

CHAPTER 13

DEPENDENTS DENTAL PLAN

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CHAPTER 13
DEPENDENTS DENTAL PLAN

A. GENERAL PROVISIONS.

1. Purpose. This section prescribes guidelines and policies for the delivery and administration of-the Active Duty Dependents Dental Plan of the Uniformed Services for the Army, the Navy, the Air Force, the Marine Corps, the Coast Guard, the Commissioned Corps of the U.S. Public Health **Service (USPHS)**, and the Commissioned Corps of the National Oceanic and Atmospheric Administration (NOAA).

2. Applicability

a. Geographic. This section is applicable geographically within the 50 States of the United States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, and the U.S. Virgin Islands.

b. Agency. The provisions of this section apply throughout the Department of Defense (DoD), the Coast Guard, the Commissioned Corps of the **USPHS**, and the Commissioned Corps of the NOAA.

3. Authority and responsibility

a. Legislative authority

(1) Joint regulations. 10 U.S.C. Chapter 55, 1076a authorizes the Secretary of Defense, in consultation with the Secretary of Health and Human Services and the Secretary of Transportation, to prescribe regulations for the administration of the Active Duty Dependents Dental Plan.

(2) Administration. 10 U.S.C. Chapter 55 also authorizes the Secretary of Defense to administer the Active Duty Dependents Dental Plan for the Army, Navy, Air Force, and Marine Corps under DoD jurisdiction, the Secretary of Transportation to administer the Active Duty Dependents Dental Plan for the Coast Guard, when the Coast Guard is not operating as a service in the Navy, and the Secretary of **Health** and Human Services to administer the Active Duty Dependents Dental Plan for the Commissioned Corps of the NOAA and the USPHS.

(3) Care outside the United States. 10 U.S.C., Chapter 55, 1076a authorizes the Secretary of Defense to establish basic dental benefit plans for eligible dependents of members of the uniformed services accompanying the member on permanent assignments of duty outside the United States.

b. Organizational delegations and assignments

(1) Assistant Secretary of Defense (Health Affairs) (ASD(HA)). The Secretary of Defense, by DoD Directive 5136.1 (reference(b)), delegated authority to the **ASD(HA)** to provide policy guidance, management control, and coordination as required for all DoD health and medical

resources and functional areas including health benefit programs. Implementing authority is contained in DoD 5025.1-M (reference(c)). For additional implementing authority see Chapter 1.C. of this Regulation.

(2) Evidence of eligibility. The Department of Defense, through the Defense Enrollment Eligibility Reporting System (**DEERS**), is responsible for establishing and maintaining a listing of persons eligible to receive benefits under the Active Duty Dependents Dental Plan.

4. Active duty dependents dental benefit plan. This is a program of dental benefits provided by the U.S. Government under public law to specified categories of individuals who are qualified for these benefits by virtue of their relationship to one of the seven Uniformed Services, and their voluntary decision to accept enrollment in the program and cost-share with the Government in the premium cost of the benefits. The Dependents Dental Plan is an insurance, service, or prepayment plan involving a contract guaranteeing the indemnification or payment of the enrolled member's dependents against a specified loss in return for a premium paid. Where state regulations, charter requirements, or other provisions of state and local regulation governing dental insurance and prepayment programs conflict with Federal law and regulation governing this Program, Federal law and regulation shall govern. Otherwise, this Program shall comply with state and local regulatory requirements.

5. Plan funds

a. Funding sources. The funds used by the Active Duty Dependents Dental Plan are **appropriated** funds furnished by the Congress through the annual appropriation acts for the Department of Defense and the Department of Health and Human Services and funds collected by the Uniformed Services monthly through payroll deductions as premium **shares** from enrolled members,

b. Disposition of funds. Plan funds are paid by the Government as premiums to an insurer, service, or **prepaid** dental care organization under a contract negotiated by the Director, **OCHAMPUS**, or a designee, under the provisions of the Federal Acquisition Regulation (FAR).

c. Plan. The Director, **OCHAMPUS** or designee provides an insurance policy, service **plan**, or prepaid contract of benefits in accordance with those prescribed by law and regulation; as interpreted and adjudicated in accord with the policy, service plan, or contract and a dental benefits brochure; and as prescribed by requirements of the dental plan organization's contract with the government.

d. Contracting out. The method of delivery of the Active Duty Dependents Dental Benefit Plan is through a **competitively** procured contract. The Director, **OCHAMPUS**, or a designee is responsible for negotiating, under provisions of the FAR, a contract for dental benefits insurance or prepayment which includes responsibility for (1) development, publication, and **enforcement** of benefit policy, exclusions, and limitations in compliance with the

law, regulation, and the contract provisions; (2) adjudicating and processing claims; and (3) conduct of related supporting activities, such as eligibility verification, provider relations, and beneficiary communications.

6. Role of Health Benefits Advisor (HBA). The HBA is appointed (generally by the commander of a Uniformed Services medical treatment facility) to serve as an advisor to patients and staff in matters involving the Active Duty Dependents Dental Plan. The HBA may assist beneficiaries or sponsors in applying for benefits, in the preparation of claims, and in their relations with OCHAMPUS and the dental plan insurer. However, the HBA is not responsible for the plan's policies and procedures and has **no** authority to make benefit determinations or obligate the plan's funds. Advice given to beneficiaries as to determination of benefits or level of payment is not binding on OCHAMPUS or the insurer.

7. Disclosure of information to the public. Records and information acquired in the administration of the Active Duty Dependents **Dental** Plan are not records of the Department of Defense. The records are established by the Dependents Dental Plan insurer in accordance with standard business practices of the industry, **and** are used in the determination of eligibility, program management and operations, utilization review, quality assurance, program integrity, and underwriting in accordance with standard business practices. By contract, the records and information are subject to government audit and the government receives reports derived from them. Records and information specified by contract are provided by an outgoing insurer to a successor insurer in the event of a change in the contractor.

8. Equality of benefits. All claims submitted for benefits under the Active Duty Dependents Dental **Plan shall** be adjudicated in a consistent, fair, and equitable manner, without regard to the rank of the sponsor.

9. Coordination of benefits. The dental plan insurer shall conduct coordination of benefits for the Active Duty Dependents Dental Plan in accordance with generally accepted business practices.

10. Information on participating providers. The Director, OCHAMPUS or designee, shall **develop** and make available to Uniformed Services **Health** Benefits Advisors and military installation personnel centers copies of lists of participating providers **and providers accepting assignment for all** localities with significant numbers of dependents of active duty members. In addition, the Director, OCHAMPUS or designee, shall respond to inquiries regarding availability of participating providers in areas not covered by the lists of participating providers.

B. DEFINITIONS

For most definitions applicable to the provisions of this section, refer to Chapter 2 of this Regulation. The following definitions apply only to this section.

Assignment. Acceptance by a nonparticipating provider of payment **directly** from the insurer while reserving the right to charge the beneficiary or sponsor for any remaining amount of the fees for services which exceeds the prevailing fee allowance of the insurer.

Authorized Provider. A dentist or dental hygienist specifically authorized to provide benefits under the Active Duty Dependents Dental Plan in Section F. of this Chapter.

Beneficiary. A dependent of an active duty member who has been enrolled in the Active Duty Dependents Dental Plan, and has been determined to be eligible for benefits, as set forth in Section C. of this Chapter.

Beneficiary Liability. The legal obligation of a beneficiary, his or her estate, or responsible family member to pay **for** the costs of dental care or treatment received. Specifically, for the purposes of services and supplies covered by the Active Duty Dependents Dental Benefit Plan, beneficiary liability includes cost-sharing amounts and any amount above the prevailing fee determination by the insurer where the provider selected by the beneficiary is not a participating provider or a provider within an approved alternative delivery system. Beneficiary liability also includes any expenses for services and supplies not covered **by** the Active Duty Dependents Dental Benefit Plan, less any discount provided as a part of the insurer's agreement with an approved alternative delivery system.

By report. Dental procedures which are authorized as benefits only in unusual circumstances requiring justification **of** exceptional conditions related to otherwise authorized procedures. For example, a house call might be justified based on an enrolled dependent's severe handicap which prevents visits in the dentist's office for traditional prophylaxis. Alternatively, additional drugs might be required separately from an otherwise authorized procedure because of an emergent reaction caused **by** drug interaction during the performance of a restoration procedure. These services are further defined in Section E. of this Chapter.

Cost-Share. The amount of money for which the beneficiary (or sponsor) is **responsible** in connection with otherwise covered dental services (other than disallowed amounts) as set forth in Sections D. and G. of this Chapter. Cost-sharing may also be referred to as "co-payment. "

Defense Enrollment Eligibility Reporting System (DEERS). The automated system that is composed of two phases:

1. Enrolling all active duty and retired service members, their dependents, and the dependents of deceased service members, and
2. Verifying their eligibility for health care benefits in the direct care facilities and through the Active Duty Dependents Dental Plan.

Dental hygienist. Practitioner in rendering complete oral prophylaxis services, applying medication, performing dental radiography, and providing dental education services with a certificate, associate degree, or bachelor's degree in the field, and licensed by an appropriate authority.

Dentist. Doctor of Dental Medicine (**D.M.D.**) or Doctor of Dental Surgery (**D.D.S.**) who is licensed to practice dentistry by an appropriate authority.

Diagnostic services. Category of dental services including (1) clinical oral examinations, (2) radiographic examinations, and (3) diagnostic laboratory tests and examinations provided in connection with other dental procedures authorized as benefits of the Active Duty Dependents Dental Plan and further defined in Section E. of this Chapter.

Emergency palliative services. Minor procedures performed for the immediate relief of pain and discomfort as further defined in Section E of this Chapter. This definition excludes those procedures other than minor palliative services which may result in the relief of pain and discomfort, but constitute the usual initial stage or conclusive treatment in procedures not otherwise defined as benefits of the Active Duty Dependents Dental Plan.

Endodontics. The etiology, prevention, diagnosis, and treatment of diseases and injuries affecting the dental pulp, tooth root, and **periapical** tissue as further defined in Section E. of this Chapter.

Initial Determination. A formal written decision on an Active Duty Dependents **Dental** Plan claim, a request by a provider for approval as an authorized provider, or a decision disqualifying or excluding a provider as an authorized provider under the Active Duty Dependents Dental Plan. Rejection of a **claim** or a request for benefit or provider authorization for failure to comply with administrative requirements, including failure to submit reasonably requested information, is not an initial determination. Responses to general or specific inquiries regarding Active Duty Dependent Dental Plan benefits are not initial determinations.

Laboratory and Pathology Services. Laboratory and pathology examinations (including machine diagnostic tests that produce hard-copy results) ordered by a dentist when necessary to, and rendered in connection with other covered dental services.

Nonparticipating provider. A dentist or dental hygienist that furnished dental services to an Active Duty Dependents Dental Plan beneficiary, but who has not agreed to participate or to accept the insurer's fee allowances and applicable cost-share as the total charge for the services. A nonparticipating provider looks to the beneficiary or sponsor for final responsibility for payment of his or her charge, but may accept payment (assignment of benefits) directly from the insurer or assist the beneficiary in filing the claim for reimbursement by the contractor. Where the nonparticipating provider does not accept payment directly from the insurer, the insurer pays the beneficiary or sponsor, not the provider.

