospitals which participate in CHAMPUS and submit CHAMPUS claims are required to provide all information necessary for CHAMPUS to properly process the claims. In order for CHAMPUS to be assured that services for which claims are submitted meet quality of care standards, hospitals are required to provide the Peer Review Organization (PRO) responsible for quality review with all the information, within timeframes to be established by OCHAMPUS, necessary to perform the review functions required by this chapter. Additionally, all participating hospitals shall provide CHAMPUS beneficiaries, upon admission, with information about the admission and quality review system including their appeal rights. A hospital which does not cooperate in this activity shall be subject to termination as a CHAMPUS-authorized provider.

1. Documentation that the beneficiary has received the required information about the CHAMPUS PRO program must be maintained in the same manner as is the notice required for the Medicare program by 42 CFR 466.78(b).

2. The physician attestation and physician acknowledgement required for Medicare under 42 CFR 412.40 and 412.46 are also required for CHAMPUS as a condition for payment and may be satisfied by the same statements as required for Medicare, with substitution or addition of "CHAMPUS" when the word "Medicare" is used.

3. Participating hospitals must execute a memorandum of understanding with the PRO providing appropriate procedures for implementation of the PRO program.

4. Participating hospitals may not charge a CHAMPUS beneficiary for inpatient hospital services excluded on the **basis** of Chapter 4, section G.1. (not medically necessary), section G.3. (inappropriate level), **or** section **G.7.** (custodial care) unless all of the conditions established by 42 CFR 412.42(c) with respect to Medicare beneficiaries have been met with respect to the CHAMPUS beneficiary. In such cases in which the patient requests a PRO review while the patient is still an inpatient in the hospital, the hospital shall provide to the PRO the records required for the review by the close of business of the day the patient requests review, if such request was made before noon. If the hospital fails to provide the records by the close of business, that day and any subsequent working day during which the hospital continues to fail to provide the records shall not **be** counted for purposes of the two-day **period of** 42 CFR **412.42(c)(3)(ii).**

5. With respect to cases subject to preadmission review, the provisions of 42 **C.F.R.** 466.78(b)(5)-(b)(7) **shall** apply to CHAMPUS cases as those provisions apply to Medicare cases.

D. AREAS OF REVIEW

1. Admissions. The following areas shall be subject to review to determine whether inpatient care was medically appropriate and necessary, was delivered in the most appropriate setting and met acceptable standards of quality. This review may include preadmission or prepayment review when appropriate.

a. Transfers of CHAMPUS beneficiaries from a hospital or hospital unit subject to the CHAMPUS **DRG-based** payment system to another hospital or hospital unit.

b. CHAMPUS admissions to a hospital or hospital unit subject to the CHAMPUS **DRG-based** payment system which occur within a certain period (specified by **OCHAMPUS**) of discharge from a hospital or hospital unit subject to the CHAMPUS **DRG-based** payment system.

c. A random sample of other CHAMPUS admissions for each hospital subject to the CHAMPUS **DRG-based** payment system.

d. **CHAMPUS** admissions in any DRGs which have been specifically identified by **OCHAMPUS** for review **or** which are under review for any other reason.

2. DRG validation. The review organization responsible for quality of care reviews shall be responsible for ensuring that the diagnostic and procedural information reported by hospitals on CHAMPUS claims which is used by the fiscal intermediary to assign claims to **DRGs** is correct and matches the information contained in the medical records. In order to accomplish this, the following review activities shall be done.

- a. Perform DRG validation reviews of each case under review.
- b. Review **of** claim adjustments submitted by hospitals which result in the assignment of a higher weighted DRG.
- c. Review for physician certification as to the major diagnoses and procedures and the physician's acknowledgment of annual receipt of the penalty statement as contained in the Medicare regulations at 42 CFR 412.40 and 412.46.
- d. Review of a **sample** of **claims** for each hospital reimbursed under the CHAMPUS **DRG-based** payment system. Sample size shall **be** determined based **upon** the volume of claims submitted.

3. Outlier review. Claims which qualify for additional payment as a long-stay **outlier** or as a **cost-outlier** shall be subject to review to ensure that the additional days **or** costs were medically necessary and appropriate and met all other requirements for CHAMPUS coverage. In addition, claims which qualify as short-stay **outliers** shall be reviewed to ensure that the admission was medically necessary and appropriate and that the discharge was not premature.

4. Procedure review. Claims for procedures identified by **OCHAMPUS** as subject to a pattern of abuse shall be the subject of intensified quality assurance review.

