PART 199.14 - 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.

(i) General--(A) 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.

(B) Assignment of discharges to DRGs. *(1)* 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.

(2) Each discharge shall be assigned to only one DRG regardless of the number of conditions treated or services furnished during the patient's stay.

(C) Basis of payment--*(1)* Hospital billing. Under the CHAMPUS DRG-based payment system, hospitals are required to submit claims (including itemized charges) in accordance with Sec. 199.7(b). The CHAMPUS fiscal intermediary will assign the appropriate DRG to the claim based on the information contained in 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.

(2) 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.

(3) Pricing of claims. All final claims with discharge dates of September 30, 2014, or earlier that are 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. All final claims with discharge dates of October 1, 2014, or later that are reimbursed under the CHAMPUS DRG-based payment system are to be priced as of the date of discharge.

(4) 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 paragraph (a)(1)(i)(C)(*5*) of this section) 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 paragraph (a)(1)(iii)(E)*(1)(i)(A)* of this section.

(5) Inpatient operating costs. The CHAMPUS DRG-based payment system provides a payment amount for inpatient operating costs, including:

(i) Operating costs for routine services, such as the costs of room, board, and routine nursing services;

(ii) Operating costs for ancillary services, such as hospital radiology and laboratory services (other than physicians' services) furnished to hospital inpatients;

(iii) Special care unit operating costs; and

(iv) Malpractice insurance costs related to services furnished to inpatients.

(6) Discharges and transfers. *(i)* 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 paragraph (a)(1)(i)(C)*(6)(ii)* of this section, 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.

(ii) Transfers. Except as provided under paragraph (a)(1)(i)(C)*(6)(i)* of this section, a discharge of a hospital inpatient is not counted for purposes of the CHAMPUS DRG-based payment system when the patient is transferred:

(A) From one inpatient area or unit of the hospital to another area or unit of the same hospital;

(B) From the care of a hospital included under the CHAMPUS DRG-based payment system to the care of another hospital paid under this system;

(C) From the care of a hospital included under the CHAMPUS DRG-based payment system to the care of another hospital that is excluded from the CHAMPUS DRG-based payment system because of participation in a statewide cost control program which is exempt from the CHAMPUS DRG-based payment system under paragraph (a)(1)(ii)(A) of this section; or

(D) From the care of a hospital included under the CHAMPUS DRG-based payment system to the care of a uniformed services treatment facility.

(iii) Payment in full to the discharging hospital. The hospital discharging an inpatient shall be paid in full under the CHAMPUS DRG-based payment system.

(iv) Payment to a hospital transferring an inpatient to another hospital. If a hospital subject to the CHAMPUS DRG-based payment system transfers an inpatient to another such hospital, the transferring hospital shall be paid a per diem rate (except that in neonatal cases, other than normal newborns, the hospital will be paid at 125 percent of that per diem rate), as determined under instructions issued by TSO, for each day of the patient's stay in that hospital, not to exceed the DRG-based payment that would have been paid if the patient had been discharged to another setting. For admissions occurring on or after October 1, 1995, the transferring hospital shall be paid twice the per diem rate for the first day of any transfer stay, and the per diem amount for each subsequent day, up to the limit described in this paragraph.

(v) Additional payments to transferring hospitals. A transferring hospital may qualify for an additional payment for extraordinary cases that meet the criteria for long-stay or cost outliers.

(D) DRG system updates. The CHAMPUS DRG-based payment system is modeled on the Medicare Prospective Payment System (PPS) and uses annually updated items and numbers from the Medicare PPS as provided for in this part and in instructions issued by the Director, DHA. The effective date of these items and numbers shall not correspond to that under Medicare PPS but shall be delayed until January 1, to align with TRICARE's program year reporting. This allows for an administrative simplicity that optimizes healthcare delivery by reducing existing administrative burden and costs.

(ii) Applicability of the DRG system. (A) Areas affected. The CHAMPUS DRG-based payment system shall apply to hospitals' services in the fifty states, the District of Columbia, and Puerto Rico, except that any state which has implemented a separate DRG-based payment system or similar payment system in order to control costs and is exempt from the Medicare Prospective Payment System may be exempt from the CHAMPUS DRG-based payment system if it requests exemption in writing, and provided payment under such system does not exceed payment which would otherwise be made under the CHAMPUS DRG-based payment system.

(B) Services subject to the DRG-based payment system. All normally covered inpatient hospital services furnished to CHAMPUS beneficiaries by hospitals are subject to the CHAMPUS DRG-based payment system.

(C) Services exempt from the DRG-based payment system. The following hospital services, even when provided in a hospital subject to the CHAMPUS DRG-based payment system, are exempt from the CHAMPUS DRG-based payment system. The services in paragraphs (a)(1)(ii)(C)(1) through (a)(1)(ii)(C)(4) and (a)(1)(ii)(C)(7) through (a)(1)(ii)(C)(9) of this section shall be reimbursed under the procedures in paragraph (a)(4) of this section, and the services in paragraphs (a)(1)(ii)(C)(5) and (a)(1)(ii)(C)(6) of this section shall be reimbursed under the procedures in paragraph (j) of this section.

(1) Services provided by hospitals exempt from the DRG-based payment system.

(2) All services related to solid organ acquisition for CHAMPUS covered transplants by

CHAMPUS-authorized transplantation centers.

(3) All services related to heart and liver transplantation for admissions prior to October 1, 1998, which would otherwise be paid under the respective DRG.

(4) All services related to CHAMPUS covered solid organ transplantations for which there is no DRG assignment.

(5) All professional services provided by hospital-based physicians.

(6) All services provided by nurse anesthetists.

(7) All services related to discharges involving pediatric bone marrow transplants (patient under 18 at admission).

(8) All services related to discharges involving children who have been determined to be HIV seropositive (patient under 18 at admission).

(9) All services related to discharges involving pediatric cystic fibrosis (patient under 18 at admission).

(10) For admissions occurring on or after October 1, 1990, and before October 1, 1994, and for discharges occurring on or after October 1, 1997, the costs of blood clotting factor for hemophilia inpatients. An additional payment shall be made to a hospital for each unit of blood clotting factor furnished to a CHAMPUS inpatient who is hemophiliac in accordance with the amounts established under the Medicare Prospective Payment System (42 CFR 412.115).

(D) Hospitals subject to the CHAMPUS DRG-based payment system. All hospitals within the fifty states, the District of Columbia, and Puerto Rico which are certified to provide services to CHAMPUS beneficiaries are subject to the DRG-based payment system except for the following hospitals or hospital units which are exempt.

(1) Psychiatric hospitals. A psychiatric hospital which is exempt from the Medicare Prospective Payment System is also exempt from the CHAMPUS DRG-based payment system. In order for a psychiatric hospital which does not participate in Medicare to be exempt from the CHAMPUS DRG-based payment system, it must meet the same criteria (as determined by the Director, OCHAMPUS, or a designee) as required for exemption from the Medicare Prospective Payment System as contained in 42 CFR 412.23.

(2) Inpatient Rehabilitation Facilities (IRF). Prior to implementation of the IRF PPS methodology described in paragraph (a)(10) of this section, an inpatient rehabilitation facility which is exempt from the Medicare prospective payment system is also exempt from the TRICARE DRG-based payment system.

(3) Psychiatric and rehabilitation units (distinct parts). Prior to implementation of the IRF PPS methodology described in paragraph (a)(10) of this section, a rehabilitation unit which is exempt from the Medicare prospective payment system is also exempt from the TRICARE DRG-based payment system. A psychiatric unit which is exempt from the

Medicare prospective payment system is also exempt from the TRICARE DRG-based payment system.

(4) Long Term Care Hospitals. Prior to implementation of the LTCH PPS methodology described in paragraph (a)(9) of this section, a long-term care hospital which is exempt from the Medicare prospective payment system is also exempt from the CHAMPUS DRG-based payment system.

(5) Hospitals within hospitals. A hospital within a hospital which is exempt from the Medicare prospective payment system is also exempt from the CHAMPUS DRG-based payment system. In order for a hospital within a hospital which does not participate in Medicare to be exempt from the CHAMPUS DRG-based payment system, it must meet the same criteria (as determined by the Director, TSO, or a designee) as required for exemption from the Medicare Prospective Payment System as contained in 42 CFR 412.22 and the criteria for one or more of the excluded hospital classifications described in Sec. 412.23 of Title 42 CFR.

(6) Sole community hospitals (SCHs). Prior to implementation of the SCH reimbursement method described in paragraph (a)(7) of this section, any hospital that has qualified for special treatment under the Medicare prospective payment system as an SCH (see subpart G of 42 CFR part 412) and has not given up that classification is exempt from the CHAMPUS DRG-based payment system.

(7) Christian Science sanitoriums. All Christian Science sanitoriums (as defined in paragraph (b)(4)(viii) of Sec. 199.6) are exempt from the CHAMPUS DRG-based payment system.

(8) Cancer hospitals. Any hospital which qualifies as a cancer hospital under the Medicare standards and has elected to be exempt from the Medicare prospective payment system is exempt from the CHAMPUS DRG-based payment system. (See 42 CFR 412.94.)

(9) Hospitals outside the 50 states, the District of Columbia, and Puerto Rico. A hospital is excluded from the CHAMPUS DRG-based payment system if it is not located in one of the fifty States, the District of Columbia, or Puerto Rico.

(10) CAHs. Effective December 1, 2009, any facility which has been designated and certified as a CAH as contained in 42 CFR Part 485.606 is exempt from the CHAMPUS DRG-based payment system.

(E) Hospitals which do not participate in Medicare. Any hospital which is subject to the CHAMPUS DRG-based payment system and which otherwise meets CHAMPUS requirements but which is not a Medicare-participating provider (having completed a form HCA-1514, Hospital Request for Certification in the Medicare / Medicaid Program and a form HCFA-1561, Health Insurance Benefit Agreement) must complete a participation agreement with TRICARE. By completing the participation agreement, the hospital agrees to participate on all CHAMPUS inpatient claims and to accept the CHAMPUS-determined allowable amount as payment in full for these claims. Any hospital which does not participate in Medicare and does not complete a participation agreement with TRICARE will not be authorized to provide services to TRICARE beneficiaries.

(F) Substance Use Disorder Rehabilitation facilities. With admissions on or after July 1, 1995, substance use disorder rehabilitation facilities, authorized under Sec. 199.6(b)(4)(xiv), are subject to the DRG-based payment system.

(iii) Determination of payment amounts. The actual payment for an individual claim under the CHAMPUS DRG-based payment system is calculated by multiplying the appropriate adjusted standardized amount (adjusted to account for area wage differences using the wage indexes used in the Medicare program) by a weighting factor specific to each DRG.

(A) Calculation of DRG weights. *(1)* Grouping of charges. All discharge records in the database shall be grouped by DRG.

(2) Remove DRGs. Those DRGs that represent discharges with invalid data or diagnoses insufficient for DRG assignment purposes are removed from the database.

(3) Indirect medical education standardization. To standardize the charges for the cost effects of indirect medical education factors, each teaching hospital's charges will be divided by 1.0 plus the following ratio on a hospital-specific basis:

$$1.43 \times \left[\left(1.0 + \frac{\text{number of interns + residents}}{\text{number of beds}} \right)^{5.795} - 1.0 \right]$$

(4) Wage level standardization. To standardize the charge records for area wage differences, each charge record will be divided into labor-related and nonlabor-related portions, and the labor-related portion shall be divided by the most recently available Medicare wage index for the area. The labor-related and nonlabor-related portions will then be added together.

(5) Elimination of statistical outliers. All unusually high or low charges shall be removed from the database.

(6) Calculation of DRG average charge. After the standardization for indirect medical education, and area wage differences, an average charge for each DRG shall be computed by summing charges in a DRG and dividing that sum by the number of records in the DRG.

(7) Calculation of national average charge per discharge. A national average charge per discharge shall be calculated by summing all charges and dividing that sum by the total number of records from all DRG categories.

(8) DRG relative weights. DRG relative weights shall be calculated for each DRG category by dividing each DRG average charge by the national average charge.

(B) Empty and low-volume DRGs. For any DRG with less than ten (10) occurrences in the CHAMPUS database, the Director, TSO, or designee, has the authority to consider alternative methods for estimating CHAMPUS weights in these low-volume DRG categories.

(C) Updating DRG weights. The CHAMPUS DRG weights shall be updated or adjusted as follows:

(1) DRG weights shall be recalculated annually using CHAMPUS charge data and the methodology described in paragraph (a)(1)(iii)(A) of this section.

(2) When a new DRG is created, CHAMPUS will, if practical, calculate a weight for it using an appropriate charge sample (if available) and the methodology described in paragraph (a)(1)(iii)(A) of this section.

(3) In the case of any other change under Medicare to an existing DRG weight (such as in connection with technology changes), CHAMPUS shall adjust its weight for that DRG in a manner comparable to the change made by Medicare.

(D) Calculation of the adjusted standardized amounts. The following procedures shall be followed in calculating the CHAMPUS adjusted standardized amounts.

(1) Differentiate large urban and other area charges. All charges in the database shall be sorted into large urban and other area groups (using the same definitions for these categories used in the Medicare program. The following procedures will be applied to each group.

(2) Indirect medical education standardization. To standardize the charges for the cost effects of indirect medical education factors, each teaching hospital's charges will be divided by 1.0 plus the following ratio on a hospital-specific basis:

$$1.43 \times \left[\left(1.0 + \frac{\text{number of interns + residents}}{\text{number of beds}} \right) 5.795 - 1.0 \right]$$

(3) Wage level standardization. To standardize the charge records for area wage differences, each charge record will be divided into labor-related and nonlabor-related portions, and the labor-related portion shall be divided by the most recently available Medicare wage index for the area. The labor-related and nonlabor-related portions will then be added together.

(4) Apply the cost to charge ratio. Each charge is to be reduced to a representative cost by using the Medicare cost to charge ratio. This amount shall be increased by 1 percentage point in order to reimburse hospitals for bad debt expenses attributable to CHAMPUS beneficiaries.

