

Part 199.14

Provider Reimbursement Methods

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(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 by oral method.**
 - (J) Professional provider services.
 - (K) Facility charges.
 - (L) Ambulatory surgery services.
 - (ii) **Outpatient services subject to OPSS--**
 - (A) **General.**
 - (E) **Temporary transitional payment adjustments (TTPAs).**
 - (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.**

