

## Part 199.14

### Provider Reimbursement Methods

Revision: C-2, December 29, 2017

Rule: Final Rule/FR Vol 82, No 249

---

**(a) Hospitals.**

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

- (v) Higher volume hospitals.
  - (A) In general.
  - (B) Hospitals that subsequently become higher volume hospitals.
  - (C) Special retrospective payment provision for new hospitals.
  - (D) Review of classification.
- (vi) Payment for hospital based professional services.
- (vii) Leave days.
- (viii) Exemptions from the CHAMPUS mental health per diem payment system.
  - (A) Non-specialty providers.
  - (B) DRG 424.
  - (C) Non-mental health services.
  - (D) Sole community hospitals (SCHs).
  - (E) Hospitals outside the U.S.
- (ix) Payment for psychiatric and substance use disorder rehabilitation partial hospitalization services, intensive outpatient psychiatric and substance use disorder services and opioid treatment services--
  - (A) Per diem payments.
  - (B) Services which may be billed separately.
- (3) Reimbursement for inpatient services provided by a CAH.
- (4) Billed charges and set rates.
- (5) CHAMPUS discount rates.
- (6) Hospital outpatient services.
  - (i) Outpatient Services Not Subject to Hospital Outpatient Prospective Payment System (OPPS).
    - (A) Laboratory services.
    - (B) Rehabilitation therapy services.
    - (C) Venipuncture.
    - (D) Radiology services.
    - (E) Diagnostic services.
    - (F) Ambulance services.
    - (G) Durable medical equipment (DME) and supplies.
    - (H) Oxygen and related supplies.
    - (I) Drugs administered other than oral method.
    - (J) Professional provider services.
    - (K) Facility charges.
    - (L) Ambulatory surgery services.
  - (ii) Outpatient Services Subject to OPPS.
  - (iii) Outpatient Services Subject to CAH Reasonable Cost Method.
  - (iv) CAH Ambulance Services.
- (7) Reimbursement for inpatient services provided by an SCH.
- (8) General temporary military contingency payment adjustment for SCHs and CAHs.
- (9) Reimbursement for inpatient services provided by a Long Term Care Hospital (LTCH).
  - (iii) Exemption.
- (10) Reimbursement for inpatient services provided by Inpatient Rehabilitation Facilities (IRF).
  - (iv) Exemption.

**(b) Skilled nursing facilities (SNFs).**

- (1) Use of Medicare prospective payment system and rates.
- (2) Payment in full.
- (3) Education costs.
- (4) Resident assessment data.

**(c) Reimbursement for Other Than Hospitals and SNFs.**

**(d) Payment of institutional facility costs for ambulatory surgery.**

- (1) In general.
- (2) Payment in full.
- (3) Calculation of standard payment rates.
  - (i) Step 1: Calculate a median standardized cost for each procedure.
  - (ii) Step 2: Grouping procedures.
  - (iii) Step 3: Adjustments to groups.
  - (iv) Step 4: Standard payment amount per group.
  - (v) Step 5: Actual payments.
- (4) Multiple procedures.
- (5) Annual updates.
- (6) Recalculation of rates.

**(e) Reimbursement of Birthing Centers.**

**(f) Reimbursement of Residential Treatment Centers.**

**(g) Reimbursement of hospice programs.**

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

**(h) Reimbursement of Home Health Agencies (HHAs).**

- (1) Split percentage payments.
- (2) Low-utilization payment.
- (3) Partial episode payment (PEP).
- (4) Significant change in condition (SCIC).
- (5) Outlier payment.

- (6) Services paid outside the HHA prospective payment system.
  - (i) Durable medical equipment (DME).
  - (ii) Osteoporosis drugs.
- (7) Accelerated payments.
  - (i) Approval of payment.
  - (ii) Amount of payment.
  - (iii) Recovery of payment.
- (8) Assessment data.
- (9) Administrative review.

**(i) Changes in Federal Law affecting Medicare.**

**(j) Reimbursement of individual health care professionals and other non-institutional, non-professional providers.**

- (1) Allowable charge method--
  - (i) Introduction--
    - (A) In general.
    - (B) CHAMPUS Maximum Allowable Charge.
    - (C) Limits on balance billing by nonparticipating providers.
    - (D) Special rule for TRICARE Prime Enrollees.
    - (E) Special rule for certain TRICARE Standard Beneficiaries.
  - (ii) Prevailing charge level.
  - (iii) Appropriate charge level.
    - (A) Step 1: Procedures classified.
    - (B) Step 2: Calculating appropriate charge levels.
    - (C) Special rule for cases in which the CHAMPUS appropriate charge was prematurely reduced.
    - (D) Special rule for cases in which the national CMAC is less than the Medicare rate.
  - (iv) Calculating CHAMPUS Maximum Allowable Charge levels for localities.
    - (A) In general.
    - (B) Special locality-based phase-in provision.
    - (C) Special locality-based waivers of reductions to assure adequate access to care.
    - (D) Special locality-based exception to applicable CMACs to assure adequate beneficiary access to care.
    - (E) Special locality-based exception to applicable CMACs to ensure an adequate TRICARE Prime preferred network.
  - (v) Special rules for 1991.
  - (vi) Special transition rule for 1992.
  - (vii) Adjustments and procedural rules.
  - (viii) Clinical laboratory services.
- (2) Bonus payments in medically underserved areas.
- (3) All-inclusive rate.
- (4) Alternative method.

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

- (l) Reimbursement Under the Military-Civilian Health Services Partnership Program.**
  - (1) Reimbursement of institutional health care providers.
  - (2) Reimbursement of individual health-care professionals and other non-institutional health care providers.
  
- (m) Accommodation of Discounts Under Provider Reimbursement Methods.**
  - (1) General rule.
  - (2) Special applications.
  - (3) Procedures.
  
- (n) Outside the United States.**
  
- (o) Implementing Instructions.**