(5) Preliminary base year standardized amount. A preliminary base year standardized amount shall be calculated by summing all costs in the database applicable to the large urban or other area group and dividing by the total number of discharges in the respective group.

(6) Update for inflation. The preliminary base year standardized amounts shall be updated using an annual update factor equal to 1.07 to produce fiscal year 1988 preliminary standardized amounts. Therefore, any development of a new standardized amount will use an inflation factor equal to the hospital market basket index used by the Health Care Financing Administration in their Prospective Payment System.

(7) The preliminary standardized amounts, updated for inflation, shall be divided by a system standardization factor so that total DRG outlays, given the database distribution across hospitals and diagnosis, are equal to the total charges reduced to costs.

(8) Labor and nonlabor portions of the adjusted standardized amounts. The adjusted standardized amounts shall be divided into labor and nonlabor portions in accordance with the Medicare division of labor and nonlabor portions.

(E) Adjustments to the DRG-based payments amounts. The following adjustments to the DRG-based amounts (the weight multiplied by the adjusted standardized amount) will be made. Additional adjustments to DRG amounts are included in paragraph (a)(1)(iv) of this section.

(1) Outliers. The DRG-based payment to a hospital shall be adjusted for atypical cases. These outliers are those cases that have either an unusually short length-of-stay or extremely long length-of-stay or that involve extraordinarily high costs when compared to most discharges classified in the same DRG. Cases which qualify as both a length-of-stay outlier and a cost outlier shall be paid at the rate which results in the greater payment.

(i) Length-of-stay outliers. Length-of-stay outliers shall be identified and paid by the fiscal intermediary when the claims are processed.

(A) Short-stay outliers. Any discharge with a length-of-stay (LOS) less than 1.94 standard deviations from the DRG's arithmetic LOS shall be classified as a short-stay outlier. Short-stay outliers shall be reimbursed at 200 percent of the per diem rate for the DRG for each covered day of the hospital stay, not to exceed the DRG amount. The per diem rate shall equal the DRG amount divided by the arithmetic mean length-of-stay for the DRG.

(B) Long-stay outliers. Any discharge (except for neonatal services and services in children's hospitals) which has a length-of-stay (LOS) exceeding a threshold established in accordance with the criteria used for the Medicare Prospective Payment System as contained in 42 CFR 412.82 shall be classified as a long-stay outlier. Any discharge for neonatal services or for services in a children's hospital which has a LOS exceeding the lesser of 1.94 standard deviations or 17 days from the DRG's arithmetic mean LOS also shall be classified as a long-stay outlier. Long-stay outliers shall be reimbursed the DRG-based amount plus a percentage (as established for the Medicare Prospective Payment System) of the per diem rate for the DRG for each covered day of care beyond the long-stay outlier threshold. The per diem rate shall equal the DRG amount divided by the arithmetic mean LOS for the DRG. For admissions on or after October 1, 1997, the long stay outlier has been eliminated for all cases except children's hospitals and neonates. For admissions on or after October 1, 1998, the long stay outlier has been eliminated for children's hospitals and neonates.

(ii) Cost outliers. Additional payment for cost outliers shall be made only upon request by the hospital.

(A) Cost outliers except those in children's hospitals or for neonatal services. Any discharge which has standardized costs that exceed a threshold established in accordance with the criteria used for the Medicare Prospective Payment System as contained in 42 CFR 412.84 shall qualify as a cost outlier. The standardized costs shall be calculated by multiplying the total charges by the factor described in paragraph (a)(1)(iii)(D)*(4)* of this

section and adjusting this amount for indirect medical education costs. Cost outliers shall be reimbursed the DRG-based amount plus a percentage (as established for the Medicare Prospective Payment System) of all costs exceeding the threshold. Effective with admissions occurring on or after October 1, 1997, the standardized costs are no longer adjusted for indirect medical education costs.

(B) Cost outliers in children's hospitals for neonatal services. Any discharge for services in a children's hospital or for neonatal services which has standardized costs that exceed a threshold of the greater of two times the DRG-based amount or $13,500 shall qualify as a cost outlier. The standardized costs shall be calculated by multiplying the total charges by the factor described in paragraph (a)(1)(iii)(D)*(4)* of this section (adjusted to include average capital and direct medical education costs) and adjusting this amount for indirect medical education costs. Cost outliers for services in children's hospitals and for neonatal services shall be reimbursed the DRG-based amount plus a percentage (as established for the Medicare Prospective Payment System) of all costs exceeding the threshold. Effective with admissions occurring on or after October 1, 1998, standardized costs are no longer adjusted for indirect medical education costs. In addition, CHAMPUS will calculate the outlier payments that would have occurred at each of the 59 Children's hospitals under the FY99 outlier policy for all cases that would have been outliers under the FY94 policies using the most accurate data available in September 1998. A ratio will be calculated which equals the level of outlier payments that would have been made under the FY94 outlier policies and the outlier payments that would be made if the FY99 outlier policies had applied to each of these potential outlier cases for these hospitals. The ratio will be calculated across all outlier claims for the 59 hospitals and will not be hospital specific. The ratio will be used to increase cost outlier payments in FY 1999 and FY 2000, unless the hospital has a negotiated agreement with a managed care support contractor which would affect this payment. For hospitals with managed care support agreements which affect these payments, CHAMPUS will apply these payments if the increased payments would be consistent with the agreements. In FY 2000 the ratio of outlier payments (long stay and cost) that would have occurred under the FY 94 policy and actual cost outlier payments made under the FY 99 policy will be recalculated. If the ratio has changed significantly, the ratio will be revised for use in FY 2001 and thereafter. In FY 2002, the actual cost outlier cases in FY 2000 and 2001 will be reexamined. The ratio of outlier payments that would have occurred under the FY94 policy and the actual cost outlier payments made under the FY 2000 and FY 2001 policies. If the ratio has changed significantly, the ratio will be revised for use in FY 2003.

(C) Cost outliers for burn cases. All cost outliers for DRGs related to burn cases shall be reimbursed the DRG-based amount plus a percentage (as established for the Medicare Prospective Payment System) of all costs exceeding the threshold. The standardized costs and thresholds for these cases shall be calculated in accordance with Sec. 199.14(a)(1)(iii)(E)(1)(ii)(A) and Sec. 199.14(a)(1)(iii)(E)(1)(ii)(B).

(2) Wage adjustment. CHAMPUS will adjust the labor portion of the standardized amounts according to the hospital's area wage index. The wage adjusted DRG payment will also be multiplied by 1.2 for an individual diagnosed with COVID-19 and/or Coronavirus discharged during the Secretary of Health and Human Services' declared public health emergency (PHE).

(3) Indirect medical education adjustment. The wage adjusted DRG payment will also be multiplied by 1.0 plus the hospital's indirect medical education ratio.

(4) Children's hospital differential. With respect to claims from children's hospitals, the appropriate adjusted standardized amount shall also be adjusted by a children's hospital differential.

(i) Qualifying children's hospitals. Hospitals qualifying for the children's hospital differential are hospitals that are exempt from the Medicare Prospective Payment System, or, in the case of hospitals that do not participate in Medicare, that meet the same criteria (as determined by the Director, OCHAMPUS, or a designee) as required for exemption from the Medicare Prospective Payment System as contained in 42 CFR 412.23.

(ii) Calculation of differential. The differential shall be equal to the difference between a specially calculated children's hospital adjusted standardized amount and the adjusted standardized amount for fiscal year 1988. The specially calculated children's hospital adjusted standardized amount shall be calculated in the same manner as set forth in Sec. 199.14(a)(1)(iii)(D), except that:

(A) The base period shall be fiscal year 1988 and shall represent total estimated charges for discharges that occurred during fiscal year 1988.

(B) No cost to charge ratio shall be applied.

(C) Capital costs and direct medical education costs will be included in the calculation.

(D) The factor used to update the database for inflation to produce the fiscal year 1988 base period amount shall be the applicable Medicare inpatient hospital market basket rate.

(iii) Transition rule. Until March 1, 1992, separate differentials shall be used for each higher volume children's hospital (individually) and for all other children's hospitals (in the aggregate). For this purpose, a higher volume hospital is a hospital that had 50 or more CHAMPUS discharges in fiscal year 1988.

(iv) Hold harmless provision. At such time as the weights initially assigned to neonatal DRGs are recalibrated based on sufficient volume of CHAMPUS claims records, children's hospital differentials shall be recalculated and appropriate retrospective and prospective adjustments shall be made. To the extent practicable, the recalculation shall also include reestimated values of other factors (including but not limited to direct education and capital costs and indirect education factors) for which more accurate data became available.

(v) No update for inflation. The children's hospital differential, calculated (and later recalculated under the hold harmless provision) for the base period of fiscal year 1988, shall not be updated for subsequent fiscal years.

(vi) Administrative corrections. In connection with determinations pursuant to paragraph (a)(1)(iii)(E)*(4)(iii)* of this section, any children's hospital that believes OCHAMPUS erroneously failed to classify the hospital as a high volume hospital or incorrectly calculated (in the case of a high volume hospital) the hospital's differential may obtain administrative corrections by submitting appropriate documentation to the Director, OCHAMPUS (or a designee).

(iv) Special Programs and Incentive Payments.(A) Additional payment for new

medical services and technologies. TRICARE will make New Technology Add On Payments (NTAPs) adjustments to DRGs as provided in paragraphs (a)(1)(iv)(A)(*1*) through (a)(1)(iv)(A)(*11*) of this section. The Director, Defense Health Agency (DHA), shall provide notice of the issuance of policies and guidelines adopting such adjustments together with any variations deemed necessary to address unique issues involving the beneficiary population or program administration.

(1) Adoption of Medicare NTAPs. For TRICARE covered services and supplies, TRICARE will adopt Medicare NTAPs as implemented under 42 CFR 412.87 under the same conditions as published by the Centers for Medicare & Medicaid Services, except for pediatric cases.

(2) Pediatric cases. For pediatric NTAP DRGs, the TRICARE NTAP adjustment shall be modified to be set at 100 percent of the costs in excess of the Medicare Severity-Diagnosis Related Group (MS-DRG) payment. As used in this paragraph, pediatric is defined as services and supplies provided to individuals under the age of 18, or who are being treated in a children's hospital or in a pediatric ward.

(3) TRICARE designated NTAP adjustments. For categories of TRICARE covered services and supplies for which Medicare has not established an NTAP adjustment for DRGs, the Director, DHA may designate a TRICARE NTAP adjustment through a process using criteria to identify and select such new technology services/supplies similar to that utilized by Medicare under 42 CFR 412.87. The Director, DHA may then designate a TRICARE NTAP reimbursement adjustment through a process using a methodology similar to the Medicare methodology outlined in 42 CFR 412.88. This discretionary authority to designate TRICARE NTAP adjustments shall apply to services and supplies typically provided to TRICARE beneficiaries age 64 or younger when Medicare has not established an NTAP adjustment for such services/supplies. As with other discretionary authority under this part, a decision to designate a TRICARE category of services/supplies for an NTAP adjustment to DRGs and the amount of such an adjustment are not subject to the appeal and hearing procedures of Sec. 199.10. The Director, DHA, shall select which new technologies may be designated as TRICARE NTAPs and will publish this list based on the eligibility criteria and reimbursement methodology provided in paragraphs (a)(1)(iv)(A)(*4*) through (a)(1)(iv)(A)(*11*) of this section.

(4) Eligibility requirements and reimbursement methodology for TRICARE designated NTAP adjustments. A new medical service or technology represents an advance that substantially improves, relative to technologies previously available, the diagnosis or treatment of TRICARE beneficiaries. The totality of the circumstances is considered when making a determination that a new medical service or technology represents an advance that substantially improves, relative to services or technologies previously available, the diagnosis or treatment of TRICARE beneficiaries.

(5) Criteria for improvement. A determination that a new medical service or technology represents an advance that substantially improves, relative to services or technologies previously available, the diagnosis or treatment of TRICARE beneficiaries means one or more of the following:

(i) The new medical service or technology offers a treatment option for a patient population unresponsive to, or ineligible for, currently available treatments.

(ii) The new medical service or technology offers the ability to diagnose a medical condition in a patient population where that medical condition is currently undetectable, or offers the ability to diagnose a medical condition earlier in a patient population than allowed by currently available methods and there must also be evidence that use of the new medical service or technology to make a diagnosis affects the management of the patient.

(iii) The use of the new medical service or technology significantly improves clinical outcomes relative to services or technologies previously available as demonstrated by one or more of the following seven outcomes: A reduction in at least one clinically significant adverse event, including a reduction in mortality or a clinically significant complication; A decreased rate of at least one subsequent diagnostic or therapeutic intervention; A decreased number of future hospitalizations or physician visits; A more rapid beneficial resolution of the disease process treatment including, but not limited to, a reduced length of stay or recovery time; An improvement in one or more activities of daily living; An improved quality of life; or A demonstrated greater medication adherence or compliance.

(iv) The totality of the information otherwise demonstrates that the new medical service or technology substantially improves, relative to technologies previously available, the diagnosis or treatment of TRICARE beneficiaries.

(6) Evidence. Evidence from scientific literature may be sufficient to establish that a new medical service or technology represents an advance that substantially improves, relative to services or technologies previously available, the diagnosis or treatment of TRICARE beneficiaries.

(7) Prevalence. The medical condition diagnosed or treated by the new medical service or technology may have a low prevalence among TRICARE beneficiaries.

(8) Subpopulation. The new medical service or technology may represent an advance that substantially improves, relative to services or technologies previously available, the diagnosis or treatment of a subpopulation of patients with the medical condition diagnosed or treated by the new medical service or technology.

(9) Newness criteria. A medical service or technology may be considered new within 2 or 3 years after the point at which data begin to become available reflecting the inpatient hospital code assigned to the new service or technology (depending on when a new code is assigned and data on the new service or technology becomes available for DRG recalibration). After TRICARE has recalibrated the DRGs, based on available data, to reflect the costs of an otherwise new medical service or technology, the medical service or technology will no longer be considered "new" under the criterion of this section.