Oral Surgery. Surgical procedures performed in the oral cavity as further defined in Section E. of this Chapter.

Orthodontics. The supervision, guidance, and correction of the growing or mature **dentofacial** structures, inducting those conditions that require movement of teeth or correction of **malrelationships** and malformations of their related structures and adjustment of relationships between and among teeth and facial bones by the application of forces and/or the stimulation and redirection **of** functional forces within the craniofacial complex.

Participating Provider. A dentist or dental hygienist who has agreed to accept the insurer's reasonable fee allowances or other fee arrangements as the total charge (even though less than the actual billed amount), including provision for payment to the provider by the beneficiary (or sponsor) of any cost-share for services.

Party to a Hearing. An appealing party or parties, the insurer, and **OCHAMPUS** .

Party to the Initial Determination. Includes the Active Duty Dependents **Dental** Plan, a beneficiary of the **Active** Duty Dependents Dental Plan and a participating provider of services whose interests have been adjudicated **by** the initial determination. In addition, a provider who has been denied approval as an authorized Active Duty Dependents Dental Plan provider is a party to that initial determination, as is a provider who is disqualified or excluded as an authorized provider, unless the provider is excluded under another federal or federally funded program. See Section H. of this Chapter for additional information concerning parties not entitled **to** administrative review under the Active Duty Dependents **Dental** Plan appeals procedures.

Periodontics. The examination, diagnosis, and treatment of diseases affecting the supporting structures of the teeth as further defined in Section E. of this Chapter.

Preventive Services. Traditional prophylaxis including scaling deposits from teeth, polishing teeth, **and** topical **application** of fluoride **to** teeth as further defined in Section **E.** of this Chapter.

Prosthodontics. The diagnosis, planning, making, insertion, adjustment, refinement, and repair of artificial devices intended for the replacement of missing teeth and associated tissues as further defined in Section E. of this Chapter.

Provider. A dentist or dental hygienist as specified in Section F. of this Chapter.

Representative. Any person who has been appointed by a **party** to the initial determination as **counsel** or advisor and who is otherwise eligible to serve as the counsel or advisor of the **party to the initial** determination, particularly in connection with a hearing.

Restorative services. Restoration of teeth including those procedures commonly described as amalgam restorations, resin restorations, pin retention, and stainless steel crowns for primary teeth as **further** defined in Section E. of this Chapter.

Sealants. A material designed for application on the **occlusal** surfaces of specified teeth to seal the surface irregularities to prevent ingress of oral fluids, food, and debris in order to prevent tooth decay.

C. **ENROLLMENT AND ELIGIBILITY**

1. **General.** Sections 1076a, 1072(2)(A), (D) or (I) and 1072(6) of 10 **U.S.C.**, Chapter 55 set forth those persons who are eligible for voluntary enrollment in the Active Duty Dependents Dental Benefit Plan. A determination that a person is eligible for voluntary enrollment does not entitle such a person automatically to benefit payments. The active duty member must enroll his or her dependents as defined in this Part, and other Parts of this Regulation set forth additional requirements that must be met before eligibility for the plan is extended.

2. **Persons eligible. Dependent.** A person who bears one of the **following** relationships to an active duty member (under a call or order that does **not** specify a period of 30 days or less):

a. **Spouse.** A lawful husband or wife, regardless of whether or not dependent upon the active duty member.

b. **Child.** To be eligible, **the child** must be unmarried and meet one of the requirements of this section.

(1) A legitimate child.

"(2) An adopted child whose adoption has been completed legally.

(3) A legitimate stepchild.

(4) An illegitimate child of a male member whose paternity has been determined judicially, or an illegitimate child of record of a female member who has been directed judicially to support the child.

(5) An illegitimate child of a male active duty member whose paternity has not been determined judicially, or an illegitimate child of record of a female active duty member who:

(a) Resides with or in a home provided by the member and

(b) Is and continues to be dependent upon the member for over 50 percent of his or her support.

(6) An illegitimate child of the spouse of an active duty member (that is, the active duty member's stepchild) who:

(a) Resides-with or in a home provided by the active duty member or the parent who is the spouse of the member and

(b) Is and continues to **be** dependent upon the member for over 50 percent of his or her support.

(7) A child placed in the custody of a service member by a court or recognized adoption agency on or after October 5, 1994, in anticipation of a legal adoption.

(8) In addition to meeting one of the criteria (1) through (6) of this paragraph C.Z., the child:

(a) Must not be married.

(b) Must be in one of the following three age groups:

1 Not passed his or her 21st birthday.

2 Passed his or her 21st. birthday, but incapable of self-support because of a mental or physical incapacity that existed before his or her 21st birthday and dependent on the member for over 50 percent of his or her support. Such incapacity must be continuous. If the incapacity significantly improves or ceases at any time after age **21**, even if such incapacity recurs subsequently, eligibility cannot be reinstated on the basis of the incapacity. If the child was not handicapped mentally or physically at his or her 21st birthday, but becomes so incapacitated after that time, no eligibility exists on the basis of the incapacity.

3 Passed his or her 21st birthday, but not his or her 23rd birthday, dependent upon the member for over 50 percent of his or her support, and pursuing a full-time course of education in an institution of higher learning approved by the Secretary of Defense or the Department of Education (as appropriate) or by a state agency under 38 U.S.C., Chapters 34 and 35.

NOTE : Courses of education offered by institutions listed in the "Education Directory, Part 3, Higher Education" or "Accredited Higher Institutions ," issued periodically by the Department of Education meet the criteria approved by the Secretary of Defense or the Department of Education, (refer to Chapter 3, **B.2.d.** (3)(c) of this Regulation). For determination of approval of courses offered by a foreign institution, by an institution not listed in either of the above directories, or by an institution not approved by a state agency pursuant to Chapters 34 and 35 of 38 U.S.C., a statement may be obtained from the Department of Education, Washington, D.C. 20202.

3. Enrollment

a. Basic active duty dependents dental benefit plan. The dependents dental plan is effective from August 1, 1987, Up to the date of implementation of the Expanded **Active** Duty Dependents Dental Benefit Plan.

(1) Initial enrollment. Eligible dependents of members on active duty status as of August 1, 1987 are automatically enrolled in the Active Duty Dependents Dental Plan; except where any of the following conditions apply:

(a) Remaining period of active duty at the time of contemplated enrollment is expected by the active duty member or the Uniformed Service to be less than two years, except that such members' dependents may be enrolled during the initial enrollment period for benefits beginning August 1, 1987 provided that the member had at least six months remaining in the initial enlistment term. Enrollment of dependents is for a period of 24 months, subject to the exceptions provided in C.5. of this section.

(b) Active duty member had completed an election to **disenroll** his or her dependents from the Basic Active Duty Dependents Dental Benefit Plan.

(c) Active duty member had only one dependent who is under four years of age as of August 1, 1987, and the member did not complete an election form to enroll the child.

(2) Subsequent enrollment. Eligible active duty members may elect to enroll their dependents for a period of not less than 24 months, provided there is an intent to remain on active duty for a period of not less than two years by the member and the Uniformed Service.

(3) Inclusive family enrollment. All eligible dependents of the active duty member must be enrolled if any were enrolled, except that a member may elect to **enroll** only those dependents who are remotely located **from** the member (e.g. , a **child** living with a divorced spouse or a child in college).

b. Expanded active duty dependents dental benefit plan. The expanded dependents dental plan is effective on April 1, 1993. The Basic Active Duty Dependents Dental Benefit Plan terminated upon implementation of the expanded plan.

(1) Initial enrollment. Enrollment in the Expanded Active Duty Dependents Dental Benefit Plan is automatic for all eligible dependents of active duty members known to have at least 24 months remaining in service, and for those dependents enrolled in the Basic Dependents Dental Benefit Plan regardless of the military member's remaining time in service unless the active duty member elects to **disenroll** his or her dependents during the

one-time disenrollment option period (one-month period before the date on which the expanded plan went into effect, and for 4 months after the beginning date). Those active duty members who intend to remain in the service for 24 months or more, whose dependents were not automatically enrolled, may enroll them at **their** military personnel office by completing the appropriate Uniformed Services Active Duty Dependents Dental Plan Enrollment Election Form.

NOTE : Use of the new plan during the one-time **disenrollment** option period by a dependent enrolled in the Basic Active Duty Dependents Dental Benefit Plan, constitutes acceptance of the plan by the military sponsor and his or her family. Once the new plan is used, the family cannot be **disenrolled**, and the premiums will not be refunded.

(2) Subsequent enrollment.. Eligible active duty members may elect to enroll **their** dependents for **a period** of not less than 24 months, provided there is an intent **to** remain on active duty for a period of not less than two years by the member and the Uniformed Service.

(3) Inclusive family enrollment. All eligible dependents of the active duty member must be **enrolled if** any are enrolled, except as defined in paragraphs C.3.b. (3)(a) and (b) below.

(a) Enrollment will be **by** either single or family premium as defined herein:

1 Single premium.

a Sponsors with only one family member age four (4) or older who elect **to enroll** that family member; or

b Sponsors who have more than one family member under age four (4) may **elect to enroll** one (1) family member under age four (4); or

c Sponsors who elect to enroll one (1) family member age four or older but **may** have **any** number of family members under age four (4) who are not elected to be covered.

NOTE : At such time when the sponsor elects to enroll more than one (1) eligible family member, regardless of age, the sponsor must then **enroll** under a family premium which covers **all** eligible family members.

2 Family premium,

a Sponsors with two (2) or **more** eligible family members age four (4) **or older must enroll under the** family premium.

b Sponsors with **one** (1) eligible family member age four (4) or **older** and one (1) or more eligible family members under the age of four **may** elect to enroll under a family premium.

c Under the family premium, all eligible family members of the sponsor-are enrolled.

(b) Exceptions.

1 A sponsor may elect to enroll only those eligible family members residing in one location when the sponsor has other eligible family members **residing** in two or more physically separate locations (e.g., children living with a divorced spouse; children attending college).

2 In instances where a family member requires hospital or special treatment environment (due to a medical, physical handicap, or mental condition) for dental care otherwise covered by the dental plan, the family member may be excluded from the dental plan enrollment and may **continue to receive care** from a military treatment facility.

(4) Enrollment Period. Enrollment of dependents is for a period of 24 months except when:

(a) The dependent's enrollment is based on his or her enrollment in the Basic Active Duty Dependents Dental Benefit; or

(b) One of the conditions for **disenrollment** in C.5. of this section is met.

4. Beginning dates of eligibility.

a. Basic active duty dependents dental benefit plan.

(1) Initial enrollment. The beginning date of eligibility for benefits is August 1, 1987.

(2) Subsequent enrollment. The beginning date of eligibility for benefits is the first day of the **month** following the month in which the election of enrollment is completed, signed, and received by the active duty member's Service representative, except that the date of eligibility **shall not** be earlier than September 1, 1987.

b. Expanded active duty dependents dental benefit plan.

(1) Initial enrollment. The beginning date of eligibility for benefits is April 1, 1993.

(2) Subsequent enrollment. The beginning date of eligibility for benefits is the first day of the month following the month in which the election of enrollment is completed, signed, and received by the active duty member's Service representative, except that the date of eligibility shall **not be** earlier than the first of the month following the **month of** implementation of the expanded benefit.