5. Other review. **Any** other **cases or** types of cases identified by OCHAMPUS shall be subject to focused review.

E. ACTIONS AS A RESULT OF REVIEW

1. Findings related to individual claims. If it is determined, based upon information obtained during reviews, that a hospital has misrepresented admission, discharge, or billing information, or is found to have quality **of** care defects, or has taken an action that results in the unnecessary admissions of an individual entitled to benefits, unnecessary multiple admission of an individual, or other inappropriate medical or other practices with respect to beneficiaries or billing for services furnished to beneficiaries, the PRO, in conjunction with the fiscal intermediary, shall, as appropriate:

- a. Deny payment for or recoup (in whole or in part) any amount claimed or paid for the inpatient hospital and professional services related to such determination.
- b. Require the hospital to take other corrective action necessary to prevent or correct the inappropriate practice.
- c. Advise the provider and beneficiary of appeal rights, as required by Chapter 10 of this Regulation.
- d. Notify **OCHAMPUS** of **all** such actions.

2. Findings related to a pattern of inappropriate practices. In all cases where a pattern of inappropriate admissions and billing practices that have the effect of circumventing the CHAMPUS **DRG-based** payment system is identified, **OCHAMPUS** shall be notified of the hospital and practice involved.

3. Revision of coding relating to DRG validation. The following provisions apply in connection with the DRG validation process set forth in subsection D.2. of this chapter.

a. If the diagnostic and procedural information attested to by the attending physician is found to be inconsistent with the hospital's coding or DRG assignment, the hospital's coding on the CHAMPUS claim will be appropriately changed and payments recalculated on the basis of the appropriate DRG assignment.

b. If the information attested to by the physician as stipulated under subsection E.2. of this chapter is found not to be correct, the PRO will change the coding and assign the appropriate DRG on the basis of the changed coding.

F. SPECIAL PROCEDURES IN CONNECTION WITH CERTAIN TYPES OF HEALTH CARE SERVICES OR CERTAIN TYPES OF REVIEW ACTIVITIES.

1. In general. Many provisions of this chapter are directed to the context of services covered by the CHAMPUS **DRG-based** payment system. This section, however, is also applicable to other services. In addition, many provisions of this chapter relate to the context of peer review activities performed by Peer Review Organizations whose sole functions for CHAMPUS relate to the Quality and Utilization Review Peer Review Organization program. However, it also applies to review activities conducted by contractors who have responsibilities broader than those related to the quality and utilization review program. Paragraph F of this chapter authorizes certain special procedures that will apply in connection with such services and such review activities.

2. Services not covered by the DRG-based payment system. In implementing the quality and utilization review program in the context of services not covered by the **DRG-based** payment system, the Director, **OCHAMPUS** may establish procedures, appropriate to the types of services being reviewed, substantively comparable to services covered by the **DRG-based** payment system regarding obligations of providers to cooperate in the quality and utilization review program, authority to require appropriate corrective actions and other procedures. The Director, **OCHAMPUS** may also establish such special, substantively comparable procedures in connection with review of health care services which, although covered by the **DRG-based** payment method, are also affected by some other special circumstances concerning payment method, nature of care, or other potential utilization or quality issue.

3. Peer review activities by contractors also performing other administration or management functions.

a. Sole-function PRO versus multi-function PRO. In all cases, peer review activities under the Quality and Utilization Review Peer Review

Organization program are carried out **by** physicians and other qualified health care professionals, usually under contract with **OCHAMPUS**. In some cases, the Peer Review Organization contractor's only functions are pursuant to the quality and utilization review program. In paragraph F.3, of this chapter, this type of contractor is referred to as a "sole function PRO." In other cases, the Peer Review Organization contractor is also performing other functions in connection with the administration and management of CHAMPUS. In paragraph F.3, of this chapter, this type of contractor is referred to as a "multi-function PRO." **As** an example **of** the latter type, managed care contractors may perform a wide range of functions regarding management of the delivery and financing **of** health care services under CHAMPUS, including **but** not limited to functions under the Quality and Utilization Review Peer Review Organization program.

b. Special rules and procedures. With respect to multi-function PROS, the Director, **OCHAMPUS** may establish special procedures to assure the independence of the Quality and Utilization Review Peer Review Organization program and otherwise advance the objectives of the program. These special rules and procedures include, but are **not** limited to, the following:

(1) A **reconsidered** determination that would be final in cases involving sole-function PROS under paragraph 1.2. of this chapter will not be final in connection with multi-function PROS. Rather, in such cases (other than any case which is appealable under paragraph 1.3. of this chapter), an opportunity for a second reconsideration shall be provided. The second reconsideration will be provided **by** **OCHAMPUS** or another contractor independent **of** the multi-function PRO that performed the review. The second reconsideration may not be further appealed by the provider.

(2) Procedures established by paragraphs G through M of this chapter **shall** not apply to any action **of** a multi-function PRO (or employee or other person or entity affiliated with the PRO) carried out in performance of functions other than functions under this section.