(10) Payment methodology. For discharges involving new medical services or technologies that meet the criteria specified in paragraphs (a)(1)(iv)(A)(*4*) through (a)(1)(iv)(A)(*9*) and that are approved as TRICARE NTAPs per paragraph (a)(1)(iv)(A)(*11*) of this section, TRICARE payment will be the lesser of:

(i) The CMS designated percentage of the estimated costs of the new technology or medical service, as published in 42 CFR 412.88; or

(ii) The CMS designated percentage of the difference between the full DRG payment and

the hospital's estimated cost for the case, as published in 42 CFR 412.88.

(11) Publication and timing. TRICARE may consider whether a new medical service or technology meets the eligibility criteria specified in paragraphs (a)(1)(iv)(A)(*4*) through (a)(1)(iv)(A)(*9*) of this section and announce the results on the NTAP website. In doing so, TRICARE only considers, for add-on payments for a particular fiscal year, an application for which the new medical device or product has received FDA marketing authorization by July 1 prior to the particular fiscal year; or the application is submitted under an alternative pathway to the FDA for which conditional NTAP approval for FDA marketing authorization is granted before July 1 of the fiscal year for which the applicant applied for new technology add-on payments.

(B) Hospital Value Based Purchasing. TRICARE will adopt the Medicare Hospital Value Based Purchasing (HVBP) Program adjustments to DRGs to incentivize hospitals as implemented under 42 CFR 412.160, when determined by the ASD(HA), as practicable. The Director, DHA, shall provide notice of the issuance of policies and guidelines adopting such adjustments together with any variations deemed necessary to address unique issues involving the beneficiary population or program administration.

(C) Updating the adjusted standardized amounts. Beginning in FY 1989, the adjusted standardized amounts will be updated by the Medicare annual update factor, unless the adjusted standardized amounts are recalculated.

(D) Annual cost pass-throughs. *(1)* Capital costs. When requested in writing by a hospital, CHAMPUS shall reimburse the hospital its share of actual capital costs as reported annually to the CHAMPUS fiscal intermediary. Payment for capital costs shall be made annually based on the ratio of CHAMPUS inpatient days for those beneficiaries subject to the CHAMPUS DRG-based payment system to total inpatient days applied to the hospital's total allowable capital costs. Reductions in payments for capital costs which are required under Medicare shall also be applied to payments for capital costs under CHAMPUS.

(i) Costs included as capital costs. Allowable capital costs are those specified in Medicare Regulation Sec. 413.130, as modified by Sec. 412.72.

(ii) Services, facilities, or supplies provided by supplying organizations. If services, facilities, or supplies are provided to the hospital by a supplying organization related to the hospital within the meaning of Medicare Regulation Sec. 413.17, then the hospital must include in its capital-related costs, the capital-related costs of the supplying organization. However, if the supplying organization is not related to the provider within the meaning of Sec. 413.17, no part of the change to the provider may be considered a capital-related cost unless the services, facilities, or supplies are capital-related in nature and:

(A) The capital-related equipment is leased or rented by the provider;

(B) The capital-related equipment is located on the provider's premises; and

(C) The capital-related portion of the charge is separately specified in the charge to the provider.

(2) Direct medical education costs. When requested in writing by a hospital, CHAMPUS shall reimburse the hospital its actual direct medical education costs as reported annually to the CHAMPUS fiscal intermediary. Such teaching costs must be for a teaching program approved under Medicare Regulation Sec. 413.85. Payment for direct medical education costs shall be made annually based on the ratio of CHAMPUS inpatient days for those beneficiaries subject to the CHAMPUS DRG-based payment system to total inpatient days applied to the hospital's total allowable direct medical education costs. Allowable direct medical education costs are those specified in Medicare Regulation Sec. 413.85.

(3) Information necessary for payment of capital and direct medical education costs. All hospitals subject to the CHAMPUS DRG-based payment system, except for children's hospitals, may be reimbursed for allowed capital and direct medical education costs by submitting a request to the CHAMPUS contractor. Beginning October 1, 1998, such request shall be filed with CHAMPUS on or before the last day of the twelfth month following the close of the hospitals' cost reporting period, and shall cover the one-year period corresponding to the hospital's Medicare cost-reporting period. The first such request may cover a period of less than a full year--from the effective date of the CHAMPUS DRG-based payment system to the end of the hospital's Medicare cost-reporting period. All costs reported to the CHAMPUS contractor must correspond to the costs reported on the hospital's Medicare cost report. An extension of the due date for filing the request may only be granted if an extension has been granted by HCFA due to a provider's operations being significantly adversely affected due to extraordinary circumstances over which the provider has no control, such as flood or fire. (If these costs change as a result of a subsequent audit by Medicare, the revised costs are to be reported to the hospital's CHAMPUS contractor within 30 days of the date the hospital is notified of the change). The request must be signed by the hospital official responsible for verifying the amounts and shall contain the following information.

(i) The hospital's name.

(ii) The hospital's address.

(iii) The hospital's CHAMPUS provider number.

(iv) The hospital's Medicare provider number.

(v) The period covered--this must correspond to the hospital's Medicare cost-reporting period.

(vi) Total inpatient days provided to all patients in units subject to DRG-based payment.

(vii) Total allowed CHAMPUS inpatient days provided in units subject to DRG-based payment.

(viii) Total allowable capital costs.

(ix) Total allowable direct medical education costs.

(x) Total full-time equivalents for:

(A) Residents.

(B) Interns.

(xi) Total inpatient beds as of the end of the cost-reporting period. If this has changed during the reporting period, an explanation of the change must be provided.

(xii) Title of official signing the report.

(xiii) Reporting date.

(xiv) The report shall contain a certification statement that any changes to the items in paragraphs (a)(1)(iii)(G)(3)(*vi*), (*vii*), (*viii*), (*ix*), or (*x*), which are a result of an audit of the hospital's Medicare cost-report, shall be reported to CHAMPUS within thirty (30) days of the date the hospital is notified of the change.

(2) CHAMPUS mental health per diem payment system. The CHAMPUS mental health per diem payment system shall be used to reimburse for inpatient mental health hospital care in specialty psychiatric hospitals and units. Payment is made on the basis of prospectively determined rates and paid on a per diem basis. The system uses two sets of per diems. One set of per diems applies to hospitals and units that have a relatively higher number of CHAMPUS discharges. For these hospitals and units, the system uses hospital-specific per diem rates. The other set of per diems applies to hospitals and units with a relatively lower number of CHAMPUS discharges. For these hospitals and units, the system uses regional per diems, and further provides for adjustments for area wage differences and indirect medical education costs and additional pass-through payments for direct medical education costs.

(i) Applicability of the mental health per diem payment system.(A) Hospitals and units covered. The CHAMPUS mental health per diem payment system applies to services covered (see paragraph (a)(2)(i)(B) of this section) that are provided in Medicare prospective payment system (PPS) exempt psychiatric specialty hospitals and all Medicare PPS exempt psychiatric specialty units of other hospitals. In addition, any psychiatric hospital that does not participate in Medicare, or any other hospital that has a psychiatric specialty unit that has not been so designated for exemption from the Medicare prospective payment system because the hospital does not participate in Medicare, may be designated as a psychiatric hospital or psychiatric specialty unit for purposes of the CHAMPUS mental health per diem payment system upon demonstrating that it meets the same criteria (as determined by the Director, OCHAMPUS) as required for the Medicare exemption. The CHAMPUS mental health per diem payment system does not apply to mental health services provided in other hospitals.

(B) Services covered. Unless specifically exempted, all covered hospitals' and units' inpatient claims which are classified into a mental health DRG (DRG categories 425-432, but not DRG 424) or an alcohol / drug abuse DRG (DRG categories 433-437) shall be subject to the mental health per diem payment system.

(ii) Hospital-specific per diems for higher volume hospitals and units. This paragraph describes the per diem payment amounts for hospitals and units with a higher volume of CHAMPUS discharges.

(A)*(1)* Per diem amount. A hospital-specific per diem amount shall be calculated for each hospital and unit with a higher volume of CHAMPUS discharges. The base period per diem amount shall be equal to the hospital's average daily charge in the base period. The base period amount, however, may not exceed the cap described in paragraph (a)(2)(ii)(B) of this section. The base period amount shall be updated in accordance with paragraph (a)(2)(iv) of this section.

(2) In states that have implemented a payment system in connection with which hospitals in that state have been exempted from the CHAMPUS DRG-based payment system pursuant to paragraph (a)(1)(ii)(A) of this section, psychiatric hospitals and units may have per diem amounts established based on the payment system applicable to such hospitals and units in the state. The per diem amount, however, may not exceed the cap amount applicable to other higher volume hospitals.

(B) Cap--*(1)* As it affects payment for care provided to patients prior to April 6, 1995, the base period per diem amount may not exceed the 80th percentile of the average daily charge weighted for all discharges throughout the United States from all higher volume hospitals.

(2) Applicable to payments for care provided to patients on or after April 6, 1996, the base period per diem amount may not exceed the 70th percentile of the average daily charge weighted for all discharges throughout the United States from all higher volume hospitals. For this purpose, base year charges shall be deemed to be charges during the period of July 1, 1991 to June 30, 1992, adjusted to correspond to base year (FY 1988) charges by the percentage change in average daily charges for all higher volume hospitals and units between the period of July 1, 1991 to June 30, 1992 and the base year.

(C) Review of per diem. Any hospital or unit which believes OCHAMPUS calculated a hospital-specific per diem which differs by more than $5.00 from that calculated by the hospital or unit may apply to the Director, OCHAMPUS, or a designee, for a recalculation. The burden of proof shall be on the hospital.

(iii) Regional per diems for lower volume hospitals and units. This paragraph describes the per diem amounts for hospitals and units with a lower volume of CHAMPUS discharges.

(A) Per diem amounts. Hospitals and units with a lower volume of CHAMPUS patients shall be paid on the basis of a regional per diem amount, adjusted for area wages and indirect medical education. Base period regional per diems shall be calculated based upon all CHAMPUS lower volume hospitals' claims paid during the base period. Each regional per diem amount shall be the quotient of all covered charges divided by all covered days of care, reported on all CHAMPUS claims from lower volume hospitals in the region paid during the base period, after having standardized for indirect medical education costs and area wage indexes and subtracted direct medical education costs. Regional per diem amounts are adjusted in accordance with paragraph (a)(2)(iii)(C) of this section. Additional pass-through payments to lower volume hospitals are made in accordance with paragraph (a)(2)(iii)(D) of this section. The regions shall be the same as the Federal census regions.

(B) Review of per diem amount. Any hospital that believes the regional per diem amount applicable to that hospital has been erroneously calculated by OCHAMPUS by more

than $5.00 may submit to the Director, OCHAMPUS, or a designee, evidence supporting a different regional per diem. The burden of proof shall be on the hospital.

(C) Adjustments to regional per diems. Two adjustments shall be made to the regional per diem rates.

(1) Area wage index. The same area wage indexes used for the CHAMPUS DRG-based payment system (see paragraph (a)(1)(iii)(E)*(2)* of this section) shall be applied to the wage portion of the applicable regional per diem rate for each day of the admission. The wage portion shall be the same as that used for the CHAMPUS DRG-based payment system.

(2) Indirect medical education. The indirect medical education adjustment factors shall be calculated for teaching hospitals in the same manner as is used in the CHAMPUS DRG-based payment system (see paragraph (a)(1)(iii)(E)*(3)* of this section) and applied to the applicable regional per diem rate for each day of the admission.

(D) Annual cost pass-through for direct medical education. In addition to payments made to lower volume hospitals under paragraph (a)(2)(iii) of this section, CHAMPUS shall annually reimburse hospitals for actual direct medical education costs associated with services to CHAMPUS beneficiaries. This reimbursement shall be done pursuant to the same procedures as are applicable to the CHAMPUS DRG-based payment system (see paragraph (a)(1)(iii)(G) of this section).

(iv) Base period and update factors. (A) Base period. The base period for calculating the hospital-specific and regional per diems, as described in paragraphs (a)(2)(ii) and (a)(2)(iii) of this section, is Federal fiscal year 1988. Base period calculations shall be based on actual claims paid during the period July 1, 1987 through May 31, 1988, trended forward to represent the 12-month period ending September 30, 1988 on the basis of the Medicare inpatient hospital market basket rate.

(B) Alternative hospital-specific data base. Upon application of a higher volume hospital or unit to the Director, OCHAMPUS, or a designee, the hospital or unit may have its hospital-specific base period calculations based on claims with a date of discharge (rather than date of payment) between July 1, 1987 through May 31, 1988 if it has generally experienced unusual delays in claims payments and if the use of such an alternative data base would result in a difference in the per diem amount of at least $5.00. For this purpose, the unusual delays means that the hospital's or unit's average time period between date of discharge and date of payment is more than two standard deviations longer than the national average.

(C) Update factors--*(1)* The hospital-specific per diems and the regional per diems calculated for the base period pursuant to paragraphs (a)(2)(ii) of this section shall remain in effect for federal fiscal year 1989; there will be no additional update for fiscal year 1989.

(2) Except as provided in paragraph (a)(2)(iv)(C)*(3)* of this section, for subsequent federal fiscal years, each per diem shall be updated by the Medicare Inpatient Prospective Payment System update factor.

(3) As an exception to the update required by paragraph (a)(2)(iv)(C)*(2)* of this section, all per diems in effect at the end of fiscal year 1995 shall remain in effect, with no additional

update, throughout fiscal years 1996 and 1997. For fiscal year 1998 and thereafter, the per diems in effect at the end of fiscal year 1997 will be updated in accordance with paragraph (a)(2)(iv)(C)*(2)*.

(4) Hospitals and units with hospital-specific rates will be notified of their respective rates prior to the beginning of each Federal fiscal year. New hospitals shall be notified at such time as the hospital rate is determined. The actual amount of each regional per diem that will apply in any Federal fiscal year shall be posted to the Agency's official Web site at the start of that fiscal year.