5. Changes in and termination of enrollment

a. Changes in status of active duty member. When an active **duty** member's period of active duty ends for any reason, his or her dependents lose their eligibility as of **11:59** p.m. of the last day of the month in which the active duty ends.

b. Termination of eligibility for basic pay. When a member ceases to be eligible for basic pay, eligibility of the member's dependents for benefits under the Dependents Dental Plan terminates as of **11:59** p.m. of the day the member became ineligible for basic pay and the Uniformed Service must notify the Plan of **disenrollment** based on termination of eligibility for basic pay. The member whose eligibility for **basic** pay is subsequently restored may enroll his or her dependents for a minimum of two years in accordance with **C.3.b.**

c. Changes in status of dependent

(1) Divorce. A spouse separated from an active duty member by a final divorce decree loses all eligibility based on his or her former marital relationship as of **11:59** p.m. of the last day of the month in which the divorce becomes final. The eligibility of the member's own children (including adopted and eligible illegitimate children) is unaffected by the divorce. An unadopted stepchild, however, loses **eligibility with the** termination of the marriage, also as of **11:59** p.m. the last day of the month in which the divorce becomes final.

(2) Annulment. A spouse whose marriage to an active duty member is **dissolved by** annulment loses eligibility as of **11:59** p.m. of the last day of the month in which the court grants the annulment order. The fact that the annulment legally declares the entire marriage void from its inception does not affect the termination date of eligibility. When there are children, the eligibility of the member's own children (including adopted and eligible illegitimate children) is unaffected by the annulment. An **unadopted** stepchild, however, loses eligibility with the annulment of the marriage, **also** as of **11:59** p.m. of the last day of the month in which the court grants the annulment order.

(3) Adoption. A child of an active duty member who is adopted by a person, other than a person whose dependents are eligible for the Active Duty Dependents Dental Plan benefits while the active duty member is living, thereby severing the legal relationship between the child and the sponsor, loses eligibility as of **11:59** p.m. of the last day of the month in which the adoption becomes final.

(4) Marriage of child. A child of an active **duty** member who marries a person whose dependents are not eligible for the Active Duty Dependents Dental Plan, loses eligibility as of **11:59** p.m. on the last day of the month in which the marriage takes place. However, should the marriage be terminated by death, divorce, or annulment before the child is 21 years old,

the child again becomes eligible for enrollment as a dependent as of **12:00** a.m. of the first day of the month following the month in which the occurrence takes place that terminates the marriage and continues up to age 21 if the child does not remarry before that time. If the marriage terminates after the child's 21st birthday, there is no reinstatement of eligibility.

(5) Disabling illness or injury of child age 21 or 22 who has eligibility based on his or her student status. A child 21 or 22 years old who is pursuing a full-time course of higher education and who, either during the school year or between semesters, suffers a disabling illness or injury with resultant inability to resume attendance at the institution remains eligible for dental benefits for 6 months after the disability is removed or **until** the student passes his or her 23rd birthday, whichever occurs first. However, if recovery occurs before the 23rd birthday and there is resumption of a full-time course of higher education, dental benefits can be continued until the 23rd birthday. The normal vacation periods during an established school year do not change the eligibility status of a dependent **child 21 or 22** years old in full-time student status. Unless an incapacitating condition existed before, and at the time of, a dependent child's 21st birthday, a dependent child 21 or 22 years old in student status does not have eligibility related to mental or physical incapacity as described in Chapter 3, **B.2.d. (3)(b)** of this Regulation.

d. Disenrollment because of no eligible dependents. When an active duty member ceases to have any eligible dependents, the member must **disenroll**.

e. Option to disenroll as a result of a change in active duty station. When an active duty member transfers with enrolled **family** members to a duty station where space-available dental care is readily available at the local military clinic, the member may elect within 90 days of the transfer to **disenroll** from the plan. If the member is later transferred to a duty station where dental care is not available in the local military clinic, the member may **re-enroll** his or her dependents in the plan.

f. Option to disenroll after an initial two-year enrollment. When an active duty member's enrollment of his or her dependents has been in effect for a continuous **period** of two years, the member may **disenroll** his or her dependents at any time. Subsequently, the member may **enroll** his or her dependents for another minimum period of two years.

6. Eligibility determination and enrollment

a. Eligibility determination and enrollment responsibility of Uniformed Services. Determination of a person's eligibility and processing of enrollment in the Active Duty Dependents Dental Benefit Plan is the responsibility of the active duty member's Uniformed Service. For the purpose of program integrity, the appropriate Uniformed Service shall, upon request of the Director, **OCHAMPUS**, review the eligibility of a specific

person when there is reason to question the eligibility status. In such cases, a report on the result of the review and any action taken will be submitted to the Director, OCHAMPUS, or a designee.

b. Procedures for determination of eligibility. Uniformed Services identification cards do not distinguish eligibility for the Active Duty Dependents Dental Plan. Procedures **for** the determination of eligibility are identified in Chapter 3, F.2. of this Regulation, except that Uniformed Services identification cards do not provide evidence of eligibility **for** the dental plan.

7. Evidence of eligibility required. Eligibility and enrollment in the Active Duty Dependents Dental Plan **will** be verified through the DEERS (DoD 1341.1-M, "Defense Enrollment Eligibility Reporting System (**DEERS**) Program Manual," May 1982).

a. Acceptable evidence of eligibility and enrollment. Eligibility information **established** and maintained in the DEERS files is the only acceptable evidence of eligibility.

b. Responsibility for obtaining evidence of eligibility. It is the responsibility of the active duty member, or Active Duty Dependent Dental Plan beneficiary, parent, or legal representative, when appropriate, to enroll with a Uniformed Service authorized representative and provide adequate evidence for entry into the DEERS file to establish eligibility for the Active Duty Dependents Dental Plan, and to ensure that all changes in status that may affect enrollment and eligibility are reported immediately to the appropriate Uniformed Service **for** action. Ineligibility for benefits is presumed in the absence of prescribed enrollment and eligibility evidence in the DEERS file.

8. Continuation of eligibility for dependents of service members who die on active duty. Eligible dependents of service members who die on for after October 1, 1993, while on active duty for a period of more than 30 days and who are enrolled in the dental benefits plan on the date of the death of the member shall be eligible for continued enrollment in the dental benefits plan for up to one year from the date of the service member's death.

D. PREMIUM SHARING

1. General. Active duty members enrolling their dependents in the Active Duty Dependents Dental Plan shall be required to pay a share of the premium cost for their dependents.

2. Premium classifications. Premium classifications are established by the Secretary of Defense, or designee, and provide for a minimum of two classifications, single and family.

3. Premium amounts. The premium amounts to be paid for the Active Duty Dependents Dental plan are established by the Secretary of Defense or designee.

4. Proportion of member's premium share. The proportion of premium share to be paid by the member is established by the Secretary of Defense or designee, at not more than 40 percent of the total premium.

5. Pay deduction. The member's premium share shall be deducted from the basic pay of the member.

E. PLAN BENEFITS

1. General

a. Scope of benefits. The Active Duty Dependents Dental Benefit Plan provides coverage for diagnostic and preventive services, sealants, restorative services, endodontics, periodontics, prosthodontics, orthodontics and oral surgery to eligible, enrolled dependents of active duty members as set forth in Section C. of this Chapter.

b. Authority to act for the plan. The authority to make benefit determinations and authorize plan payments under the Active Duty Dependents Dental Plan rests primarily with the insurance, service plan, or prepayment dental plan contractor, subject to compliance with federal law and regulation and government contract provisions. The Director, **OCHAMPUS**, or designee, provides required benefit policy decisions resulting from changes in federal law and regulation and appeal decisions. No other persons or agents (such as dentists or Uniformed Services health benefits advisors) have such authority.

c. Right to information. As a condition precedent to the provision of benefits hereunder, the Director, **OCHAMPUS**, or designee, shall be entitled to receive information from an authorized provider or other person, institution, or organization (including a local, state, or U.S. Government agency) providing services or supplies to the beneficiary for which claims for benefits are submitted. While establishing enrollment and eligibility, benefits, and benefit utilization and performance reporting information standards; the government has not established and does not maintain a system of records and information for the Dependents Dental Plan. By contract, the government audits the adequacy and accuracy of the dental contractor's system of records and requires access to information and records to meet program accountabilities. Such information and records may relate to attendance, testing, monitoring, examination, or diagnosis of dental disease or conditions; or treatment rendered; or services and supplies furnished to a beneficiary; and shall be necessary for the accurate and efficient administration and payment of benefits under this plan. Before a determination will be made on a claim of benefits, a beneficiary or active duty member must provide particular additional information relevant to the requested determination, when necessary. Failure to provide the requested information may result in denial of the claim. The recipient of such information shall in every case hold such records confidential except when:

(1) Disclosure of such information is necessary to the determination **by** a provider or the plan contractor of beneficiary enrollment or eligibility for coverage of specific services;

(2) Disclosure of such information is authorized specifically **by** the beneficiary;

(3) Disclosure is necessary to permit authorized governmental officials to investigate and prosecute criminal actions; or

(4) Disclosure constitutes a standard and acceptable business practice commonly used among dental insurers which is consistent with the principle of preserving confidentiality of personal information and detailed clinical data. For example, the release of utilization information for the purpose of determining eligibility for certain services, such as the number of dental prophylaxis procedures performed for a beneficiary, is authorized.

(5) Disclosure by the Director, **OCHAMPUS**, or designee. is for the purpose of determining the applicability of, and implementing the provisions of, other dental benefits coverage or entitlement.

NOTE : Release **by** the recipient of the information under the confidentiality exceptions identified in **E.1.c.** is authorized without consent or notice to any beneficiary or sponsor, to any person, organization, government agency, provider, or other entity.

d. Dental insurance policy, prepayment, or dental service plan contract. The Director, **OCHAMPUS**, or designee, shall develop a standard insurance policy, prepayment agreement, or dental service plan contract designating **OCHAMPUS** as the policyholder or purchaser. The policy shall be in the form customarily employed by the dental plan insurer, subject to its compliance with federal law and the provisions of this Regulation.

e. Dental benefits brochure

(1) Cent.en~. The Director, **OCHAMPUS**, or designee shall establish a dental benefits brochure explaining the benefits of the plan in common lay terminology. The brochure shall include the limitations and exclusions and other benefit determination rules for administering the benefits in accordance with the law and this part. The brochure shall include the **rules** for adjudication and payment of claims, appealable issues, and appeal procedures in sufficient detail to serve as a common basis for interpretation and understanding of the rules by providers, beneficiaries, claims examiners, correspondence specialists, employees and representatives of other government bodies, health benefits advisors, and other interested parties. Any conflict which may occur between the dental benefits brochure and law or regulation shall be resolved in favor of law and regulation.