G. PROCEDURES REGARDING INITIAL DETERMINATIONS

The CHAMPUS PROS shall establish and follow procedures for initial determinations that are substantively the same or comparable to the procedures applicable to Medicare under 42 CFR 466.83 to 466.104. In addition, these procedures **shall** provide that a PRO's determination that an admission is medically necessary is not a guarantee **of** payment by CHAMPUS; normal CHAMPUS benefit and procedural coverage requirements must. also be applied.

H. PROCEDURES REGARDING RECONSIDERATIONS

The CHAMPUS PROS shall establish and follow procedures for reconsiderations that are substantively the same or comparable to the procedures applicable to

reconsiderations under Medicare pursuant to 42 CFR 473.15 to 473.34, except that the time limit for requesting reconsideration (see 42 CFR 473.20(a)(1)) shall be 90 days. A PRO reconsidered determination is final and binding upon all parties to the reconsideration except to the extent of any further appeal pursuant to section I. of this chapter.

1. APPEALS AND HEARINGS

1. Beneficiaries may appeal a PRO reconsideration determination to **OCHAMPUS** and obtain a hearing on such appeal to the extent allowed and under the procedures set forth in Chapter 10, section D.

2. Except as provided in subsection 1.3., a PRO reconsidered determination may not be further appealed by a provider.

3. A provider may appeal a PRO reconsideration determination to **OCHAMPUS** and obtain a hearing on such appeal to the extent allowed under the procedures set forth in Chapter 10, section D. if it is a determination pursuant to Chapter 4, section H. that the provider knew or could reasonably have been expected to know that the services were excludable.

4. For purposes of the hearing process, a PRO reconsidered determination shall be considered as the procedural equivalent of a formal review determination under Chapter 10, unless revised at the initiative of the Director, **OCHAMPUS** prior to a hearing on the appeal, in which case the revised determination shall be considered as the procedural equivalent of a formal review determination under Chapter 10.

5. The provisions of Chapter 10, section E. concerning final action shall apply to hearings cases.

J. ACQUISITION, PROTECTION AND DISCLOSURE OF PEER REVIEW INFORMATION

The provisions of 42 CFR Part 476, except section 476.108, shall be applicable to the CHAMPUS PRO program as they are to the Medicare PRO program.

K. LIMITED IMMUNITY FROM LIABILITY FOR PARTICIPANTS IN PRO PROGRAM

The provisions of section 1157 of the Social Security Act (42 U.S.C. 1320c-6) are applicable to the CHAMPUS PRO program in the same manner as they apply to the Medicare PRO program. Section 1102(g) of title 10, United States Code also applies to the CHAMPUS PRO program.

L. ADDITIONAL PROVISION REGARDING CONFIDENTIALITY OF RECORDS

1. General rule. The provisions of 10 U.S.C. 1102 regarding the confidentiality of medical quality assurance records shall apply to the activities of the CHAMPUS PRO program as they do to the activities of the external civilian PRO program that reviews medical care provided in military hospitals.

2. Specific applications.

a. Records concerning PRO deliberations are generally **nondisclosable** quality assurance records under 10 **U.S.C.** 1102.

b. Initial denial determinations by PROS pursuant to section G. of this chapter (concerning medical necessity determinations, DRG validation actions, etc.) and subsequent decisions regarding those determinations are not **nondisclosable** quality assurance records under 10 **U.S.C.** 1102.

c. Information the subject. of mandatory PRO disclosure under 42 CFR Part 476 is not a **nondisclosable** quality assurance record under 10 **U.S.C.** 1102.

M. OBLIGATIONS, SANCTIONS AND PROCEDURES

1. The provisions of 42 CFR 1004.1 - 1004.80 shall apply to the CHAMPUS PRO program as they **do** the Medicare PRO program, except that the functions specified in those sections for the Office of Inspector General of the Department of Health and Human Services shall **be** the responsibility of **OCHAMPUS**.

2. The provisions of 42 **U.S.C.** section **1395ww(f)(2)** concerning circumvention by any hospital of the applicable payment methods for inpatient services shall apply to CHAMPUS payment methods as they do to Medicare payment methods.

3. The Director, or a designee, of CHAMPUS shall determine whether to impose a sanction pursuant to subsections M1. and M.2. of this chapter. Providers may appeal adverse sanctions decisions under the procedures set forth in Chapter 10, section D.

CHAPTER 16

SUPPLEMENTAL HEALTH CARE PROGRAM FOR ACTIVE DUTY MEMBERS

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CHAPTER 16  
SUPPLEMENTAL HEALTH CARE PROGRAM FOR ACTIVE DUTY MEMBERS

A. Purpose and applicability.

1. The purpose of this chapter is to implement, with respect to health care services provided under the supplemental health care program for active duty members of the uniformed services, the provision of **10 U.S.C. 1074(c)**.