(v) Higher volume hospitals. This paragraph describes the classification of and other provisions pertinent to hospitals with a higher volume of CHAMPUS patients.

(A) In general. Any hospital or unit that had an annual rate of 25 or more CHAMPUS discharges of CHAMPUS patients during the period July 1, 1987 through May 31, 1988 shall be considered a higher volume hospital has 25 or more CHAMPUS discharges, that hospital shall be considered to be a higher volume hospital during Federal fiscal year 1989 and all subsequent fiscal years. All other hospitals and units covered by the CHAMPUS mental health per diem payment system shall be considered lower volume hospitals.

(B) Hospitals that subsequently become higher volume hospitals. In any Federal fiscal year in which a hospital, including a new hospital (see paragraph (a)(2)(v)(C) of this section), not previously classified as a higher volume hospital has 25 or more CHAMPUS discharges, that hospital shall be considered to be a higher volume hospital during the next Federal fiscal year and all subsequent fiscal years. The hospital specific per diem amount shall be calculated in accordance with the provisions of paragraph (a)(2)(ii) of this section, except that the base period average daily charge shall be deemed to be the hospital's average daily charge in the year in which the hospital had 25 or more discharges, adjusted by the percentage change in average daily charges for all higher volume hospitals and units between the year in which the hospital had 25 or more CHAMPUS discharges and the base period. The base period amount, however, may not exceed the cap described in paragraph (a)(2)(ii)(B) of this section.

(C) Special retrospective payment provision for new hospitals. For purposes of this paragraph, a new hospital is a hospital that qualifies for the Medicare exemption from the rate of increase ceiling applicable to new hospitals which are PPS-exempt psychiatric hospitals. Any new hospital that becomes a higher volume hospital, in addition to qualifying prospectively as a higher volume hospital for purposes of paragraph (a)(2)(v)(B) of this section, may additionally, upon application to the Director, OCHAMPUS, receive a retrospective adjustment. The retrospective adjustment shall be calculated so that the hospital receives the same government share payments it would have received had it been designated a higher volume hospital for the federal fiscal year in which it first had 25 or more CHAMPUS discharges and the preceding fiscal year (if it had any CHAMPUS patients during the preceding fiscal year). Such new hospitals must agree not to bill CHAMPUS beneficiaries for any additional costs beyond that determined initially.

(D) Review of classification. Any hospital or unit which OCHAMPUS erroneously fails to classify as a higher volume hospital may apply to the Director, OCHAMPUS, or a designee, for such a classification. The hospital shall have the burden of proof.

(vi) Payment for hospital based professional services. Lower volume hospitals and units may not bill separately for hospital based professional mental health services; payment for those services is included in the per diems. Higher volume hospitals and units, whether they billed CHAMPUS separately for hospital based professional mental health services or included those services in the hospital's billing to CHAMPUS, shall continue the practice in effect during the period July 1, 1987 to May 31, 1988 (or other data base period used for calculating the hospital's or unit's per diem), except that any such hospital or unit may change its prior practice (and obtain an appropriate revision in its per diem) by providing to OCHAMPUS notice in accordance with procedures established by the Director, OCHAMPUS, or a designee.

(vii) Leave days. CHAMPUS shall not pay for days where the patient is absent on leave from the specialty psychiatric hospital or unit. The hospital must identify these days when claiming reimbursement. CHAMPUS shall not count a patients's leave of absence as a discharge in determining whether a facility should be classified as a higher volume hospital pursuant to paragraph (a)(2)(v) of this section.

(viii) Exemptions from the CHAMPUS mental health per diem payment system. The following providers and procedures are exempt from the CHAMPUS mental health per diem payment system.

(A) Non-specialty providers. Providers of inpatient care which are not either psychiatric hospitals or psychiatric specialty units as described in paragraph (a)(2)(i)(A) of this section are exempt from the CHAMPUS mental health per diem payment system. Such providers should refer to paragraph (a)(1) of this section for provisions pertinent to the CHAMPUS DRG-based payment system.

(B) DRG 424. Admissions for operating room procedures involving a principal diagnosis of mental illness (services which group into DRG 424) are exempt from the per diem payment system. They will be reimbursed pursuant to the provisions of paragraph (a)(3) of this section.

(C) Non-mental health services. Admissions for non-mental health procedures in specialty psychiatric hospitals and units are exempt from the per diem payment system. They will be reimbursed pursuant to the provisions of paragraph (a)(3) of this section.

(D) Sole community hospitals (SCHs). Prior to implementation of the SCH reimbursement method described in paragraph (a)(7) of this section, any hospital that has qualified for special treatment under the Medicare prospective payment system as an SCH and has not given up that classification is exempt.

(E) Hospitals outside the U.S. A hospital is exempt if it is not located in one of the 50 states, the District of Columbia or Puerto Rico.

(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. Psychiatric and substance use disorder partial hospitalization services, intensive outpatient psychiatric and substance use disorder services and opioid treatment services authorized by Sec. 199.4(b)(9), (b)(10), and (b)(11), respectively, and provided by institutional providers authorized under

Sec. 199.6(b)(4)(xii), (b)(4)(xviii) and (b)(4)(xix), respectively, are reimbursed on the basis of prospectively determined, all-inclusive per diem rates pursuant to the provisions of paragraphs (a)(2)(ix)(A)*(1)* through *(3)* of this section, with the exception of hospital-based psychiatric and substance use disorder and opioid services which are reimbursed in accordance with provisions of paragraph (a)(6)(ii) of this section and freestanding opioid treatment programs when reimbursed on a fee-for-service basis as specified in paragraph (a)(2)(ix)(A)(3)(ii) of this section. The per diem payment amount must be accepted as payment in full, subject to the outpatient cost-sharing provisions under Sec. 199.4(f), for institutional services provided, including board, routine nursing services, group therapy, ancillary services (e.g., music, dance, and occupational and other such therapies), psychological testing and assessment, overhead and any other services for which the customary practice among similar providers is included in the institutional charges, except for those services which may be billed separately under paragraph (a)(2)(ix)(B) of this section. Per diem payment will not be allowed for leave days during which treatment is not provided.

(1) Partial hospitalization programs. For any full-day partial hospitalization program (minimum of 6 hours), the maximum per diem payment amount is 40 percent of the average inpatient per diem amount per case established under the TRICARE mental health per diem reimbursement system during the fiscal year for both high and low volume psychiatric hospitals and units [as defined in paragraph (a)(2) of this section]. Intensive outpatient services provided in a PHP setting lasting less than 6 hours, with a minimum of 2 hours, will be paid as provided in paragraph (a)(2)(ix)(A)*(2)* of this section. PHP per diem rates will be updated annually by the Medicare update factor used for their Inpatient Prospective Payment System.

(2) Intensive outpatient programs. For intensive outpatient programs (IOPs) (minimum of 2 hours), the maximum per diem amount is 75 percent of the rate for a full-day partial hospitalization program as established in paragraph (a)(2)(ix)(A)(1) of this section. IOP per diem rates will be updated annually by the Medicare update factor used for their Inpatient Prospective Payment System.

(3) Opioid treatment programs. Opioid treatment programs (OTPs) authorized by Sec. 199.4(b)(11) and provided by providers authorized under Sec. 199.6(b)(4)(xix) will be reimbursed based on the variability in the dosage and frequency of the drug being administered and in related supportive services.

(i) Weekly all-inclusive per diem rate. Methadone OTPs will be reimbursed the lower of the billed charge or the weekly all-inclusive per diem rate (the weekly national all-inclusive rate adjusted for locality), including the cost of the drug and related services (i.e., the costs related to the initial intake/assessment, drug dispensing and screening and integrated psychosocial and medical treatment and support services). The bundled weekly per diem payments will be accepted as payment in full, subject to the outpatient cost-sharing provisions under Sec. 199.4(f). The methadone per diem rate for OTPs will be updated annually by the Medicare update factor used for their Inpatient Prospective Payment System.

(ii) Exceptions to per diem reimbursement. When providing other medications which are more likely to be prescribed and administered in an office-based opioid treatment setting, but which are still available for treatment of substance use disorders in an outpatient treatment program setting, OTPs will be reimbursed on a fee-for-service basis (i.e., separate

payments will be allowed for both the medication and accompanying support services), subject to the outpatient cost-sharing provisions under Sec. 199.4(f). OTPs' rates will be updated annually by the Medicare update factor used for their Inpatient Prospective Payment System.

(iii) Discretionary authority. The Director, TRICARE, will have discretionary authority in establishing the reimbursement methodologies for new drugs and biologicals that may become available for the treatment of substance use disorders in OTPs. The type of reimbursement (e.g., fee-for-service versus bundled per diem payments) will be dependent on the variability of the dosage and frequency of the medication being administered, as well as the support services.

(B) Services which may be billed separately. Psychotherapy sessions and non-mental health related medical services not normally included in the evaluation and assessment of PHP, IOP or OTPs, provided by authorized independent professional providers who are not employed by, or under contract with, PHP, IOP or OTPs for the purposes of providing clinical patient care are not included in the per diem rate and may be billed separately. This includes ambulance services when medically necessary for emergency transport.

(3) Reimbursement for inpatient services provided by a CAH. (i) For admissions on or after December 1, 2009, inpatient services provided by a CAH, other than services provided in psychiatric and rehabilitation distinct part units, shall be reimbursed at allowable cost (i.e., 101 percent of reasonable cost) under procedures, guidelines, and instructions issued by the Director, DHA, or designee. This does not include any costs of physicians' services or other professional services provided to CAH inpatients. Inpatient services provided in psychiatric distinct part units would be subject to the TRICARE mental health payment system. Inpatient services provided in rehabilitation distinct part units would be subject to billed charges. Upon implementation of TRICARE's IRF PPS, inpatient services provided in rehabilitation distinct part units would be subject to the TRICARE IRF PPS methodology in paragraph (a)(10) of this section.

(ii) The percentage amount stated in paragraph (a)(3)(i) of this section is subject to possible upward adjustment based on a inpatient GTMCPA for TRICARE network hospitals deemed essential for military readiness and support during contingency operations under paragraph (a)(8) of this section.

(4) Billed charges and set rates. The allowable cost for authorized care in all hospitals not subject to the TRICARE DRG-based payment system, the TRICARE mental health per-diem system, the TRICARE reasonable cost method for CAHs, the TRICARE reimbursement rules for SCHs, the TRICARE LTCH-PPS, or the TRICARE IRF PPS shall be determined on the basis of billed charges or set rates.

(i) The actual charge for such service made to the general public; or

(ii) The allowed charge applicable to the policyholders or subscribers of the CHAMPUS fiscal intermediary for comparable services under comparable circumstances, when extended to CHAMPUS beneficiaries by consent or agreement; or

(iii) The allowed charge applicable to the citizens of the community or state as established by local or state regulatory authority, excluding title XIX of the Social Security Act or other

welfare program, when extended to CHAMPUS beneficiaries by consent or agreement.

(5) CHAMPUS discount rates. The CHAMPUS-determined allowable cost for authorized care in any hospital may be based on discount rates established under paragraph (l) of this section.

(6) Hospital outpatient services. This paragraph (a)(6) identifies and clarifies payment methods for certain outpatient services, including emergency services, provided by hospitals.

(i) Outpatient Services Not Subject to Hospital Outpatient Prospective Payment System (OPPS). The following are payment methods for outpatient services that are either provided in an OPPS exempt hospital or paid outside the OPPS payment methodology under existing fee schedules or other prospectively determined rates in a hospital subject to OPPS reimbursement.

(A) Laboratory services. TRICARE payments for hospital outpatient laboratory services including clinical laboratory services are based on the allowable charge method under paragraph (j)(1) of the section. In the case of laboratory services for which the CMAC rates are established under that paragraph, a payment rate for the technical component of the laboratory services is provided. Hospital charges for an outpatient laboratory service are reimbursed using the CMAC technical component rate.

(B) Rehabilitation therapy services. Rehabilitation therapy services provided on an outpatient basis by hospitals are paid on the same basis as rehabilitation therapy services covered by the allowable charge method under paragraph (j)(1) of this section.

(C) Venipuncture. Routine venipuncture services provided on an outpatient basis by hospitals are paid on the same basis as such services covered by the allowable charge method under paragraph (j)(1) of this section. Routine venipuncture services provided on an outpatient basis by institutional providers other than hospitals are also paid on this basis.

(D) Radiology services. TRICARE payments for hospital outpatient radiology services are based on the allowable charge method under paragraph (j)(1) of the section. In the case of radiology services for which the CMAC rates are established under that paragraph, a payment rate for the technical component of the radiology services is provided. Hospital charges for an outpatient radiology service are reimbursed using the CMAC technical component rate.

(E) Diagnostic services. TRICARE payments for hospital outpatient diagnostic services are based on the allowable charge method under paragraph (j)(1) of the section. In the case of diagnostic services for which the CMAC rates are established under that paragraph, a payment rate for the technical component of the diagnostic services is provided. Hospital charges for an outpatient diagnostic service are reimbursed using the CMAC technical component rate.

(F) Ambulance services. Ambulance services provided on an outpatient basis by hospitals are paid on the same basis as ambulance services covered by the allowable charge method under paragraph (j)(1) of this section.

(G) Durable medical equipment (DME) and supplies. Durable medical equipment and supplies provided on an outpatient basis by hospitals are paid on the same basis as durable medical equipment and supplies covered by the allowable charge method under paragraph (j)(1) of this section.

(H) Oxygen and related supplies. Oxygen and related supplies provided on an outpatient basis by hospitals are paid on the same basis as oxygen and related supplies covered by the allowable charge method under paragraph (j)(1) of this section.

(I) Drugs administered other than by oral method. Drugs administered other than by oral method provided on an outpatient basis by hospitals are paid on the same basis as drugs administered other than by oral method covered by the allowable charge method under paragraph (j)(1) of this section.