(2) Distribution. The dental benefits brochure shall be printed and distributed with the assistance of the Uniformed Services health benefits advisors, major personnel centers at Uniformed Services installations, and authorized providers of care to all active duty members enrolling their dependents.

f. Utilization review and quality assurance. Claims submitted for benefits under the Active Duty Dependents **Dental** Plan are subject to review by the Director, **OCHAMPUS** or designee for quality of care and appropriate utilization. The Director, **OCHAMPUS** or designee is responsible for appropriate utilization review and quality assurance standards, norms, and criteria consistent with the level of benefits.

g. Alternative course of treatment policy. The Director, OCHAMPUS or designee may establish, in accordance with generally accepted dental benefit practices, an alternative course of treatment policy which provides reimbursement in instances where the dentist and beneficiary select a more expensive service, procedure, or course of treatment than is customarily provided. The benefit policy must meet the following conditions:

(1) The service, procedure, or course of **treatment must** be consistent with sound professional standards of dental practice for the dental condition concerned.

(2) The service, procedure, or course of treatment must be a generally accepted alternative **for** a service or procedure covered by this plan for the dental condition.

(3) Payment for the alternative service or procedure may not exceed the lower of the prevailing limits for the alternative procedure, the prevailing limits or scheduled allowance for the otherwise authorized benefit procedure for which the alternative is substituted, **or** the actual charge for the alternative procedure.

2. Benefits

a. Diagnostic and preventive services. Benefits may be extended for those dental services **described** as oral examination, diagnostic, and preventive services defined as traditional prophylaxis (i.e., scaling deposits from teeth, polishing teeth, and topical application of fluoride to teeth) when performed directly by dentists or dental hygienists as authorized under Section F. of this Chapter. These services are defined (subject to the dental plan's exclusions, limitations, and benefit determination rules approved by **OCHAMPUS**) using the American Dental Association's Code on Dental Procedures and Nomenclature as listed in the Current Dental Terminology manual to include the following categories of services:

(1) Diagnostic services

(a) Clinical Oral examinations

(b) Radiographs

(c) Tests and laboratory examinations

(2) Preventive services

(a) Dental prophylaxis

(b) Topical fluoride treatment (office procedure)

(c) Sealants

(d) Space maintenance (passive appliances)

b. Adjunctive general services (Services "By Report"). The following categories of services are authorized when performed directly by dentists or dental hygienists only in unusual circumstances requiring justification of exceptional conditions directly related to otherwise authorized procedures. Use of the procedures may not result in the fragmentation of services normally included in a single procedure. These services are defined (subject to the dental plan's exclusions, limitations, and benefit determination rules as adopted by **OCHAMPUS**) using the American Dental Association's Code on Dental Procedures and Nomenclature as listed in the Current Dental Terminology manual to include the following categories of service:

(1) Emergency oral examinations

(2) Palliative emergency treatment of dental pain

(3) Professional consultation

(4) Professional visits

(5) Drugs

(6) Post-surgical complications

c. Restorative. Benefits may be extended for basic restorative services when performed directly by dentists or dental hygienists, or under orders and supervision by dentists, as authorized under Section F. of this Chapter. These services are defined (subject to the dental plan's exclusions, limitations, and benefit determination rules as adopted by **OCHAMPUS**) using the American Dental Association's Code on Dental Procedures and Nomenclature as listed" in the Current Dental Terminology manual to include the following categories of services:

(1) Restorative Services

(a) Amalgam restorations

(b) Silicate restorations

(c) Resin restorations

(d) Prefabricated crowns

(e) Pin retention

(2) Other restorative services

(a) Diagnostic casts

(b) Onlay restoration - metallic

(c). Crowns

d. Endodontics services. Benefits may be extended for those dental services involved in treatment of diseases and injuries affecting the dental pulp, tooth root, and **periapical** tissue when performed directly by dentists as authorized under Section F. of this Chapter. These services are defined (subject to the dental plan's exclusions, limitations, and **benefit** determination rules as adopted by **OCHAMPUS**) using the American Dental Association's Code on Dental Procedures and Nomenclature as listed in the Current Dental Terminology manual to include the following categories of services:

(1) Pulp capping - indirect

(2) **Pulpotomy**

(3) Root canal therapy

(4) **Periapical** services

(5) Hemisection

e. Periodontics services. Benefits may be extended for those dental services involved in prevention and treatment of diseases affecting the supporting structures of the teeth to include periodontal prophylaxis, gingivectomy or **gingivoplasty**, **gingival** curettage, etc., when performed directly by dentists as authorized under Section F. of this Chapter. These services are defined (subject to the dental plan's exclusions, limitations, and benefit determination rules as adopted by **OCHAMPUS**) using the American Dental Association's Code on Dental Procedures and Nomenclature as listed in the Current Dental Terminology manual to include the following categories of services:

(1) Surgical services

(2) Periodontal scaling and root planing

(3) Unscheduled dressing change

f. Prosthodontic services. Benefits may be extended for those dental services involved in fabrication, insertion, adjustment, refinement, and repair of artificial teeth **and** associated **tissues** to include removable complete and **partial** dentures, fixed crowns and bridges when performed directly by dentists as authorized under Section F. of this Chapter. These services are defined (subject to the dental plan's exclusions, limitations, and benefit determination rules as adopted by **OCHAMPUS**) using the American Dental Association's Code on **Dental** procedures and Nomenclature as listed in the Current Dental Terminology manual to include the following categories of services:

(1) Prosthodontics (removable)

- (a) Complete/partial dentures
- (b) Adjustments to removable prosthesis
- (c) Repairs to complete/partial dentures
- (d) Denture rebase procedures
- (e) Denture reline procedures
- (f) Interim complete/partial dentures
- (g) Tissue conditioning

(2) Prosthodontics (fixed)

- (a) Bridge pontics
- (b) Retainers (by report)
- (c) Bridge retainers-crowns
- (d) Other fixed prosthetic services

g. Orthodontic services. Benefits may be extended for the supervision, guidance, and correction of growing **or** mature **dentofacial** structures, including those conditions that require movement of teeth or correction of malrelationships and malformations through the use of orthodontic procedures and devices when performed directly by dentists as authorized under Section F. of this Chapter to include in-process orthodontics. Coverage of in-process orthodontics is limited to services rendered on or after the date of enrollment in the expanded dependents dental plan. These services are defined (subject to the dental plan's exclusions, limitations, and benefit determination rules as adopted by **OCHAMPUS**) using

- (1) Minor treatment for tooth guidance
- (2) Minor treatment to control harmful habits
- (3) Interceptive orthodontic treatment
- (4) Comprehensive orthodontic treatment - transitional dentition
- (5) Comprehensive orthodontic treatment - permanent dentition
- (6) Treatment **of the** atypical or extended skeletal case
- (7) Post-treatment stabilization

NOTE : Coverage of in-process orthodontics is limited to services rendered on or after the date of enrollment in the expanded dependents dental plan.

h. Oral surgery services. Benefits may be extended for basic surgical procedure of the extraction, reimplantation, stabilization and repositioning of teeth, **alveoloplasties**, incision and drainage of abscesses, suturing of wounds, biopsies, etc., when performed directly by dentists as authorized under Section F. of this Chapter. These services are defined (subject to the dental plan's exclusions, limitations, and benefit determination rules as adopted by **OCHAMPUS**) using the American Dental Association's Code on Dental Procedures and Nomenclature as listed in the Current Dental Terminology manual to include the following categories of services:

- (1) Extractions
- (2) Surgical extractions
- (3) Other surgical procedures
- (4) **Alveoloplasty** - surgical preparation of ridge for denture
- (5) Surgical incision and drainage of abscess - intraoral soft tissue
- (6) Repair of traumatic wounds
- (7) Complicated suturing
- (8) Excision of **pericoronal** gingiva

i. Exclusion of adjunctive dental care. Under limited circumstances, **benefits** are available for dental services and supplies under CHAMPUS when the dental care is medically necessary in the treatment of an

otherwise covered medical (not dental) condition, is an integral part of the treatment of such medical condition, and is essential to the control of the primary medical condition; or is required in preparation for, or as the result of, dental trauma which may be or is caused by medically necessary treatment of an injury or disease (**iatrogenic**). These benefits are excluded under the Active Duty Dependents Dental Plan. For further information on **adjunctive** dental care benefits under CHAMPUS, see Chapter 4, Section E.10. of this Regulation.

j. Exclusion of benefit services performed in military dental care facilities. Except for emergency treatment, dental care provided outside the United States, and services incidental to noncovered services, dependents enrolled in the Active Duty Dependents Dental Plan may not obtain those services which are benefits of the Plan in military dental care facilities. Enrolled dependents may continue to obtain noncovered services from military dental care facilities subject to the provisions for space available care.

k. Benefit limitations and exclusions. The Director, **OCHAMPUS** or designee may establish such exclusions and limitations as are consistent with those established by dental insurance and prepayment plans to control utilization and quality of care for the services and items covered by this dental plan.

3. Beneficiary or sponsor liability

a. Diagnostic and preventive services. Enrolled dependents of active duty members or their **sponsors** are responsible for the payment of only those amounts which are for services rendered by nonparticipating providers of care which exceed the equivalent of the statewide or regional prevailing fee levels as established by the insurer, except in the case of sealants where the dependents or their sponsors will also be responsible **for** payment of 20 percent of the insurer's determined allowable amount. Where the dental plan is unable to identify a participating provider of care within 35 miles of the dependent's place of residence with appointment availability within 21 calendar days, the dental plan will reimburse the dependent, or sponsor, or the nonparticipating provider selected by the dependent within 35 miles of the dependent's place of residence at the level of the provider's usual fees less 20 percent of the insurer's allowable amount for sealants.

b. Restorative services. Enrolled dependents of active **duty** members or their sponsors **are** responsible for payment of 20 percent of the amounts determined by the insurer for services rendered by participating providers of care, or 20 percent of these amounts plus any remainder of the charges made by nonparticipating providers of care, except in the case of crowns **and** casts where the dependents or their sponsors will **be** responsible **for** payment of 50 percent of the insurer's determined allowable amount. Where the dental plan is unable to identify a participating provider **of** care within 35 miles of the dependent's place of residence with appointment availability within 21 calendar days, dependents or their sponsors are

responsible for payment of 20 percent (50 percent in the case of crowns and casts) of the charges made by nonparticipating providers located within 35 miles of the dependent's place of residence.

c. Endodontics, periodontics, and oral surgery services. Enrolled dependents of active duty members or their sponsors are responsible for payment of 40 percent of the amounts determined by the insurer for services rendered by participating providers of care, or 40 percent of these amounts plus any remainder of the charges made by nonparticipating providers of care. Where the dental plan is unable to identify a participating provider of care within 35 miles of the dependent's place of residence with appointment availability within 21 calendar days, dependents or their sponsors are responsible for payment of 40 percent of the charges made by nonparticipating providers located within 35 miles of the dependent's place of residence.

d. Prosthodontic and orthodontic services. Enrolled dependents of active duty members or their sponsors are responsible for payment of 50 percent of the amounts determined by the insurer for services rendered by participating providers of care, or 50 percent of these amounts plus any remainder of the charges made by nonparticipating providers of care. Where the dental plan is unable to identify a participating provider of care within 35 miles of the dependent's place of residence with appointment availability within 21 calendar days, dependents or their sponsors are responsible for payment of 50 percent of the charges made by nonparticipating providers located within 35 miles of the dependent's place of residence.

e. Adjunctive general services (Services "By Report."). The beneficiary or-sponsor liability is dependent on the particular service provided. Emergency oral examinations and palliative emergency treatment of dental pain are paid in full except for those amounts for services rendered by nonparticipating providers of care which exceed the equivalent of the statewide or regional prevailing fee levels as established by the insurer which are the responsibility of the enrolled dependents or their sponsors. Enrolled dependents or their sponsors are responsible for payment of 20 percent of the amounts determined by the insurer for professional consultations/visits and postsurgical services and 50 percent for covered medications when provided by participating providers of care, or these percentage payments plus any remaining amounts in excess of the prevailing charge limits established by the insurer for services rendered by nonparticipating providers, subject to the exceptions for dependent lack of access to participating providers as provided in paragraphs E.3.a. through E.3.d. of this Chapter. The contracting dental insurer may recognize a "by report" condition by providing additional allowance to the primary covered procedure instead of recognizing or permitting a distinct billing for the "by report" service.

f. Amounts over the dental insurer's established allowance for charges. It is the responsibility of the dental plan insurer to determine allowable charges for the procedures identified as benefits of this plan.