This section of law authorizes DoD to establish for the supplemental care program the same payment rules, subject to appropriate modifications, as apply under CHAMPUS.

2. This **chapter** applies to the program, known as the supplemental care program, which provides for the payment by the uniformed services to private sector health care providers for **health** care services provided to active duty members of the uniformed services. Although not part of CHAMPUS, the supplemental care program is similar to CHAMPUS in that it is a program for the uniformed services to purchase civilian health care services for active duty members. For this reason, the Director, **OCHAMPUS**, assists the uniformed services in the administration of the supplemental care program.

3. This chapter applies to all health care services covered by CHAMPUS. For purposes of this chapter, health care services ordered by a military treatment facility (**MFT**) provider for an **MTF** patient (who is not an active duty member) **for whom** the MTF provider maintains responsibility are also covered by the supplemental care program and subject to the requirements of this chapter.

B. Obligation of providers concerning payment for supplemental health care for active duty members.

1. Hospitals covered by DRG-based payment system. For a hospital covered by the CHAMPUS DRG-based payment system to maintain its status as an authorized provider for CHAMPUS pursuant to Chapter 6, that hospital must also be a participating provider for purposes of the supplemental care program. As a participating provider, each hospital must accept the **DRG-based** payment system amount determined pursuant to Chapter 14 as payment in full for the hospital services covered by the system. The failure of any hospital to **comply** with this obligation subjects that hospital to exclusion as a CHAMPUS-authorized provider.

2. Other participating providers. For any institutional or individual provider, other than those described in paragraph B.1 of this Chapter that is a participating provider, the provider must also be a participating provider for purposes of the supplemental care program. The provider must accept the CHAMPUS allowable **amount** determined pursuant to Chapter 14 as payment in full for the hospital services covered by the system. The **failure** of any provider to comply with this obligation subjects the provider to exclusion as a participating provider.

c. General rule for payment and administration. Subject to the special rules and procedures in paragraph D. of this chapter, and the **waiver** authority in paragraph E. of this chapter, as a general rule the **provisions** of Chapter 14 **shall** govern payment and administration of claims under **the** supplemental care program as they do claims under CHAMPUS. To the extent necessary to interpret or" implement the provisions of Chapter 14, related provisions **of** DoD 6010.8-R **shall** also be applicable.

D. Special rules and procedures. **As** exceptions **to** the general rule in paragraph C. of this chapter, the special rules and procedures in this chapter shall govern payment and administration of claims under the supplemental care program. These, special rules and procedures are subject to the waiver authority of paragraph E. of this chapter.

1. There is no patient cost sharing under the supplemental care program. **All amounts due to be** paid to the provider shall be paid **by** the program.

2. **Preauthorization** by the uniformed services of each service, except for services in cases of medical emergency (for which the definition in Chapter 2 shall apply), is required for the supplemental care program. It is the responsibility of the active duty members to obtain preauthorization for each service. With respect to each emergency inpatient admission, after such time as the emergency condition is addressed, authorization for any proposed continued stay must be obtained within two working days of admission.

3. With respect **to** the filing of claims and similar administrative matters for which DoD 6010.8-R refers to activities **of** the CHAMPUS fiscal intermediaries, for purposes of the supplemental care program, responsibilities for claims processing, payment and **some** other administrative matters may be assigned by the Director, **OCHAMPUS** to the same fiscal intermediaries, other contractor, or to the nearest military medical treatment facility or medical claims office.

4. The annual **cost pass-throughs** for capital and direct medical education costs that are available under the CHAMPUS **DRG-based** payment system are **also** available, upon request., under the supplemental care program. To obtain payment include the number of active duty bed days as a separate line item on the annual request to the CHAMPUS fiscal intermediaries.

5 For providers other than participating providers, the Director, **OCHAMPUS** may authorize payment in excess of CHAMPUS allowable amounts. **No** provider may bill an active duty member any amount in excess of the CHAMPUS allowable amount.

**E. Waiver authority.** With the exception of statutory requirements, any restrictions or limitations pursuant to the general rule in paragraph C of this chapter, and special rules and procedures in paragraph D of this chapter may be waived by the Director, **OCHAMPUS** at the request of an authorized official of the uniformed service concerned, based on a determination that such waiver is necessary to assure adequate availability of health care services to active duty members.

F. Authorities.

1. The Uniformed Services may establish additional procedures, consistent with this chapter, for the effective administration of the supplemental care program in their respective services.

2. The Assistant Secretary of Defense for Health Affairs is responsible for the overall policy direction of the supplemental care program and the administration of this chapter.

3. The Director, OCHAMPUS shall issue procedural requirements for the implementation of this Chapter, including the requirement for claims submission similar to those established by Chapter 17.

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