(J) Professional provider services. TRICARE payments for hospital outpatient professional provider services rendered in an emergency room, clinic, or hospital outpatient department, etc., are based on the allowable charge method under paragraph (j)(1) of the section. In the case of professional services for which the CMAC rates are established under that paragraph, a payment rate for the professional component of the services is provided. Hospital charges for an outpatient professional service are reimbursed using the CMAC professional component rate. If the professional outpatient hospital services are billed by a professional provider group, not by the hospital, no payment shall be made to the hospital for these services.

(K) Facility charges. TRICARE payments for hospital outpatient facility charges that would include the overhead costs of providing the outpatient service would be paid as billed. For the definition of facility charge, see Sec. 199.2(b).

(L) Ambulatory surgery services. Hospital outpatient ambulatory surgery services shall be paid in accordance with Sec. 199.14(d).

(ii) Outpatient services subject to OPPS--(A) General. Outpatient services provided in hospitals subject to Medicare OPPS as specified in 42 CFR 413.65 and 42 CFR 419.20 will be paid in accordance with the provisions outlined in sections 1833t of the Social Security Act and its implementing Medicare regulation (42 CFR part 419) subject to exceptions as authorized by this paragraph (a)(6)(ii).

(B) Under the above governing provisions, TRICARE will recognize to the extent practicable, in accordance with 10 U.S.C. 1089(j)(2), Medicare's OPPS reimbursement methodology to include specific coding requirements, ambulatory payment classifications (APCs), nationally established APC amounts and associated adjustments (e.g., discounting across geographical regions and outlier calculations).

(C) While TRICARE intends to remain as true as possible to Medicare's basic OPPS methodology, there will be some deviations required to accommodate TRICARE's unique benefit structure and beneficiary population as authorized under the provisions of 10 U.S.C. 1079(j)(2).

(D) TRICARE is also authorized to deviate from Medicare's basic OPPS methodology to establish special reimbursement methods, amounts, and procedures to encourage use of

high-value products and discourage use of low-value products with respect to pharmaceutical agents provided as part of medical services from authorized providers. Therefore, drugs administered other than oral method provided on an outpatient basis by hospitals are paid on the same basis as drugs administered other than oral method covered by the allowable charge method under paragraph (j)(1) of this section.

(E) Temporary transitional payment adjustments (TTPAs). Temporary transitional payment adjustments will be in place for all hospitals, both network and non-network, in order to buffer the initial decline in payments upon implementation of TRICARE's OPPS.

(1) For network hospitals. The temporary transitional payment adjustments will cover a four-year period. The four-year transition will set higher payment percentages for the ten Ambulatory Payment Classification (APC) codes 604-609 and 613-616, with reductions in each of the transition years. For non-network hospitals, the adjustments will cover a three year period, with reductions in each of the transition years. For network hospitals, under the TTPAs, the APC payment level for the five clinic visit APCs would be set at 175 percent of the Medicare APC level, while the five ER visit APCs would be increased by 200 percent in the first year of OPPS implementation. In the second year, the APC payment levels would be set at 150 percent of the Medicare APC level for clinic visits and 175 percent for ER APCs. In the third year, the APC visit amounts would be set at 130 percent of the Medicare APC level for clinic visits and 150 percent for ER APCs. In the fourth year, the APC visit amounts would be set at 115 percent of the Medicare APC level for clinic visits and 130 percent for ER APCs. In the fifth year, the TRICARE and Medicare payment levels for the 10 APC visit codes would be identical.

(2) For non-network hospitals. Under the TTPAs, the APC payment level for the five clinic and ER visit APCs would be set at 140 percent of the Medicare APC level in the first year of OPPS implementation. In the second year, the APC payment levels would be set at 125 percent of the Medicare APC level for clinic and ER visits. In the third year, the APC visit amounts would be set at 110 percent of the Medicare APC level for clinic and ER visits. In the fourth year, the TRICARE and Medicare payment levels for the 10 APC visit codes would be identical.

(3) An additional temporary military contingency payment adjustment (TMCPA) will also be available at the discretion of the Director, Defense Health Agency (DHA), or a designee, at any time after implementation to adopt, modify and/or extend temporary adjustments to OPPS payments for TRICARE network hospitals deemed essential for military readiness and deployment in time of contingency operations. Any TMCPAs to OPPS payments shall be made only on the basis of a determination that it is impracticable to support military readiness or contingency operations by making OPPS payments in accordance with the same reimbursement rules implemented by Medicare. The criteria for adopting, modifying, and/or extending deviations and/or adjustments to OPPS payments shall be issued through TRICARE policies, instructions, procedures and guidelines as deemed appropriate by the Director, DHA, or a designee. TMCPAs may also be extended to non-network hospitals on a case-by-case basis for specific procedures where it is determined that the procedures cannot be obtained timely enough from a network hospital. For such case-by-case extensions, "Temporary" might be less than three years at the discretion of the DHA Director, or designee.

(iii) Outpatient Services Subject to CAH Reasonable Cost Method. For services on or after December 1, 2009, outpatient services provided by a CAH, shall be reimbursed at 101 percent of reasonable cost. This does not include any costs of physician services or other professional services provided to CAH outpatients.

(iv) CAH Ambulance Services. Effective for services provided on or after December 1, 2009, payment for ambulance services furnished by a CAH or an entity that is owned and operated by a CAH is the reasonable costs of the CAH or the entity in furnishing those services, but only if the CAH or the entity is the only provider or supplier of ambulance services located within a 35-mile drive of the CAH or the entity as specified under 42 CFR part 413.70(b)(5)(ii).

(7) Reimbursement for inpatient services provided by an SCH. (i) In accordance with 10 U.S.C. 1079(j)(2), TRICARE payment methods for institutional care shall be determined, to the extent practicable, in accordance with the same reimbursement rules as those that apply to payments to providers of services of the same type under Medicare. TRICARE's SCH reimbursements approximate Medicare's for SCHs. Inpatient services provided by an SCH, other than services provided in psychiatric and rehabilitation distinct part units, shall be reimbursed through a two-step process.

(ii) The first step referred to in paragraph (a)(7)(i) of this section will be to calculate the TRICARE allowable cost by multiplying the applicable TRICARE percentage by the billed charge amount on each institutional inpatient claim. The applicable TRICARE percentage is the greater of: the SCH's most recently available cost-to-charge ratio (CCR) from the Centers for Medicare and Medicaid Services' (CMS') inpatient Provider Specific File (after the ratio has been converted to a percentage), or the TRICARE allowed-to-billed ratio, defined as the ratio of the TRICARE allowed amounts (including discounts) to the amount of billed charges for TRICARE inpatient admissions at the SCH in FY 2012 (after it has been converted to a percentage). The TRICARE allowed-to-billed ratio in FY 2012 shall be reduced as follows (after the ratio has been converted to a percentage:

(A) In the first year of implementation, 10 percentage points for network SCHs and 15 percentage points for non-network SCHs.

(B) In the second year of implementation, 20 percentage points for network SCHs and 30 percentage points for non-network SCHs.

(C) In the third year of implementation, 30 percentage points for network SCHs and 45 percentage points for non-network SCHs.

(D) In the fourth year of implementation, 40 percentage points for network SCHs and 60 percentage points for non-network SCHs.

(E) In the fifth year of implementation, 50 percentage points for network SCHs and 75 percentage points for non-network SCHs.

(F) In the sixth year of implementation, 60 percentage points for network SCHs and 90 percentage points for non-network SCHs.

(G) In the seventh year of implementation, 70 percentage points for network SCHs and 100

percentage points for non-network SCHs.

(H) In the eighth year of implementation, 80 percentage points for network SCHs and 100 percentage points for non-network SCHs.

(I) In the ninth year of implementation, 90 percentage points for network SCHs and 100 percentage points for non-network SCHs.

(J) In the tenth year of implementation, 100 percentage points for network SCHs and 100 percentage points for non-network SCHs.

(iii) The second step referred to in paragraph (a)(7)(i) of this section is a year-end adjustment. The year-end adjustment will compare the aggregate allowable costs over a 12-month period under paragraph (a)(7)(ii) of this section to the aggregate amount that would have been allowed for the same care using the TRICARE DRG-method (under paragraph (a)(1) of this section). In the event that the DRG method amount is the greater, the year-end adjustment will be the amount by which it exceeds the aggregate allowable costs. In addition, the year-end adjustment also may incorporate a possible upward adjustment for inpatient services based on a GTMCPA for TRICARE network hospitals under paragraph (a)(8) of this section.

(iv) At the end of an SCH's transition period, when the SCH reaches its Medicare CCR, a special allowable cost shall be applicable for discharges that group to inpatient nursery and labor/delivery DRGs. For these discharges, instead of using the percentage of the SCH's Medicare cost-to-charge ratio (as described in paragraph (a)(7)(ii) of this section), the percentage will be 130 percent of the Medicare CCR.

(v) The SCH reimbursement provisions of paragraphs (a)(7)(i) through (iv) of this section do not apply to any costs of physician services or other professional services provided to SCH inpatients (which are subject to individual provider payment provisions of this section), inpatient services provided in psychiatric distinct part units (which are subject to the CHAMPUS mental health per-diem payment system), or inpatient services provided in rehabilitation distinct part units (which are reimbursed on the basis of billed charges or set rates).

(vi) The SCH payment system under this paragraph (a)(7) applies to hospitals classified by CMS as Essential Access Community Hospitals (EACHs).

(vii) The SCH payment system under this paragraph (a)(7) does not apply to hospitals in States that are paid by Medicare and TRICARE under a cost containment waiver.

(8) General temporary military contingency payment adjustment for SCHs and CAHs. (i) Payments under paragraph (a) of this section for inpatient services provided by SCHs and CAHs may be supplemented by a GTMCPA. This is a year-end discretionary, temporary adjustment that the TMA Director may approve based on all the following criteria:

(A) The hospital serves a disproportionate share of ADSMs and ADDs;

(B) The hospital is a TRICARE network hospital;

(C) The hospital's actual costs for inpatient services exceed TRICARE payments or other extraordinary economic circumstance exists; and,

(D) Without the GTMCPA, DoD's ability to meet military contingency mission requirements will be significantly compromised.

(ii) Policy and procedural instructions implementing the GTMCPA will be issued as deemed appropriate by the Director, TMA, or a designee. As with other discretionary authority under this Part, a decision to allow or deny a GTMCPA to a hospital is not subject to the appeal and hearing procedures of Sec. 199.10.

(9) Reimbursement for inpatient services provided by a Long Term Care Hospital (LTCH). (i) In accordance with 10 U.S.C. 1079(i)(2), TRICARE payment methods for institutional care shall be determined, to the extent practicable, in accordance with the same reimbursement rules as those that apply to payments to providers of services of the same type under Medicare. The TRICARE-LTC-DRG reimbursement methodology shall be in accordance with Medicare's Medicare Severity Long Term Care Diagnosis Related Groups (MS-LTC-DRGs) as found in regulation at 42 CFR part 412, subpart O. Inpatient services provided in hospitals subject to the Medicare LTCH Prospective Payment System (PPS) and classified as LTCHs and also as specified in 42 CFR parts 412 and 413 will be paid in accordance with the provisions outlined in sections 1886(d)(1)(B)(IV) and 1886(m)(6) of the Social Security Act and its implementing Medicare regulation (42 CFR parts 412, 413, and 170) to the extent practicable. Under the above governing provisions, TRICARE will recognize, to the extent practicable, in accordance with 10 U.S.C. 1079(i)(2), Medicare's LTCH PPS methodology to include the relative weights, inpatient operating and capital costs of furnishing covered services (including routine and ancillary services), interrupted stay policy, short-stay and high cost outlier payments, site-neutral payments, wage adjustments for variations in labor-related costs across geographical regions, cost-of-living adjustments, payment adjustments associated with the quality reporting program, method of payment for preadmission services, and updates to the system. TRICARE will not be adopting Medicare's 25 percent threshold payment adjustment.

Note to paragraph (a)(9)(i): LTCH admissions that are in response to the COVID-19 declared PHE and occur during the COVID-19 PHE period will be reimbursed the LTCH PPS standard Federal rate.

(ii) Implementation of the TRICARE LTCH PPS will include a gradual transition to full implementation of the Medicare LTCH PPS rates as follows:

(A) For the first 12 months following implementation, the TRICARE LTCH PPS allowable cost will be 135 percent of Medicare LTCH PPS amounts.

(B) For the second 12 months of implementation, TRICARE LTCH PPS allowable cost will be 115 percent of the Medicare LTCH PPS amounts.

(C) For the third 12 months of implementation, and subsequent years, TRICARE LTCH PPS allowable cost will be 100 percent of the Medicare LTCH PPS amounts.

(iii) Exemption. The TRICARE LTCH PPS methodology under this paragraph does not apply to hospitals in States that are reimbursed by Medicare and TRICARE under a waiver

that exempts them from Medicare's inpatient prospective payment system or the TRICARE DRG-based payment system, to Children's Hospitals, or to Neoplastic Disease Care Hospitals, respectively.

(10) Reimbursement for inpatient services provided by Inpatient Rehabilitation Facilities (IRF). (i) In accordance with 10 U.S.C. 1079(i)(2), TRICARE payment methods for institutional care shall be determined to the extent practicable, in accordance with the same reimbursement rules as those that apply to payments to providers of services of the same type under Medicare. The TRICARE IRF PPS reimbursement methodology shall be in accordance with Medicare's IRF PPS as found in 42 CFR part 412. Inpatient services provided in IRFs subject to the Medicare IRF prospective payment system (PPS) and classified as IRFs and also as specified in 42 CFR 412.604 will be paid in accordance with the provisions outlined in section 1886(j) of the Social Security Act and its implementing Medicare regulation found at 42 CFR part 412, subpart P to the extent practicable. Under the above governing provisions, TRICARE will recognize, to the extent practicable, in accordance with 10 U.S.C. 1079(i)(2), Medicare's IRF PPS methodology to include the relative weights, payment rates covering all operating and capitals costs of furnishing rehabilitative services adjusted for wage variations in labor-related costs across geographical regions, adjustments for the 60 percent compliance threshold, teaching adjustment, rural adjustment, high-cost outlier payments, low income payment adjustment, payment adjustments associated with the quality reporting program, and updates to the system.