All benefits of the plan are based on the insurer's determination of the allowable charges, subject to the exceptions for lack of access to participating providers as provided in paragraphs E.3.a. through E.3.d. of this Chapter.

g. Maximum coverage amounts. Enrolled dependents of active duty members are subject to an annual maximum coverage amount for non-orthodontic **dental** benefits and a lifetime maximum coverage amount for orthodontia as established by the Secretary of Defense or designee.

F. AUTHORIZED PROVIDERS

1. General. This section sets forth general policies and procedures that are the **basis** for the Active Duty Dependents Dental Plan cost sharing of dental services and supplies provided by or under the direct supervision or prescription by dentists, and by dental hygienists, within the scope of their **licensure**.

a. Listing of provider does not guarantee payment of benefits. The fact that a type of provider is listed in this section is not to be construed to mean that the Active Duty Dependents Dental Plan will pay automatically a claim for services or supplies provided by such a provider. The Director, **OCHAMPUS** or designee also must determine if the patient is an eligible beneficiary, whether the services or supplies billed are authorized and medically necessary, and whether any of the authorized exclusions of otherwise qualified providers presented in this section apply.

b. Conflict of interest. See Chapter 9, D. of this Regulation.

c. Fraudulent practices or procedures. See Chapter 9, C. of this Regulation.

d. Utilization review and quality assurance. Services and supplies furnished by providers of care **shall be** subject to utilization review and quality assurance standards, norms, and criteria established by the dental plan. Utilization review and quality assurance assessments shall **be performed by** the dental **plan** consistent with the nature and **level** of benefits of the plan, and shall include analysis of the data and findings by the dental plan insurer from other dental accounts,

e. Provider required. In order to be considered benefits, all services and supplies shall **be** rendered by, prescribed by, or furnished at the direction of, **or on the order of** an Active Duty Dependents Dental Plan authorized provider practicing within the scope of his or her license.

f. Participating provider. An authorized provider may elect to participate and accept the fee or **charge** determinations as established and made known to the provider by the dental plan insurer. The fee or charge determinations are binding upon the provider in accordance with the dental

plan insurer's procedures for participation. The authorized provider may not participate on a claim-by-claim basis. The participating provider must agree to accept, within one day of a request for appointment, beneficiaries in need of emergency palliative treatment. Payment to the participating provider is based on the lower of the actual-charge or the insurer's determination of the allowable charge. Payment is made directly to the participating provider, and the participating provider **may** only charge the beneficiary the percent cost-share of the insurer's allowable charge for those benefit categories as specified in paragraphs **E.3.a.** through E.3.e. of this Chapter, in addition to the charges for any services not authorized as benefits.

g. Nonparticipating provider. An authorized provider may elect for all beneficiaries not to participate and request the beneficiary or sponsor to pay any amount of the provider's **billed** charge in excess of the dental plan insurer's determination of allowable charges. Neither the government nor the dental plan insurer **shall** have any responsibility for any amounts over the allowable charges as determined by the dental plan insurer, except where the dental plan insurer **is** unable to identify a participating provider of care within 35 miles of the dependent's place of residence with appointment availability within 21 calendar days. In such instances of the nonavailability of a participating provider, the nonparticipating provider located within 35 miles of the dependent's **place** of residence shall be paid his or her usual fees, less the percent cost-share as specified in paragraphs E.3.a. through E.3.e. of this Chapter.

(1) Assignment. A nonparticipating provider may accept assignment of claims for beneficiaries certifying their willingness to make such assignment by filing the claims completed with the assistance of the beneficiary or sponsor for direct payment **by** the dental plan insurer to the provider.

(2) Nonassignment. A nonparticipating provider for **all** beneficiaries may request the beneficiary or sponsor **to** file the claim directly with the dental plan insurer, making arrangements with the beneficiary or sponsor for direct payment by the beneficiary or sponsor.

2. Dentists. Subject to standards of participation provisions of this part, the following are authorized providers of care:

a. Doctors of Dental Surgery (D.D.S.) having a degree from an accredited school of dentistry, licensed to practice dentistry by a state **board** of dental examiners, and practicing within the scope of their licenses, whether in individual, group, or clinic practice settings.

b. Doctors of Dental Medicine (D.M.D.) having a degree from an accredited school of dentistry, licensed to practice dentistry by a state board of dental examiners, and practicing within the scope of their licenses, whether in individual, group, or clinic practice settings.

3. **Dental hygienists.** Subject to state **licensure** laws and standards of participation provisions of this part, dental hygienists having either an associate degree, certificate, or baccalaureate degree from an accredited school of dental hygiene, licensed to practice **dental** hygiene by a state board, and practicing within **the** scope of their licenses, whether in individual, group, **or** clinic practice settings.

NOTE : Dental hygienists may independently bill and receive payment only in a few states where state **licensure laws** authorize them as independent providers of care. In **nearly** all states at the present time, the dental hygienist performs services under the supervision of a dentist and the Dependents Dental Plan will pay for such services in these states only when supervised and billed **by** a dentist.

4. **Alternative delivery systems**

a. **General.** Alternative delivery systems may be established by the Director, **OCHAMPUS** or designee as authorized providers. Only dentists and dental hygienists shall be authorized to provide or direct the provision of authorized services and supplies in an approved alternative delivery system.

b. **Defined.** An alternative delivery system may be any approved arrangement for a preferred provider organization, cavitation plan, dental health maintenance or clinic organization, or other contracted arrangement which is approved **by OCHAMPUS** in accordance with requirements and guidelines.

c. **Elective or exclusive arrangement.** Alternative delivery systems may be established by contract or other arrangement on either an elective or exclusive basis for beneficiary selection of participating and authorized providers in accordance with contractual requirements and guidelines.

d. **Provider election of participation.** Otherwise authorized providers must **be** provided with the opportunity of applying **for** participation in an alternative delivery system and of achieving participation status based **on** reasonable criteria for timeliness of application, quality of care, cost containment, geographic location, patient availability, and acceptance of reimbursement allowances.

e. **Limitation on authorized providers.** Where exclusive alternative delivery systems are established, only -providers participating in the alternative delivery system are authorized providers of care. In such instances, **the** dental plan shall continue to pay beneficiary claims for services rendered **by** otherwise authorized providers in accordance with established rules for reimbursement of nonparticipating providers where the beneficiary has established a patient relationship with the nonparticipating provider prior to the dental plan's proposal to subcontract with the alternative delivery system,

f. Charge agreements. Where the alternative delivery system employs a discounted **fee-for-service** reimbursement methodology or schedule of charges or rates which includes all or most dental services and procedures recognized by the American Dental Association, Council on Dental Care Programs "Code on Dental Procedures and Nomenclature, " the discounts or schedule of charges or rates for **all** dental services and procedures shall be extended by its participating providers to beneficiaries of the Active Duty Dependents Dental Plan as an incentive for beneficiary participation in the alternative delivery system.

5. Billing practices. The Director, **OCHAMPUS**, or designee, approves the dental plan's procedures governing the itemization and completion of claims for services rendered by authorized providers to enrolled beneficiaries of the Active Duty Dependents Dental Plan consistent with the insurer's existing procedures for completion and submittal of dental claims for its other dental plans **and** accounts.

6. Reimbursement of authorized providers. The Director, **OCHAMPUS** or designee, approves the dental plan methodology for reimbursement of services rendered by authorized providers consistent with law, regulation, and contract provisions, and the benefits of the Active Duty Dependents Dental Plan. The following general requirements for the methodology shall be met., subject to modifications and exceptions approved by the Director, **OCHAMPUS** or a designee.

a. Nonparticipating providers (or the dependents or sponsors for unassigned claims) shall **be** reimbursed at the equivalent of not less than the 50th percentile of prevailing charges made for similar services in the same locality (region) or state, or the provider's actual charge, whichever **is** lower; less any cost-share amount due for authorized services, except where the dental plan insurer is unable to identify a participating provider of care within 35 miles of the dependent's place of residence with appointment availability within 21 calendar days. **In** such instances of the **nonavailability** of a participating provider, the nonparticipating provider located within 35 miles of the dependent's place of residence shall be paid his or her usual fees, less the cost-share **for** the authorized services.

b. Participating providers shall be reimbursed at the equivalent **of** a percentile of prevailing charges sufficiently above the 50th percentile of prevailing charges made for similar services in the same locality (region) or state as to constitute a significant financial incentive **for** participation, or the provider's actual charge, whichever is lower; less any cost-share amount due for authorized services.

G. BENEFIT PAYMENT

1. General. Active Duty Dependent Dental Plan benefit payments are made either directly to the provider or to the beneficiary or sponsor, depending on the manner in which the **claim** is submitted or the terms of the subcontract of an alternative **delivery** system with the dental plan insurer.

2. Benefit payments made to a participating provider. When the authorized provider has elected to participate in accordance with the arrangement and procedures established by the dental plan insurer, payment is made based on the lower of the **actual** charge or the insurer's determination of the allowable charge. Payment is made directly to the participating provider as payment in full, less the percent cost-share of the insurer's allowable charge as specified in paragraphs E.3.a. through **E.3.e.** of this Chapter.

3. Benefit payments made to a nonparticipating provider. When the authorized provider has elected not to participate in accordance with the arrangement and procedures established by the dental plan, payment is made by the insurer based on the lower of the actual charge or the insurer's determination of the allowable charge. The beneficiary is responsible for payment of a percent cost-share of the insurer's allowable charge as specified in paragraphs **E.3.a.** through E.3.e. of this Chapter. Where the dental plan is unable to identify a participating provider of care within 35 miles of the dependent's place of residence with appointment availability within 21 calendar **days**, dependents or their sponsors are responsible for payment of a percent cost-share of the charges made by nonparticipating providers located within 35 miles of the dependent's place of residence as specified in paragraphs **E.3.a.** through **E.3.d.** of this Chapter.

a. Assigned claims are claims submitted directly by the nonparticipating provider and are paid directly to the provider.

b. **Nonassigned** claims are claims submitted by the beneficiary, provider, or sponsor and are paid directly to the claimant.

4. Dental Explanation of Benefits (DEOB). An explanation of benefits is sent to the beneficiary or sponsor and provides the following information:

a. Name and address of the beneficiary.

b. Social Security Account Number (**SSAN**) of the sponsor.

c. Name and address of the provider.

d. Services or supplies covered by the claim for which the DEOB applies.

e. Dates the services or supplies were provided.

f. Amount billed; allowable charge; and amount of payment.

g. To whom payment, if any, was made.

h. Reasons for any denial.

i. Recourse available to beneficiary for review of claim decision (refer to section H. of this Chapter).