(ii) Implementation of the TRICARE IRF PPS will include a gradual transition to full implementation of the Medicare IRF PPS rates as follows:

(A) For the first 12 months of implementation, the TRICARE IRF PPS allowable cost will be 135 percent of Medicare IRF PPS amounts.

(B) For the second 12 months of implementation, the TRICARE IRF PPS allowable cost will be 115 percent of the Medicare IRF PPS amounts.

(C) For the third 12 months of implementation, and subsequent years, the TRICARE IRF PPS allowable cost will be 100 percent of the Medicare IRF PPS amounts.

(iii) The IRF PPS allowable cost in paragraph (a)(10)(ii) of this section may be supplemented by an inpatient general temporary military contingency payment adjustment (GTMCPA) for TRICARE authorized IRFs.

(A) This is a year-end discretionary, temporary adjustment that the Director, DHA (or designee) may approve based on the following criteria:

(1) The IRF serves a disproportionate share of ADSMs and ADDs;

(2) The IRF is a TRICARE network hospital;

(3) The IRF's actual costs for inpatient services exceed TRICARE payments or other extraordinary economic circumstance exists; and

(4) Without the GTMCPA, DoD's ability to meet military contingency mission requirements will be significantly compromised.

(B) Policy and procedural instructions implementing the GTMCPA will be issued as deemed appropriate by the Director, DHA (or designee). As with other discretionary authority under this part, a decision to allow or deny a GTMCPA to an IRF is not subject to the appeal and hearing procedures of Sec. 199.10.

(iv) Exemption. The TRICARE IRF PPS methodology under this paragraph does not apply to hospitals in States that are reimbursed by Medicare and TRICARE under a waiver that exempts them from Medicare's inpatient prospective payment system or the TRICARE DRG-based payment system, to Children's hospitals, or to VA hospitals, respectively.

(b) Skilled nursing facilities (SNFs). (1) Use of Medicare prospective payment system and rates. TRICARE payments to SNFs are determined using the same methods and rates used under the Medicare prospective payment system for SNFs under 42 CFR part 413, subpart J, except for children under age ten. SNFs receive a per diem payment of a predetermined Federal payment rate appropriate for the case based on patient classification (using the RUG classification system), urban or rural location of the facility, and area wage index.

(2) Payment in full. The SNF payment rates represent payment in full (subject to any applicable beneficiary cost shares) for all costs (routine, ancillary, and capital-related) associated with furnishing inpatient SNF services to TRICARE beneficiaries other than costs associated with operating approved educational activities.

(3) Education costs. Costs for approved educational activities shall be subject to separate payment under procedures established by the Director, TRICARE Management Activity. Such procedures shall be similar to procedures for payments for direct medical education costs of hospitals under paragraph (a)(1)(iii)(G)*(2)* of this section.

(4) Resident assessment data. SNFs are required to submit the same resident assessment data as is required under the Medicare program. (The residential assessment is addressed in the Medicare regulations at 42 CFR 483.20.) SNFs must submit assessments according to an assessment schedule. This schedule must include performance of patient assessments on the 5th, 14th, and 30th days of SNF care and at each successive 30 day interval of SNF admissions that are longer than 30 days. It must also include such other assessments that are necessary to account for changes in patient care needs. TRICARE pays a default rate for the days of a patient's care for which the SNF has failed to comply with the assessment schedule.

(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, with the exception of ambulatory surgery procedures performed in hospital outpatient departments or in CAHs, which are to be reimbursed in accordance with the provisions of paragraph (a)(6)(ii) or (a)(6)(iii) respectively, of this section. This payment method is similar to that used by the Medicare program for ambulatory surgery. This paragraph applies to payment for 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 the paragraph shall be published periodically by the Director, TRICARE Management Activity (TMA). 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:

(i) 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.

(ii) 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.

(iii) 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.

(iv) 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. For cases in which the standard payment amount per group exceeds the CHAMPUS-determined inpatient allowable amount, the Director, TSO or his designee, may make adjustments.

(v) 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 section.

(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. 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.

(2) 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.

(3) Extraordinary maternity care services, when otherwise authorized, may be reimbursed at the lesser of the billed charge or the CHAMPUS allowable charge.

(4) Reimbursement for an incomplete course of care will be limited to claims for professional services and tests where the beneficiary has been screened but rejected for admission into the birthing center program, or where the woman has been admitted but is discharged from the birthing center program prior to delivery, adjudicated as individual professional services and items.

(5) The beneficiary's share of the total reimbursement to a birthing center is limited to the cost-share amount plus the amount billed for non-covered services and supplies.

(f) Reimbursement of Residential Treatment Centers. The CHAMPUS rate is the per diem rate that CHAMPUS will authorize for all mental health services rendered to a patient and the patient's family as part of the total treatment plan submitted by a CHAMPUS-approved RTC, and approved by the Director, OCHAMPUS, or designee.

(1) The all-inclusive per diem rate for RTCs operating or participating in CHAMPUS during the base period of July 1, 1987, through June 30, 1988, will be the lowest of the following conditions:

(i) The CHAMPUS rate paid to the RTC for all-inclusive services as of June 30, 1988,

adjusted by the Consumer Price Index--Urban (CPI-U) for medical care as determined applicable by the Director, OCHAMPUS, or designee; or

(ii) The per diem rate accepted by the RTC from any other agency or organization (public or private) that is high enough to cover one-third of the total patient days during the 12-month period ending June 30, 1988, adjusted by the CPI-U; or

NOTE: The per diem rate accepted by the RTC from any other agency or organization includes the rates accepted from entities such as Government contractors in CHAMPUS demonstration projects.

(iii) An OCHAMPUS determined capped per diem amount not to exceed the 80th percentile of all established CHAMPUS RTC rates nationally, weighted by total CHAMPUS days provided at each rate during the base period discussed in paragraph (f)(1) of this section.

(2) The all-inclusive per diem rates for RTCs which began operation after June 30, 1988, or began operation before July 1, 1988, but had less than 6 months of operation by June 30, 1988, will be calculated based on the lower of the per diem rate accepted by the RTC that is high enough to cover one-third of the total patient days during its first 6 to 12 consecutive months of operation, or the CHAMPUS determined capped amount. Rates for RTCs beginning operation prior to July 1, 1988, will be adjusted by an appropriate CPI-U inflation factor for the period ending June 30, 1988. A period of less than 12 months will be used only when the RTC has been in operation for less than 12 months. Once a full 12 months is available, the rate will be recalculated.

(3) For care on or after April 6, 1995, the per diem amount may not exceed a cap of the 70th percentile of all established Federal fiscal year 1994 RTC rates nationally, weighted by total CHAMPUS days provided at each rate during the first half of Federal fiscal year 1994, and updated to FY95. For Federal fiscal years 1996 and 1997, the cap shall remain unchanged. For Federal fiscal years after fiscal year 1997, the cap shall be adjusted by the Medicare update factor for hospitals and units exempt from the Medicare prospective payment system.

(4) All educational costs, whether they include routine education or special education costs, are excluded from reimbursement except when appropriate education is not available from, or not payable by, a cognizant public entity.

(i) The RTC shall exclude educational costs from its daily costs.

(ii) The RTC's accounting system must be adequate to assure CHAMPUS is not billed for educational costs.

(iii) The RTC may request payment of educational costs on an individual case basis from the Director, OCHAMPUS, or designee, when appropriate education is not available from, or not payable by, a cognizant public entity. To qualify for reimbursement of educational costs in individual cases, the RTC shall comply with the application procedures established by the Director, OCHAMPUS, or designee, including, but not limited to, the following:

(A) As part of its admission procedures, the RTC must counsel and assist the beneficiary and the beneficiary's family in the necessary procedures for assuring their rights to a free and

appropriate public education.

(B) The RTC must document any reasons why an individual beneficiary cannot attend public educational facilities and, in such a case, why alternative educational arrangements have not been provided by the cognizant public entity.

(C) If reimbursement of educational costs is approved for an individual beneficiary by the Director, OCHAMPUS, or designee, such educational costs shall be shown separately from the RTC's daily costs on the CHAMPUS claim. The amount paid shall not exceed the RTC's most-favorable rate to any other patient, agency, or organization for special or general educational services whichever is appropriate.

(D) If the RTC fails to request CHAMPUS approval of the educational costs on an individual case, the RTC agrees not to bill the beneficiary or the beneficiary's family for any amounts disallowed by CHAMPUS. Requests for payment of educational costs must be referred to the Director, OCHAMPUS, or designee for review and a determination of the applicability of CHAMPUS benefits.

(5) Subject to the applicable RTC cap, adjustments to the RTC rates may be made annually.

(i) For Federal fiscal years through 1995, the adjustment shall be based on the Consumer Price Index-Urban (CPI-U) for medical care as determined applicable by the Director, OCHAMPUS.

(ii) For purposes of rates for Federal fiscal years 1996 and 1997:

(A) For any RTC whose 1995 rate was at or above the thirtieth percentile of all established Federal fiscal year 1995 RTC rates normally, weighted by total CHAMPUS days provided at each rate during the first half of Federal fiscal year 1994, that rate shall remain in effect, with no additional update, throughout fiscal years 1996 and 1997; and

(B) For any RTC whose 1995 rate was below the 30th percentile level determined under paragraph (f)(5)(ii)(A) of this section, the rate shall be adjusted by the lesser of: the CPI-U for medical care, or the amount that brings the rate up to that 30th percentile level.

(iii) For subsequent Federal fiscal years after fiscal year 1997, RTC rates shall be updated by the Medicare update factor for hospitals and units exempt from the Medicare prospective payment system.

(6) For care provided on or after July 1, 1995, CHAMPUS will not pay for days in which the patient is absent on leave from the RTC. The RTC must identify these days when claiming reimbursement.

(g) Reimbursement of hospice programs. Hospice care will be reimbursed at one of four predetermined national CHAMPUS rates based on the type and intensity of services furnished to the beneficiary. A single rate is applicable for each day of care except for continuous home care where payment is based on the number of hours of care furnished during a 24-hour period. These rates will be adjusted for regional differences in wages using wage indices for hospice care.

(1) National hospice rates. CHAMPUS will use the national hospice rates for reimbursement of each of the following levels of care provided by or under arrangement with a CHAMPUS approved hospice program:

(i) Routine home care. The hospice will be paid the routine home care rate for each day the patient is at home, under the care of the hospice, and not receiving continuous home care. This rate is paid without regard to the volume or intensity of routine home care services provided on any given day.

(ii) Continuous home care. The hospice will be paid the continuous home care rate when continuous home care is provided. The continuous home care rate is divided by 24 hours in order to arrive at an hourly rate.

(A) A minimum of 8 hours of care must be provided within a 24-hour day starting and ending at midnight.

(B) More than half of the total actual hours being billed for each 24-hour period must be provided by either a registered or licensed practical nurse.

(C) Homemaker and home health aide services may be provided to supplement the nursing care to enable the beneficiary to remain at home.

(D) For every hour or part of an hour of continuous care furnished, the hourly rate will be reimbursed to the hospice up to 24 hours a day.

(iii) Inpatient respite care. The hospice will be paid at the inpatient respite care rate for each day on which the beneficiary is in an approved inpatient facility and is receiving respite care.

(A) Payment for respite care may be made for a maximum of 5 days at a time, including the date of admission but not counting the date of discharge. The necessity and frequency of respite care will be determined by the hospice interdisciplinary group with input from the patient's attending physician and the hospice's medical director.

(B) Payment for the sixth and any subsequent days is to be made at the routine home care rate.

(iv) General inpatient care. Payment at the inpatient rate will be made when general inpatient care is provided for pain control or acute or chronic symptom management which cannot be managed in other settings. None of the other fixed payment rates (i.e., routine home care) will be applicable for a day on which the patient receives general inpatient care except on the date of discharge.

(v) Date of discharge. For the day of discharge from an inpatient unit, the appropriate home care rate is to be paid unless the patient dies as an inpatient. When the patient is discharged deceased, the inpatient rate (general or respite) is to be paid for the discharge date.

(2) Use of Medicare rates. CHAMPUS will use the most current Medicare rates to reimburse hospice programs for services provided to CHAMPUS beneficiaries. It is

CHAMPUS' intent to adopt changes in the Medicare reimbursement methodology as they occur; e.g., Medicare's adoption of an updated, more accurate wage index.

(3) Physician reimbursement. Payment is dependent on the physician's relationship with both the beneficiary and the hospice program.

(i) Physicians employed by, or contracted with, the hospice. (A) Administrative and supervisory activities (i.e., establishment, review and updating of plans of care, supervising care and services, and establishing governing policies) are included in the adjusted national payment rate.

(B) Direct patient care services are paid in addition to the adjusted national payment rate.

(1) Physician services will be reimbursed an amount equivalent to 100 percent of the CHAMPUS' allowable charge; i.e., there will be no cost-sharing and/or deductibles for hospice physician services.

(2) Physician payments will be counted toward the hospice cap limitation.

(ii) Independent attending physician. Patient care services rendered by an independent attending physician (a physician who is not considered employed by or under contract with the hospice) are not part of the hospice benefit.

(A) Attending physician may bill in his/her own right.

(B) Services will be subject to the appropriate allowable charge methodology.

(C) Reimbursement is not counted toward the hospice cap limitation.

(D) Services provided by an independent attending physician must be coordinated with any direct care services provided by hospice physicians.

(E) The hospice must notify the CHAMPUS contractor of the name of the physician whenever the attending physician is not a hospice employee.

(iii) Voluntary physician services. No payment will be allowed for physician services furnished voluntarily (both physicians employed by, and under contract with, the hospice and independent attending physicians). Physicians may not discriminate against CHAMPUS beneficiaries; e.g., designate all services rendered to non-CHAMPUS patients as volunteer and at the same time bill for CHAMPUS patients.