5. Fraud

a. Federal laws. 18 **U.S.C.** 287 and 1001 provide for criminal penalties for submitting knowingly or making any false, fictitious, or **fraudulent** statement or claim in any matter within the jurisdiction of any department or agency of the United States. Examples of fraud **include** situations in which ineligible persons not enrolled in the Active Duty Dependents Dental Plan obtain care and file claims for benefits under the name and identification of an enrolled beneficiary; or when providers submit claims for services and supplies not rendered to enrolled beneficiaries; or when a participating provider bills the beneficiary for amounts over the dental plan insurer's determination of allowable charges; or fails to **collect** the specified patient copayment amount.

b. Suspected fraud. Any person, including the dental plan insurer, who **becomes** aware of a suspected fraud shall report the circumstances in writing, together with copies of any available documents pertaining thereto, to the Director, **OCHAMPUS**, or a designee, who **shall** initiate an official investigation of the case.

H. APPEAL AND HEARING PROCEDURES

1. General. This section sets forth the policies and procedures for appealing decisions made by the dental plan adversely affecting the rights and liabilities of beneficiaries, participating providers, and providers denied the status of authorized provider under the Active Duty Dependents Dental Plan. An appeal under the Active Duty Dependents Dental Plan is an administrative review of program determinations made under the provisions of law and regulation. An appeal cannot challenge the propriety, equity, or legality of any provision of law and regulation.

a. Initial determination

(1) Notice of initial determination and right to appeal

(a) The dental plan contractor shall mail notices of initial determinations to the Active Duty Dependents Dental Plan beneficiary at the last known address. For beneficiaries who are under 18 years of age or who are incompetent., a notice issued to the parent or guardian constitutes notice to the beneficiary.

(b) The dental plan contractor shall notify providers of an initial determination on a claim only if the providers participated in the claim or accepted assignment.

(c) Notice of an initial determination on a claim by the dental plan contractor shall be made in the contractor's explanation of benefits (beneficiary) or with the summary of payment (provider).

(d) Each notice of an initial determination on a request for benefit authorization, a request by a provider for approval as an authorized provider, or a decision to disqualify or exclude a provider as an authorized provider under the Active Duty Dependents Dental Plan shall state the reason for the determination and the underlying facts supporting the determination.

(e) In any case when the initial determination is adverse to the beneficiary or participating provider or to the provider seeking approval as an authorized provider, the notice shall include a statement of the beneficiary's or provider's right to appeal the determination. The procedure for filing the appeal also shall be explained.

(2) Effect of initial determination. The **initial** determination is final, unless appealed in accordance with this section or unless the initial determination is reopened by **OCHAMPUS** or the dental plan contractor.

b. Participation in an appeal. Participation in an appeal is limited to any party to the initial determination, including **OCHAMPUS**, the dental plan contractor, and authorized representatives of the parties. Any party to the initial determination, except **OCHAMPUS** and the dental plan contractor, may appeal an adverse determination. The appealing party is the party who actually files the appeal.

(1) Parties to the initial determination. For purposes of these appeal and hearing procedures, the following are not parties to an initial determination and are not entitled to administrative review under this section.

(a) A provider disqualified or excluded as an authorized provider **under** the Active Duty Dependents Dental Plan based on a determination under another **Federal** or **federally** funded program is not a party to the **OCHAMPUS** action and may not appeal under this section.

(b) A sponsor or parent of a beneficiary under 18 years of age or guardian of an incompetent beneficiary is not a party to the initial determination and may not serve as the appealing party, although such persons may represent the appealing party in an appeal.

(c) A third party other than the **dental** plan contractor, such as an insurance company, is not a party to the initial determination and is not entitled to appeal, even though it may have an indirect interest in the initial determination.

(d) A nonparticipating provider is not a party to the initial determination and may **not** appeal.

(2) Representative. Any party to the initial determination may appoint a representative to act on behalf of the party in connection with an appeal. Generally, the parent of a minor beneficiary and the legally appointed guardian of an incompetent beneficiary shall be presumed to have been appointed representative without specific designation by the beneficiary.

(a) The representative shall have the same authority as the party to the appeal, and notice given to the representative shall constitute notice required to be given to the party under this part.

(b) To avoid possible conflicts of interest, an officer or employee of the United States, such as an employee or member of a Uniformed Service, including an employee or staff member of a Uniformed Service legal office, or a CHAMPUS advisor, subject to the exceptions in 18 U.S.C. 205, is not eligible to serve as a representative. An exception usually is made for an employee or member of a Uniformed Service who represents an immediate family member. In addition, the Director, OCHAMPUS, or designee, may appoint an officer or employee of the United States as the OCHAMPUS representative at a hearing.

c. Burden of proof. The burden of proof is on the appealing party to establish affirmatively by substantial evidence the appealing party's entitlement under law and this Regulation to the authorization of the Active Duty Dependents Dental Plan benefits or approval as an authorized provider. Any cost or fee associated with the production or submission of information in support of an appeal may not be paid by OCHAMPUS.

d. Late filing. If a request for reconsideration, formal review, or hearing is filed after the time permitted in this section, written notice shall be issued denying the request. Late filing may be permitted only if the appealing party reasonably can demonstrate to the satisfaction of the dental plan contractor, or the Director, OCHAMPUS, or designee, that timely filing of the request was not feasible due to extraordinary circumstances over which the appealing party had no practical control. Each request for an exception to the filing requirement will be considered on its own merits.

e. Appealable issue. An appealable issue is required in order for an adverse determination to be appealed under the provisions of this section. Examples of issues that are not appealable under this section include:

(1) A dispute regarding a requirement of the law or regulation.

(2) The amount of the dental plan contractor-determined allowable charge since the methodology constitutes a limitation on benefits under the provisions of this part.

(3) Certain other issues on the basis that the authority for the initial determination is not vested in OCHAMPUS. Such issues include but are not limited to the following examples:

(a) Determination of a person's eligibility as an enrolled beneficiary in the Active Duty Dependents Dental Plan is the responsibility of the appropriate Uniformed Service. Although OCHAMPUS and the dental plan contractor must make determinations concerning a beneficiary's enrollment, ultimate responsibility for resolving a beneficiary's eligibility and **enrollment** rests with the Uniformed Services. Accordingly, a disputed question of fact concerning a beneficiary's enrollment or eligibility will not be considered an appealable issue under the provisions of this section, but shall **be** resolved in accordance with Section C of this Chapter.

(b) The decision to disqualify or exclude a provider because of a determination against that provider under another Federal or federally funded program is not an initial determination that is appealable under this section. The provider is limited to exhausting administrative **appeal** rights offered under the Federal or federally funded program that made the initial determination. However, a determination to disqualify or exclude a provider because of abuse or fraudulent practices or procedures under the Active Duty Dependents **Dental** Plan is an initial determination that is appealable under this section.

f. Amount in dispute. An **amount** in dispute is required for an adverse determination to **be** appealed under the provisions of this section, except as set forth in the following.

(1) The amount in dispute is calculated as the amount of money the dental plan contractor would pay if the services and supplies involved in dispute were determined to **be** authorized benefits of the Active Duty Dependents Dental Plan. Examples of amounts of money that are excluded by this section from payments for authorized benefits include, but are **not** limited to:

(a) Amounts in excess of the dental plan **contractor-**determined allowable charge.

(b) The beneficiary's cost-share amounts for restorative services.

(c) Amounts that the beneficiary, or parent, guardian, or other responsible person has no legal obligation to pay.

(2) There is no requirement for an amount in dispute when the appealable issue involves a **denial** of a provider's request for approval as an authorized provider or the determination to disqualify or exclude a provider as an authorized provider.

(3) Individual claims may be combined to meet the required amount in dispute if **all** of the following exist:

(a) The claims involve the same beneficiary.

(b) The claims involve the same issue.

(c) At least one of the claims so combined has had a reconsideration decision issued by the dental plan contractor.

NOTE: A request for administrative review under this appeal process which involves a dispute regarding a requirement of **law** or regulation (paragraph i.e.(1) of this section) or does not involve a sufficient amount in dispute (paragraph 1.f. of this section) may not be rejected at the reconsideration level of appeal. However, an appeal shall involve an appealable issue and sufficient amount in dispute under these subsections to be granted a formal review or hearing.

g. Levels of appeal. The sequence and procedures of an Active Duty Dependents Dental Plan appeal are contained in the following.

(1) Reconsideration by the dental plan contractor.

(2) Formal review by **OCHAMPUS**.

(3) Hearing.

2. Reconsideration. Any party to the initial determination made by the dental plan contractor may request a reconsideration.

a. Requesting a reconsideration

(1) Written request required. The request must be in writing, shall state the specific matter in dispute, and shall include a copy of the notice of initial determination made by the dental plan contractor, such as the explanation of benefits.

(2) Where to file. The request shall be submitted to the dental plan contractor's office as designated in the notice of initial determination.

(3) Allowed time to file. The request must be mailed within 90 days after the date of the notice of initial determination.

(4) Official filing date. A request for a reconsideration shall be deemed filed on the date it is mailed and postmarked. If the request does not have a postmark, it shall be deemed filed on the date received by the dental plan contractor.

b. The reconsideration process. The purpose of the reconsideration is to determine whether **the** initial determination was made in accordance with law, regulation, policies, and guidelines in effect at the time the care was provided or requested or at the time the provider requested

approval as an authorized provider. The reconsideration is performed by a member of the dental plan contractor's staff who was not involved in making the initial determination and is a thorough and independent review of the case. The reconsideration is based on the information submitted that led to the initial determination, plus any additional information that the appealing party may submit or the dental plan contractor may obtain.

c. Timeliness of 'reconsideration determination. The dental plan contractor normally shall issue its reconsideration determination no later than 60 days from the date of its receipt of the request for reconsideration.

d. Notice of reconsideration determination. The dental plan contractor shall issue a written notice of the reconsideration determination to the appealing party at his or her last known address. The notice of the reconsideration determination must contain the following elements:

(1) A statement of the issue or issues under appeal.

(2) The provisions of law, regulation, policies, and guidelines that apply to the issue or issues under appeal.

(3) A discussion of the original and additional information that is relevant to the issue or issues under appeal.

(4) Whether the reconsideration upholds the initial determination or reverses it, in whole or in part, and the rationale for the action.

(5) A statement of the right to appeal further in any case when the reconsideration determination is less than fully favorable to the appealing party and the amount in dispute is \$50 or more.

e. Effect of reconsideration determination. The reconsideration determination is final if either of the following exist:

(1) The amount in dispute is less than \$50.

(2) Appeal rights have been offered, but a request for **formal** review is not received by OCHAMPUS within 60 days of the date of the notice of the reconsideration determination.

3. Formal review. Any party to the initial determination may request a formal review by OCHAMPUS if the party is dissatisfied with the reconsideration determination and the reconsideration determination is not final under the provisions of paragraph 2.e. of this section. Any party to the initial determination made by OCHAMPUS may request a formal review by OCHAMPUS if the party is dissatisfied with the initial determination.

a. Requesting a formal review

(1) Written request required. The request must **be** in writing, shall state the **specific** matter in dispute, shall include copies of the written determination (notice of reconsideration determination) being appealed, and **shall** include any additional information or documents not submitted previously.