(4) Unrelated medical treatment. Any covered CHAMPUS services not related to the treatment of the terminal condition for which hospice care was elected will be paid in accordance with standard reimbursement methodologies; i.e., payment for these services will be subject to standard deductible and cost-sharing provisions under the CHAMPUS. A determination must be made whether or not services provided are related to the individual's terminal illness. Many illnesses may occur when an individual is terminally ill which are brought on by the underlying condition of the ill patient. For example, it is not unusual for a terminally ill patient to develop pneumonia or some other illness as a result of his or her weakened condition. Similarly, the setting of bones after fractures occur in a bone cancer

patient would be treatment of a related condition. Thus, if the treatment or control of an upper respiratory tract infection is due to the weakened state of the terminal patient, it will be considered a related condition, and as such, will be included in the hospice daily rates.

(5) Cap amount. Each CHAMPUS-approved hospice program will be subject to a cap on aggregate CHAMPUS payments from November 1 through October 31 of each year, hereafter known as "the cap period."

(i) The cap amount will be adjusted annually by the percent of increase or decrease in the medical expenditure category of the Consumer Price Index for all urban consumers (CPI-U).

(ii) The aggregate cap amount (i.e., the statutory cap amount times the number of CHAMPUS beneficiaries electing hospice care during the cap period) will be compared with total actual CHAMPUS payments made during the same cap period.

(iii) Payments in excess of the cap amount must be refunded by the hospice program. The adjusted cap amount will be obtained from the Health Care Financing Administration (HCFA) prior to the end of each cap period.

(iv) Calculation of the cap amount for a hospice which has not participated in the program for an entire cap year (November 1 through October 31) will be based on a period of at least 12 months but no more than 23 months. For example, the first cap period for a hospice entering the program on October 1, 1994, would run from October 1, 1994 through October 31, 1995. Similarly, the first cap period for hospice providers entering the program after November 1, 1993 but before November 1, 1994 would end October 31, 1995.

(6) Inpatient limitation. During the 12-month period beginning November 1 of each year and ending October 31, the aggregate number of inpatient days, both for general inpatient care and respite care, may not exceed 20 percent of the aggregate total number of days of hospice care provided to all CHAMPUS beneficiaries during the same period.

(i) If the number of days of inpatient care furnished to CHAMPUS beneficiaries exceeds 20 percent of the total days of hospice care to CHAMPUS beneficiaries, the total payment for inpatient care is determined follows:

(A) Calculate the ratio of the maximum number of allowable inpatient days of the actual number of inpatient care days furnished by the hospice to Medicare patients.

(B) Multiply this ratio by the total reimbursement for inpatient care made by the CHAMPUS contractor.

(C) Multiply the number of actual inpatient days in excess of the limitation by the routine home care rate.

(D) Add the amounts calculated in paragraphs (g)(6)(i)(B) and (C) of this section.

(ii) Compare the total payment for inpatient care calculated in paragraph (g)(6)(i)(D) of this section to actual payments made to the hospice for inpatient care during the cap period.

(iii) Payments in excess of the inpatient limitation must be refunded by the hospice

program.

(7) Hospice reporting responsibilities. The hospice is responsible for reporting the following data within 30 days after the end of the cap period:

(i) Total reimbursement received and receivable for services furnished CHAMPUS beneficiaries during the cap period, including physician's services not of an administrative or general supervisory nature.

(ii) Total reimbursement received and receivable for general inpatient care and inpatient respite care furnished to CHAMPUS beneficiaries during the cap period.

(iii) Total number of inpatient days furnished to CHAMPUS hospice patients (both general inpatient and inpatient respite days) during the cap period.

(iv) Total number of CHAMPUS hospice days (both inpatient and home care) during the cap period.

(v) Total number of beneficiaries electing hospice care. The following rules must be adhered to by the hospice in determining the number of CHAMPUS beneficiaries who have elected hospice care during the period:

(A) The beneficiary must not have been counted previously in either another hospice's cap or another reporting year.

(B) The beneficiary must file an initial election statement during the period beginning September 28 of the previous cap year through September 27 of the current cap year in order to be counted as an electing CHAMPUS beneficiary during the current cap year.

(C) Once a beneficiary has been included in the calculation of a hospice cap amount, he or she may not be included in the cap for that hospice again, even if the number of covered days in a subsequent reporting period exceeds that of the period where the beneficiary was included.

(D) There will be proportional application of the cap amount when a beneficiary elects to receive hospice benefits from two or more different CHAMPUS-certified hospices. A calculation must be made to determine the percentage of the patient's length of stay in each hospice relative to the total length of hospice stay.

(8) Reconsideration of cap amount and inpatient limit. A hospice dissatisfied with the contractor's calculation and application of its cap amount and/or inpatient limitation may request and obtain a contractor review if the amount of program reimbursement in controversy--with respect to matters which the hospice has a right to review--is at least $1000. The administrative review by the contractor of the calculation and application of the cap amount and inpatient limitation is the only administrative review available. These calculations are not subject to the appeal procedures set forth in Sec. 199.10. The methods and standards for calculation of the hospice payment rates established by CHAMPUS, as well as questions as to the validity of the applicable law, regulations or CHAMPUS decisions, are not subject to administrative review, including the appeal procedures of Sec. 199.10.

(9) Beneficiary cost-sharing. There are no deductibles under the CHAMPUS hospice benefit. CHAMPUS pays the full cost of all covered services for the terminal illness, except for small cost-share amounts which may be collected by the individual hospice for outpatient drugs and biologicals and inpatient respite care.

(i) The patient is responsible for 5 percent of the cost of outpatient drugs or $5 toward each prescription, whichever is less. Additionally, the cost of prescription drugs (drugs or biologicals) may not exceed that which a prudent buyer would pay in similar circumstances; that is, a buyer who refuses to pay more than the going price for an item or service and also seeks to economize by minimizing costs.

(ii) For inpatient respite care, the cost-share for each respite care day is equal to 5 percent of the amount CHAMPUS has estimated to be the cost of respite care, after adjusting the national rate for local wage differences.

(iii) The amount of the individual cost-share liability for respite care during a hospice cost-share period may not exceed the Medicare inpatient hospital deductible applicable for the year in which the hospice cost-share period began. The individual hospice cost-share period begins on the first day an election is in effect for the beneficiary and ends with the close of the first period of 14 consecutive days on each of which an election is not in effect for the beneficiary.

(h) Reimbursement of Home Health Agencies (HHAs). HHAs will be reimbursed using the same methods and rates as used under the Medicare HHA prospective payment system under Section 1895 of the Social Security Act (42 U.S.C. 1395fff) and 42 CFR Part 484, Subpart E except as otherwise necessary to recognize distinct characteristics of TRICARE beneficiaries and as described in instructions issued by the Director, TMA. Under this methodology, an HHA will receive a fixed case-mix and wage-adjusted national 60-day episode payment amount as payment in full for all costs associated with furnishing home health services to TRICARE-eligible beneficiaries with the exception of osteoporosis drugs and DME. The full case-mix and wage-adjusted 60-day episode amount will be payment in full subject to the following adjustments and additional payments:

(1) Split percentage payments. The initial percentage payment for initial episodes is paid to an HHA at 60 percent of the case-mix and wage adjusted 60-day episode rate. The residual final payment for initial episodes is paid at 40 percent of the case-mix and wage adjusted 60-day episode rate subject to appropriate adjustments. The initial percentage payment for subsequent episodes is paid at 50 percent of the case-mix and wage-adjusted 60-day episode rate. The residual final payment for subsequent episodes is paid at 50 percent of the case-mix and wage-adjusted 60-day episode rate subject to appropriate adjustments.

(2) Low-utilization payment. A low utilization payment is applied when a HHA furnishes four or fewer visits to a beneficiary during the 60-day episode. The visits are paid at the national per-visit amount by discipline updated annually by the applicable market basket for each visit type.

(3) Partial episode payment (PEP). A PEP adjustment is used for payment of an episode of less than 60 days resulting from a beneficiary's elected transfer to another HHA prior to the end of the 60-day episode or discharge and readmission of a beneficiary to the same HHA before the end of the 60-day episode. The PEP payment is calculated by multiplying the

proportion of the 60-day episode during which the beneficiary remained under the care of the original HHA by the beneficiary's assigned 60-day episode payment.

(4) Significant change in condition (SCIC). The full-episode payment amount is adjusted if a beneficiary experiences a significant change in condition during the 60-day episode that was not envisioned in the initial treatment plan. The total significant change in condition payment adjustment is a proportional payment adjustment reflecting the time both prior to and after the patient experienced a significant change in condition during the 60-day episode. The initial percentage payment provided at the start of the 60-day episode will be adjusted at the end of the episode to reflect the first and second parts of the total SCIC adjustment determined at the end of the 60-day episode. The SCIC payment adjustment is calculated in two parts:

(i) The first part of the SCIC payment adjustment reflects the adjustment to the level of payment prior to the significant change in the patient's condition during the 60-day episode.

(ii) The second part of the SCIC payment adjustment reflects the adjustment to the level of payment after the significant change in the patient's condition occurs during the 60-day episode.

(5) Outlier payment. Outlier payments are allowed in addition to regular 60-day episode payments for beneficiaries generating excessively high treatment costs. The following methodology is used for calculation of the outlier payment:

(i) TRICARE makes an outlier payment for an episode whose estimated cost exceeds a threshold amount for each case-mix group.

(ii) The outlier threshold for each case-mix group is the episode payment amount for that group, the PEP adjustment amount for the episode or the total significant change in condition adjustment amount for the episode plus a fixed dollar loss amount that is the same for all case-mix groups.

(iii) The outlier payment is a proportion of the amount of estimated cost beyond the threshold.

(iv) TRICARE imputes the cost for each episode by multiplying the national per-visit amount of each discipline by the number of visits in the discipline and computing the total imputed cost for all disciplines.

(v) The fixed dollar loss amount and the loss sharing proportion are chosen so that the estimated total outlier payment is no more than the predetermined percentage of total payment under the home health PPS as set by the Centers for Medicare & Medicaid Services (CMS).

(6) Services paid outside the HHA prospective payment system. The following are services that receive a separate payment amount in addition to the prospective payment amount for home health services:

(i) Durable medical equipment (DME). Reimbursement of DME is based on the same amounts established under the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule under 42 CFR part 414, subpart D.

(ii) Osteoporosis drugs. Although osteoporosis drugs are subject to home health consolidated billing, they continue to be paid on a cost basis, in addition to episode payments.

(7) Accelerated payments. Upon request, an accelerated payment may be made to an HHA that is receiving payment under the home health prospective payment system if the HHA is experiencing financial difficulties because there is a delay by the contractor in making payment to the HHA. The following are criteria for making accelerated payments:

(i) Approval of payment. An HHA's request for an accelerated payment must be approved by the contractor and TRICARE Management Activity (TMA).

(ii) Amount of payment. The amount of the accelerated payment is computed as a percentage of the net payment for unbilled or unpaid covered services.

(iii) Recovery of payment. Recovery of the accelerated payment is made by recoupment as HHA bills are processed or by direct payment by the HHA.

(8) Assessment data. Beneficiary assessment data, incorporating the use of the current version of the OASIS items, must be submitted to the contractor for payment under the HHA prospective payment system.

(9) Administrative review. An HHA is not entitled to judicial or administrative review with regard to:

(i) Establishment of the payment unit, including the national 60-day prospective episode payment rate, adjustments and outlier payment.

(ii) Establishment of transition period, definition and application of the unit of payment.

(iii) Computation of the initial standard prospective payment amounts.

(iv) Establishment of case-mix and area wage adjustment factors.

(i) Changes in Federal Law affecting Medicare. With regard to paragraph (b) and (h) of this section, the Department of Defense must, within the time frame specified in law and to the extent it is practicable, bring the TRICARE program into compliance with any changes in Federal Law affecting the Medicare program that occur after the effective date of the DoD rule to implement the prospective payment systems for skilled nursing facilities and home health agencies.

(j) Reimbursement of individual health care professionals and other non-institutional, non-professional providers. The CHAMPUS-determined reasonable charge (the amount allowed by CHAMPUS) for the service of an individual health care professional or other non-institutional, non-professional 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--(i) Introduction--(A) 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).

(B) 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 (j)(1)(iv) of this section.

(C) 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 Sec. 199.10.

(D) Special rule for TRICARE Prime Enrollees. In the case of a TRICARE Prime enrollee (see section 199.17) who receives authorized care from a non-participating provider, the CHAMPUS determined reasonable charge will be the CMAC level as established in paragraph (j)(1)(i)(B) of this section plus any balance billing amount up to the balance billing limit as referred to in paragraph (j)(1)(i)(C) of this section. The authorization for such care shall be pursuant to the procedures established by the Director, OCHAMPUS (also referred to as the TRICARE Support Office).

(E) Special rule for certain TRICARE Standard Beneficiaries. In the case of dependent spouse or child, as defined in paragraphs (b)(2)(ii)(A) through (F) and (b)(2)(ii)(H)*(1)*, *(2)*, and *(4)* of Sec. 199.3, of a Reserve Component member serving on active duty pursuant to a call or order to active duty for a period of more than 30 days in support of a contingency operation under a provision of law referred to in section 101(a)(13)(B) of title 10, United States Code, the Director, TRICARE Management Activity, may authorize non-participating providers the allowable charge to be the CMAC level as established in paragraph (j)(l)(i)(B) of this section plus any balance billing amount up to the balance billing limit as referred to in paragraph (j)(l)(i)(C) of this section.

(ii) Prevailing charge level. (A) Beginning in calendar year 1992, the prevailing charge level shall be calculated on a national basis.

(B) The national prevailing charge level referred to in paragraph (j)(1)(ii)(A) 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).

(C) For purposes of paragraph (j)(1)(ii)(B) 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.

(iii) Appropriate charge level. Beginning in calendar year 1992, the appropriate charge level shall be calculated on a national basis. The appropriate charge level for each procedure is the product of the two-step process set forth in paragraphs (j)(1)(iii)(A) and (B) of this section. 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 year 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.

(A) Step 1: Procedures classified. All procedures are classified into one of three categories, as follows:

(1) Overpriced procedures. These are the procedures for which the prior year's national CMAC exceeds the Medicare fee.