(2) Where to file. The request shall be submitted to the Chief, Appeals and Hearings, **OCHAMPUS**, Aurora, Colorado 80045-6900.

(3) Allowed time to file. The request shall **be** mailed within 60 days after the date of the notice of the reconsideration determination being appealed.

(4) Official filing date. A request for a formal review shall be deemed filed on the date it is mailed and postmarked. If the request **does** not have a postmark, it shall be deemed filed on the date received by **OCHAMPUS**.

b. The formal review process. The purpose of the formal review is to determine whether the initial determination or reconsideration determination was made in accordance with law, regulation, policies, and guidelines in effect at the time the care was **provided** or requested, at the time the provider requested approval as an authorized provider, or at the time of **the** action by **OCHAMPUS** to disqualify or exclude a provider. The formal review is performed by the Chief, Appeals and Hearings, **OCHAMPUS**, or a **designee**, and is a thorough review of the case. The formal review determination shall be based on the information upon which the initial determination or reconsideration **determination** was based and any additional information the appealing party or the dental plan contractor may submit or **OCHAMPUS** may obtain.

c. Timeliness of formal review determination. The Chief, Appeals and Hearings, **OCHAMPUS**, or a designee, normally shall issue the formal review determination no later than 90 days from the date of receipt of the request for formal review by the **OCHAMPUS**.

d. Notice of formal review determination. The Chief, Appeals and Hearings, **OCHAMPUS**, or a designee, shall issue a written notice of the formal review determination to the appealing party at his or her last known address. The notice of the formal review determination must contain the following elements:

(1) A statement of the issue or issues under appeal.

(2) The provisions of law, regulation, policies, and guidelines that apply to the issue or issues under appeal.

(3) A discussion of the original and additional information that is relevant to the issue or issues under appeal.

(4) Whether the formal review upholds the prior determination or determinations or reverses the prior determination or determinations in whole or in part and the rationale for the action.

(5) A statement of the right to request a hearing in any case when the formal review determination is less than fully favorable, the issue is appealable, and the amount in dispute is \$300 or more.

e. Effect of formal review determination. The formal review determination is final if one or more of the following exist:

(1) The issue is not appealable. (See paragraph I.e. of this section.)

(2) The amount in dispute is less than \$300. (See paragraph 1.f. of this section.)

(3) Appeal rights have been offered, but a request for hearing is not received by OCHAMPUS within 60 days of the date of the notice of the formal review determination.

4. Hearing. Any party to the initial determination may request a hearing. if the party is dissatisfied with the formal review determination and the formal review determination is not final under the provisions of paragraph 3.e. of this section.

a. Requesting a hearing

(1) Written request required. The request shall be in writing, state the specific matter in dispute, include a copy of the formal review determination, and include any additional information or documents not submitted previously.

(2) Where to file. The request shall be submitted to the Chief, Appeals and Hearings, OCHAMPUS, Aurora, Colorado 80045-6900.

(3) Allowed time to file. The request shall be mailed within 60 days after the date of the notice of the formal review determination being appealed.

(4) Official filing date. A request for hearing shall be deemed filed on the date it is mailed and postmarked. If a request for hearing does not have a postmark, it shall be deemed filed on the date received by OCHAMPUS.

b. The hearing process. The hearing shall be conducted as a nonadversary, administrative proceeding to determine the facts of the case and to allow the appealing party the opportunity personally to present the case before an impartial hearing officer. The hearing is a forum in which facts

relevant to the case are presented and evaluated in relation to applicable law, regulation, policies, and guidelines in effect at the time the care was provided or requested, or at the time the provider requested approval as an authorized provider.

c. Timeliness of hearing

(1) Except **as** otherwise provided in this section, within 60 days following receipt of a request for hearing, the Director, **OCHAMPUS**, or a designee, normally **will** appoint a hearing officer to hear the appeal. Copies of **all** records in the possession of **OCHAMPUS** that **are** pertinent to the matter to **be heard** or that formed the basis of the **formal** review determination **shall** be provided to the hearing officer and, upon request, to the appealing party.

(2) The hearing officer, except as otherwise provided in this section, normally shall have 60 days from **the** date of written notice of assignment to review the file, schedule and hold the hearing, and issue a recommended decision to the Director, **OCHAMPUS**, or designee.

(3) The Director, **OCHAMPUS**, or designee, may delay the case assignment to the hearing officer if additional information is needed that cannot be obtained and included in the record within the time period specified above. The appealing party will be notified in writing of the **delay** resulting from the request for additional information. The Director, **OCHAMPUS**, or a designee, in such circumstances, will assign the case to a hearing officer within 30 days of receipt of **all** such additional information or within 60 days of receipt of the request for hearing, whichever shall occur last.

(4) The hearing officer may delay submitting the recommended decision if, at the close of the hearing, any party to the hearing requests that the record remain open for submission of additional information. In such circumstances, the hearing officer will have 30 days following receipt of all such additional information including comments from the other parties to the hearing concerning the additional information to submit the recommended decision to the Director, **OCHAMPUS**, or a designee.

d. Representation at a hearing. Any party to the hearing may appoint a representative to act on behalf of the party at the hearing, unless such person currently is disqualified or suspended from acting in another Federal administrative proceeding, or unless otherwise prohibited by law, this part, or any other DoD regulation (see paragraph 1 of this section). A hearing officer may refuse to **allow** any person to represent a party at the hearing when such person engages in unethical, disruptive, or contemptuous conduct, or intentionally fails to comply with proper instructions or requests of the hearing officer or the provisions of this part. The representative **shall** have the same authority as the appealing party, and notice given to the representative shall constitute notice required to be given to the appealing party.

e. Consolidation of proceedings. The Director, **OCHAMPUS**, or a designee, may consolidate any number of proceedings for hearing when the facts and circumstances are similar and no substantial right of an appealing party will be prejudiced.

f. Authority of the hearing officer. The hearing officer, in exercising the authority to conduct a hearing under this part, will **be** bound by 10 U.S.C., Chapter 55 and this part. The hearing officer in addressing substantive, appealable issues shall be bound by the dental benefits brochure, policies, procedures, and other guidelines issued by the **ASD(HA)**, or a designee, or **by** the Director, **OCHAMPUS**, or a designee, in effect for the period in which the matter in dispute arose. A hearing officer **may** not establish or amend the dental benefits brochure, policy, procedures, instructions, or guidelines. However, the hearing officer may recommend reconsideration of the policy, procedures, instructions or guidelines **by** the ASD(HA), or a designee, when the final decision is issued in **the case**.

g. Disqualification of hearing officer. A hearing officer voluntarily shall disqualify himself or herself and withdraw from any proceeding in which the hearing officer cannot give fair or impartial hearing, or in which there is a conflict of interest. A party to the hearing may request the disqualification of a hearing officer **by** filing a statement detailing the reasons the party believes that a fair and impartial hearing cannot be given or that a conflict of interest exists. Such request immediately shall be sent by the appealing party or the hearing officer to the Director, **OCHAMPUS**, or a designee, who shall investigate the allegations and advise the complaining party of the decision in writing. A copy of such decision also shall be mailed to all other parties to the hearing. If the Director, **OCHAMPUS**, or a designee, reassigns the case to another hearing officer, **no** investigation shall be required.

h. Notice and scheduling of hearing. The hearing officer shall issue by certified mail, when practicable, a written notice to the parties to the hearing of the time and place for the hearing. Such notice shall be **mailed** at least 15 days before the scheduled date of the hearing. The notice shall contain sufficient information about the hearing procedure, including the party's right to representation, to allow for effective preparation. The notice also shall advise the appealing party of the right to request a **COPY** of the record before the hearing. Additionally, the notice shall advise the appealing party of his or her responsibility to furnish the hearing officer, no later than 7 days before the scheduled date of the hearing, a list of **all** witnesses who will testify and a copy of all additional information to be presented at the hearing. The time and place of the hearing shall be determined by the hearing officer, who shall select a reasonable time and location mutually convenient to the appealing party and **OCHAMPUS**.

i. Dismissal of request for hearing

(1) By application of appealing party. A request for hearing may be dismissed by the Director, **OCHAMPUS**, or a designee, at any time **before** the mailing of the final decision, upon the application of the appealing party. A request for dismissal must be in writing and filed with the Chief,

appeals and Hearings, **OCHAMPUS**, or the hearing officer. When dismissal is requested, the formal review determination in the case shall be deemed final, unless the dismissal is vacated in accordance with subparagraph (5) below.

(2) By stipulation of the parties to the hearing. A request for a hearing may **be** dismissed **by** the Director, **OCHAMPUS**, or a designee, at any time before the mailing of notice of the final decision under a stipulation agreement between the appealing party **and** **OCHAMPUS**. When dismissal is entered under a stipulation, the formal review decision shall be deemed final, **unless** the dismissal is vacated in accordance with subparagraph (5) below.

(3) By abandonment. The Director, **OCHAMPUS**, or a designee, may dismiss a request for, hearing upon abandonment by the appealing party.

(a) An appealing party shall be deemed **to have** abandoned a request for hearing, **other** than when personal appearance is waived in accordance with paragraph **4.k.** (13), below, if neither the appealing party nor an appointed representative appears at the time and place fixed for the hearing and if, within 10 days after the mailing **of** a notice by certified mail to the appealing party by the hearing officer to show cause, **such party** does not show good and sufficient cause for such failure to appear and failure to notify the hearing officer before the time fixed for hearing that an appearance could not be made.

(b) An appealing party **shall be** deemed to have abandoned a request for hearing if, before assignment of the case to the hearing officer, **OCHAMPUS** is unable to locate either the appealing party or an appointed representative.

(c) An appealing party shall **be** deemed to have abandoned a request for hearing if the appealing party fails to prosecute the appeal. Failure to prosecute the appeal includes, but is not limited to, an appealing party's failure to provide information reasonably requested by **OCHAMPUS** or the hearing officer for consideration in the appeal.

(c1) If the Director, **OCHAMPUS**, or a designee, dismisses the request for hearing because of abandonment, the formal review determination in the case **shall** be deemed **to** be final, **unless** the dismissal is vacated in accordance with paragraph **4.i.**(5) below.

(4) For cause. The Director, **OCHAMPUS**, or a designee, may dismiss for cause a request for hearing either entirely or as to any stated issue. If the Director, **OCHAMPUS**, or a designee, dismisses a hearing request for cause, the formal review determination in the case shall be deemed **to be** final, unless the dismissal is vacated in accordance with paragraph **4.i.**(5) below. A dismissal for cause may be issued under any of the following circumstances:

(a) When the appealing party requesting the hearing is not a proper party under paragraph 1b.(1), above, or does not otherwise have a right to participate in a hearing.

(b) When the appealing party who filed the hearing request dies, and there is no information before the Director, **OCHAMPUS**, or a designee, showing that a party to the initial determination who is not an appealing party may be prejudiced by the **formal** review determination.

(c) When the issue is not appealable (See paragraph 1.e. of this section.)

(d) When the amount in dispute is less than \$300 (See paragraph 1.f. of this section.)