(2) 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.

(3) Underpriced procedures. These are the procedures for which the prior year's national CMAC is less than the Medicare fee.

(B) Step 2: Calculating appropriate charge levels. For each year, appropriate charge levels will be calculated by adjusting the prior year's CMAC as follows:

(1) 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.

(2) For other procedures, the appropriate charge level for each procedure shall be the same as the prior year's CMAC.

(3) 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) Special rule for cases in which the national CMAC is less than the Medicare rate.

NOTE: This paragraph will be implemented when CMAC rates are published.

In any case in which the national CMAC calculated in accordance with paragraphs (j)(1)(i) through (iii) of this section is less than the Medicare rate, the Director, TSO, may determine that the use of the Medicare Economic Index under paragraph (j)(1)(iii)(B) of this section will result in a CMAC rate below the level necessary to assure that beneficiaries will retain adequate access to health care services. Upon making such a determination, the Director, TSO, may increase the national CMAC to a level not greater than the Medicare rate.

(iv) Calculating CHAMPUS Maximum Allowable Charge levels for localities. (A) 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.

(B) Special locality-based phase-in provision. *(1)* 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.

(2) Exception. The special locality-based phase-in provision established by paragraph (j)(1)(iv)(B)(*1*) of this 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.

(C) 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 paragraph (j)(1)(iii)(A)*(1)* of this section, 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 paragraphs (j)(1)(iii) and (j)(1)(iv) of this section may be waived pursuant to paragraph (j)(1)(iii)(C) of this section.

(1) Waiver based on balanced billing rates. Except as provided in paragraph (j)(1)(iv)(C)*(2)* of this section 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 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 waive the reduction is not subject to the appeal and hearing procedures of Sec. 199.10.

(2) Exception. As an exception to the paragraph (j)(1)(iv)(C)*(1)* of this section, the waiver required by that paragraph 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 paragraph (j)(1)(iv)(C)*(3)* of this section.

(3) 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 to that implementation. The Director, OCHAMPUS may establish procedures for handling petitions. A decision by the Director to waive or not waive a reduction is not subject to the appeal and hearing procedures of Sec. 199.10.

(D) Special locality-based exception to applicable CMACs to assure adequate beneficiary access to care. In addition to the authority to waive reductions under paragraph (j)(1)(iv)(C) of this section, the Director may authorize establishment of higher payment rates for specific services than would otherwise be allowable, under paragraph (j)(1) of this section, if the Director determines that available evidence shows that access to health care services is severely impaired. For this purpose, such evidence may include consideration of the number of providers in the locality who provide the affected services, the number of providers who are CHAMPUS participating providers, the number of CHAMPUS beneficiaries in the locality, the availability of military providers in the location or nearby, and any other factors the Director determines relevant.

(1) Procedure. Providers or beneficiaries in a locality may submit to the Director, a petition, together with appropriate documentation regarding relevant factors, for a determination that adequate access to health care services is severely impaired. The Director, will consider and respond to all petitions. A decision to authorize a higher payment amount is subject to review and determination or modification by the Director at any time if circumstances change so that adequate access to health care services would no longer be severely impaired. A decision by the Director, to authorize, not authorize, terminate, or modify authorization of higher payment amounts is not subject to the appeal and hearing procedures of Sec. 199.10 of the part.

(2) Establishing the higher payment rate(s). When the Director, determines that beneficiary access to health care services in a locality is severely impaired, the Director may establish the higher payment rate(s) as he or she deems appropriate and cost-effective through one of the following methodologies to assure adequate access:

(i) A percent factor may be added to the otherwise applicable payment amount allowable under paragraph (j)(1) of this section;

(ii) A prevailing charge may be calculated, by applying the prevailing charge methodology of paragraph (j)(1)(ii) of this section to a specific locality (which need not be the same as the

localities used for purposes of paragraph (j)(1)(iv)(A) of this section; or another government payment rate may be adopted, for example, an applicable state Medicaid rate).

(3) Application of higher payment rates. Higher payment rates defined under paragraph (j)(1)(iv)(D) of this section may be applied to all similar services performed in a locality, or, if circumstances warrant, a new locality may be defined for application of the higher payments. Establishment of a new locality may be undertaken where access impairment is localized and not pervasive across the existing locality. Generally, establishment of a new, more specific locality will occur when the area is remote so that geographical characteristics and other factors significantly impair transportation through normal means to health care services routinely available within the existing locality.

(E) Special locality-based exception to applicable CMACs to ensure an adequate TRICARE Prime preferred network. The Director, may authorize reimbursements to health care providers participating in a TRICARE preferred provider network under Sec. 199.17(p) of this part at rates higher than would otherwise be allowable under paragraph (j)(1) of this section, if the Director, determines that application of the higher rates is necessary to ensure the availability of an adequate number and mix of qualified health care providers in a network in a specific locality. This authority may only be used to ensure adequate networks in those localities designated by the Director, as requiring TRICARE preferred provider networks, not in localities in which preferred provider networks have been suggested or established but are not determined by the Director to be necessary. Appropriate evidence for determining that higher rates are necessary may include consideration of the number of available primary care and specialist providers in the network locality, availability (including reassignment) of military providers in the location or nearby, the appropriate mix of primary care and specialists needed to satisfy demand and meet appropriate patient access standards (appointment / waiting time, travel distance, etc.), the efforts that have been made to create an adequate network, other cost-effective alternatives, and other relevant factors. The Director, may establish procedures by which exceptions to applicable CMACs are requested and approved or denied under paragraph (j)(1)(iv)(E) of this section. A decision by the Director, to authorize or deny an exception is not subject to the appeal and hearing procedures of Sec. 199.10. When the Director, determines that it is necessary and cost-effective to approve a higher rate or rates in order to ensure the availability of an adequate number of qualified health care providers in a network in a specific locality, the higher rate may not exceed the lesser of the following:

(1) The amount equal to the local fee for service charge for the service in the service area in which the service is provided as determined by the Director, based on one or more of the following payment rates:

(i) Usual, customary, and reasonable;

(ii) The Health Care Financing Administration's Resource Based Relative Value Scale;

(iii) Negotiated fee schedules;

(iv) Global fees; or

(v) Sliding scale individual fee allowances.

(2) The amount equal to 115 percent of the otherwise allowable charge under paragraph (j)(1) of the section for the service.

(v) Special rules for 1991. (A) Appropriate charge levels for care provided on or after January 1, 1991, and before the 1992 appropriate levels take effect shall be the same as those in effect on December 31, 1990, except that appropriate charge levels for care provided on or after October 7, 1991, shall be those established pursuant to this paragraph (j)(1)(v) of this section.

(B) Appropriate charge levels will be established for each locality for which a appropriate 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 (j)(1)(v)(B)(*1*) through (*3*) of this section.

(1) 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.

(2) 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.

(3) 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.

(C) For purposes of this paragraph (j)(i)(v), "appropriate charge levels" in effect at any time prior to October 7, 1991 shall mean the lesser of:

(1) The prevailing charge levels then in effect, or

(2) The fiscal year 1988 prevailing charge levels adjusted by the Medicare Economic Index (MEI), as the MEI was applied beginning in the fiscal year 1989.

(vi) Special transition rule for 1992. (A) 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 (j)(1)(ii)(B) of this section), adjusted to calendar year 1991 based on the adjustments made for maximum CHAMPUS allowable charge levels through 1990 and the application of paragraph (j)(1)(v) of this section for 1991.

(B) The adjustment to calendar year 1991 of the product of paragraph (j)(1)(vi)(A) of this section shall be as follows:

(1) For procedures other than those described in paragraph (j)(1)(vi)(B)*(2)* of this section, the adjustment to 1991 shall be on the same basis as that provided under paragraph (j)(1)(v) of this section.

(2) For any procedure that was considered an overpriced procedure for purposes of the 1991 appropriate charge levels under paragraph (j)(1)(v) of this section for which the resulting 1991 appropriate 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 (j)(1)(v)(B)*(2)* of this section for purposes of the 1991 appropriate charge level.

(vii) Adjustments and procedural rules. (A) The Director, OCHAMPUS may make adjustments to the appropriate charge levels calculated pursuant to paragraphs (j)(1)(iii) and (j)(1)(v) 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.

(B) The Director, OCHAMPUS will issue procedural instructions for administration of the allowable charge method.

(viii) 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 (j)(1)(i) through (j)(1)(iv) of this section, with the following exceptions and clarifications.

(A) The calculation of national prevailing charge levels, national appropriate charge levels and national CMACs for laboratory service 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 (j)(1)(viii) of this section as the "base period").

(B) For purposes of comparison to Medicare allowable payment amounts pursuant to paragraph (j)(1)(iii) of this section, the Medicare national laboratory payment limitation amounts shall be used.

(C) For purposes of establishing laboratory service local CMACs pursuant to paragraph (j)(1)(iv) of this section, the adjustment factor shall equal the ratio of the local average charge (standardized for the distribution of clinical laboratory services) to the national average charge for all clinical laboratory services during the base period.

(D) For purposes of a special locality-based phase-in provision similar to that established by paragraph (j)(1)(iv)(B) of this section, 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.

(ix) The allowable charge for physician assistant services other than assistant-at-surgery shall be at the same percentage, used by Medicare, 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 shall be at the same percentage, used by Medicare, of the allowable

charge for a physician serving as an assistant surgeon when authorized as CHAMPUS benefits in accordance with the provisions of Sec. 199.4(c)(3)(iii). Physician assistant services must be billed through the employing physician who must be an authorized CHAMPUS provider.

(x) 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.

(xi) Pharmaceutical agents utilized as part of medically necessary medical services. In general, the TRICARE-determined allowed amount shall be equal to an amount determined to be appropriate, to the extent practicable, in accordance with the same reimbursement rules as apply to payments for similar services under Medicare. Under the authority of 10 U.S.C. 1079(q), in the case of any pharmaceutical agent utilized as part of medically necessary medical services, the Director may adopt special reimbursement methods, amounts, and procedures to encourage the use of high-value products and discourage the use of low-value products, as determined by the Director. For this purpose, the Director may obtain recommendations from the Pharmaceutical and Therapeutics Committee under Sec. 199.21 or other entities as the Director, DHA deems appropriate with respect to the relative value of products in a class of products subject to this paragraph (j)(1)(xi). Among the special reimbursement methods the Director may choose to adopt under this paragraph (j)(1)(xi) is to reimburse the average sales price of a product plus six percent of the median of the average sales prices of products in the product class or category. The Director shall issue guidance regarding the special reimbursement methods adopted and the appropriate reimbursement rates.

(2) Bonus payments in medically underserved areas. A bonus payment, in addition to the amount normally paid under the allowable charge methodology, may be made to physicians in medically underserved areas. For purposes of this paragraph, medically underserved areas are the same as those determined by the Secretary of Health and Human Services for the Medicare program. Such bonus payments shall be equal to the bonus payments authorized by Medicare, except as necessary to recognize any unique or distinct characteristics or requirements of the TRICARE program, and as described in instructions issued by the Executive Director, TRICARE Management Activity. If the Department of Health and Human Services acts to amend or remove the provision for bonus payments under Medicare, TRICARE likewise may follow Medicare in amending or removing provision for such payments.

(3) 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.

(4) 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.

(k) Reimbursement of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS). Reimbursement of DMEPOS may be based on the same amounts established under the Centers for Medicare and Medicaid Services (CMS) DMEPOS fee schedule under 42 CFR part 414, subpart D.

(l) 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 paragraph (p) of Sec. 199.1 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 professionals and other non-institutional health care providers shall be on the same basis as non-Partnership providers as detailed in paragraph (j) of this section.

(m) 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 section 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.

(i) In the case and individual health care professionals and other non-institutional providers, if the discounted fee is below the provider's normal billed charge and the prevailing charge level (see paragraph (g) of this section), the discounted fee shall be the provider's actual billed charge and the CHAMPUS allowable charge.

(ii) In the case of institutional providers normally paid on the basis of a pre-set amount (such as DRG-based amount under paragraph (a)(1) of this section or per-diem amount under paragraph (a)(2) of this section), 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. (i) This paragraph applies only 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.

(ii) The Director of OCHAMPUS may establish uniform terms, conditions and limitations for this payment method in order to avoid administrative complexity.

(n) 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.

(o) 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 section.

[55 FR 13266, Apr 10, 1990, as amended at 55 FR 31180, Aug 1, 1990; 55 FR 42562, Oct 22, 1990; 55 FR 43342, Oct 29, 1990; 56 FR 44006, Sep 6, 1991; 56 FR 50273, Oct 4, 1991; 58 FR 35408, Jul 1, 1993; 58 FR 51239, Oct 1, 1993; 58 FR 58961, Nov 5, 1993; 60 FR 6019, Feb 1, 1995; 60 FR 12437, Mar 7, 1995; 60 FR 52094, Oct 5, 1995; 63 FR 7287, Feb 13, 1998; 63 FR 48446, Sep 10, 1998; 63 FR 56082, Oct 21, 1998; 64 FR 60671, Nov 8, 1999; 65 FR 41003, Jul 3, 2000; 67 FR 45172, Aug 28, 2001; 67 FR 18115, Apr 15, 2002; 67 FR 40604, Jun 13, 2002; 69 FR 60555, Oct 12, 2004; 70 FR 61378, Oct 24, 2005; 72 FR 63988, Nov 14, 2007; 73 FR 46809, Aug 12, 2008; 73 FR 74965, Dec 10, 2008; 74 FR 44755, Aug 31, 2009; 77 FR 38175, Jun 27, 2012; 78 FR 48309, Aug 8, 2013; 79 FR 29087, May 21, 2014; 81 FR 61097, Sep 2, 2016; 82 FR 61692, Dec 29, 2017; 83 FR 63576, Dec 11, 2018; 84 FR 4333, Feb 15, 2019; 85 FR 34104, Jun 3, 2020; 85 FR 54924, Sep 3, 2020; 87 FR 33013, Jun 1, 2022]