(e) When **all** appealable issues have been resolved in favor of the appealing party.

(5) Vacation of dismissal. Dismissal of a request for hearing may be vacated by the Director, **OCHAMPUS**, or a designee, upon written request of the appealing party, if the request is received within 6 months of the date of the notice of dismissal mailed to the last known address of the party requesting the hearing.

j. Preparation for hearing

(1) Preheating statement of contentions. The hearing officer may on reasonable notice, require a party to the hearing to **submit** a written statement of contentions and reasons. The written statement shall be **provided** to all parties to the hearing before the hearing takes place.

(2) Agency records

(a) Hearing officer. A hearing officer may ask **OCHAMPUS** to produce, for inspection, any records or relevant portions of records when they are needed to decide the issues in any proceeding before the hearing officer or to assist an appealing party in preparing for the proceeding.

(b) Appealing party. A request to a hearing officer by an appealing party for disclosure or inspection of **OCHAMPUS** or the dental plan contractor records shall **be** in writing and shall state clearly what information and records are required.

(3) Witnesses and evidence. All parties to a hearing are responsible for producing, at each party's expense, meaning without reimbursement of payment by **OCHAMPUS**, witnesses and other evidence in their own behalf, and for furnishing copies of any such documentary evidence to the hearing officer and other party or parties to the hearing. The Department of Defense is not authorized to subpoena witnesses or records. The hearing

officer may issue invitations and requests to individuals to appear and testify without cost to the Government, so that the full facts in the case may be presented.

(4) Interrogatories and depositions. A hearing officer may arrange to take interrogatories and depositions, recognizing that the Department of Defense does not have subpoena authority. The expense shall be assessed to the requesting party, with copies furnished to the hearing officer and other party or parties to the hearing.

k. Conduct of hearing

(1) Right to open hearing. Because of the personal nature of the matters to be considered, hearings normally shall be closed to the public. However, the appealing party may request an open hearing. If this occurs, the hearing shall be open, except when protection of other legitimate Government purposes dictates closing certain portions of the hearing.

(2) Right to examine parties to the hearing and their witnesses. Each party to the hearing shall have the right to produce and examine witnesses, to introduce exhibits, to question opposing witnesses on any matter relevant to the issue even though the matter was not covered in the direct examination, to impeach any witness regardless of which party to the hearing first called the witness to testify, and to rebut any evidence presented. Except for those witnesses employed by **OCHAMPUS** at the time of the hearing or records in the possession of **OCHAMPUS**, a party to a hearing shall be responsible, that is to say no payment or reimbursement shall be made by **CHAMPUS** for the cost or fee associated with producing witnesses or other evidence in the party's own behalf, or for furnishing copies of documentary evidence to the hearing officer and other party or parties to the hearing.

(3) Burden of proof. The burden of proof is on the appealing party affirmatively to establish by substantial evidence the appealing party's entitlement under law and this Regulation to the authorization of Active Duty Dependents Dental Plan benefits or approval as an authorized provider. Any part of the cost or fee associated with producing or submitting in support of an appeal may not be paid by **OCHAMPUS**.

(4) Taking of evidence. The hearing officer shall control the taking of evidence in a manner best suited to ascertain the facts and safeguard the rights of the parties to the hearing. Before taking evidence, the hearing officer shall identify and state the issues in dispute on the record and the order in which evidence will be received.

(5) Questioning and admission of evidence. A hearing officer may question any witness and shall admit any relevant evidence. Evidence that is irrelevant or unduly repetitious shall be excluded.

(6) Relevant evidence. Any relevant evidence shall be admitted, unless unduly repetitious, **if** it is the type of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the existence of any common law or statutory rule that might make improper the admission of such evidence over objection in civil **or** criminal actions.

(7) Active Duty Dependents Dental Plan determination first. The basis of the Active Duty Dependents Dental Plan determinations shall **be** presented to the hearing officer first. The appealing party shall then be given the opportunity to establish affirmatively why this determination is held to be in error.

(8) Testimony. Testimony shall be taken only on **oath**, affirmation, or penalty of perjury.

(9) Oral argument and briefs. At the request of any party to the hearing made before the close of the hearing, the hearing officer **shall** grant oral argument. If written argument is requested, it shall be granted, **and** the parties to the hearing **shall** be advised as to the time and manner within which such argument is to be filed. The hearing officer may require any party to the hearing to submit written memoranda pertaining to any or all issues raised in the hearing.

(1.0) Continuance of hearing. A hearing officer may continue a hearing to another time or place on his or her own motion or, upon showing of good cause, at the request of any party. Written notice of the time and place of the continued hearing, except as otherwise provided here, shall **be** in accordance with this part. When a continuance is ordered during a hearing, oral notice of the time and place of the continued hearing may be given to each party to the hearing who is present at the hearing.

(11) Continuance for additional evidence. If the hearing officer determines, after a hearing has begun, that additional evidence is necessary for the proper determination of the case, the following procedures may be invoked:

(a) Continue hearing. The hearing may **be** continued to a later date in **accordance with paragraph 4.k.** (10) of this section.

(b) Closed hearing. The hearing may be closed, but the record held open in **order** to permit the introduction **of** additional evidence. Any evidence submitted after the close of the hearing shall be made available to all parties to the hearing, and all parties to the hearing shall have the opportunity for comment. The hearing officer may reopen the hearing if any portion of the additional evidence makes further hearing desirable. Notice thereof shall be given in accordance with paragraph 4.h. of this section.

(12) Transcript of hearing. A verbatim taped record of the hearing shall be made and shall become a permanent part of the record. Upon request, the appealing party **shall** be furnished a duplicate copy of the

tape. A typed transcript of the testimony will **be** made only when determined to be necessary **by OCHAMPUS**. If a typed transcript is made, the appealing party shall be furnished a copy without charge. Corrections shall be allowed in the typed transcript **by** the hearing officer **solely** for the purpose of conforming the transcript to the actual testimony.

(13) Waiver of right to appear and present evidence. If all parties waive their right to appear before the hearing officer for presenting evidence and contentions personally or by representation, it will not be necessary for the hearing officer to give notice of, or to conduct a formal hearing. A waiver of the right to appear must be in writing and filed with the hearing officer or the Chief, Appeals and Hearings, **OCHAMPUS**. Such waiver may be withdrawn by the party **by** written notice received by the hearing officer or Chief, Appeals and Hearings, no later than 7 days before the scheduled hearing or the mailing of notice of the final decision, whichever occurs first. For purposes of this section, failure of a party to appear personally or by representation after filing written notice of waiver, will not be cause for finding of abandonment and the hearing officer **shall** make the recommended decision on the basis of **all** evidence of record.

(14) Recommended decision. At the conclusion of the hearing and after the record has been closed, the matter shall be taken under consideration **by** the hearing officer. Within the time frames previously set forth in this section, the hearing officer shall submit to the Director, **OCHAMPUS**, or a designee, a written recommended **decision** containing a statement of findings and a statement of reasons based on the evidence adduced at the hearing and otherwise included in the hearing record.

(a) Statement of findings. A statement **of** findings is a clear and concise statement of fact evidenced in the record or conclusions that readily can **be** deduced from the evidence of record. Each finding must **be** supported **by** substantial evidence that is defined as such evidence as a reasonable mind can accept as adequate to support a conclusion.

(b) Statement of reasons. A reason **is** a clear and concise statement of law, regulation, policies, or guidelines relating to the statement of findings that provides the basis for the recommended decision.

5. Final decision

a. Director, OCHAMPUS. The recommended decision shall **be** reviewed by the Director, **OCHAMPUS**, or a designee, who shall adopt or reject the recommended decision or refer the recommended decision for review by the Assistant Secretary of Defense (Health Affairs). The Director, **OCHAMPUS**, or designee, normally will take action with regard to the recommended decision within **90** days of receipt of the recommended decision or receipt of the revised recommended decision following a remand order to the Hearing Officer.

(1) Final action. If the Director, **OCHAMPUS**, or a designee, concurs in the recommended decision, no further agency action is required and **the** recommended decision, as adopted by the Director, **OCHAMPUS**, is the final

agency decision in the appeal. In the case of rejection, the Director, **OCHAMPUS**, or a designee, shall state the reason for disagreement with the recommended decision and the underlying facts supporting such disagreement. In these circumstances, the Director, **OCHAMPUS**, or a designee, may have a final decision prepared based on the record, or may remand the matter to the Hearing Officer for appropriate action. In the latter instance, the Hearing Officer shall take appropriate action and submit a new recommended decision **within** 60 days of receipt of the remand order. The decision by the Director, **OCHAMPUS**, or a designee, concerning a case arising under the procedures of this section, shall be the final agency decision and the final decision shall be sent by certified mail to the appealing party or parties. A **final** agency decision under this paragraph 5a. will not be relied on, used, or cited as precedent by the Department of Defense or the dental plan contractor in the administration of the Active Duty Dependents Dental Plan.

(2) Referral for review by **ASD(HA)**. The Director, **OCHAMPUS**, or a designee, may refer a hearing case to the Assistant Secretary of Defense (Health Affairs) when the hearing involves the resolution of policy and issuance of a final decision which may be relied on, used, or cited as precedent in the administration of the Active Duty Dependents Dental Plan. In such a circumstance, the Director, **OCHAMPUS**, or a designee, shall **forward** the recommended decision, together with the recommendation of the Director, **OCHAMPUS**, or a designee, regarding disposition of the hearing case.

b. **ASD(HA)**. The **ASD(HA)**, or a designee, after reviewing a case arising under the procedures of this section may issue a final decision based on the record in the hearing case or remand the case to the Director, **OCHAMPUS**, or a designee, **for** appropriate action. A decision issued **by** the **ASD(HA)**, or a designee, shall be the final agency decision in the appeal and a copy of the final decision shall be sent by certified mail to the appealing party or parties. A final decision of the **ASD(HA)**, or a designee, issued under this paragraph **5.b.** may be relied on, used, or cited as precedent in the administration of the Active Duty Dependents Dental Plan.

CHAPTER 14

PROVIDER REIMBURSEMENT METHODS

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CHAPTER 14
PROVIDER REIMBURSEMENT METHODS

A. HOSPITALS

The CHAMPUS-determined allowable cost for reimbursement of a hospital shall be determined on the basis of one of the following methodologies.

1. CHAMPUS Diagnosis Related Group(DRG)-based payment system. Under the CHAMPUS **DRG-based** payment system, payment for the operating costs of inpatient hospital services furnished by hospitals subject to the system is made on the basis of prospectively-determined rates and applied on a per discharge basis using DRGs. Payments under this system will include a differentiation for urban (using large urban and other urban areas) and rural hospitals and an adjustment for area wage differences and indirect medical education costs. Additional payments will be made for capital costs, direct medical education costs, and outlier cases.

a. General.

(1) DRGs used. The CHAMPUS **DRG-based** payment system will use the same DRGs used in the most recently available grouper for the Medicare Prospective Payment System, except as necessary to recognize distinct characteristics of CHAMPUS beneficiaries and as described in instructions issued by the Director, OCHAMPUS.

(2) Assignment of discharges to DRGs.

(a) The classification of a particular discharge shall be based on the patient's age, sex, principal diagnosis (that is, the diagnosis established, after study, to be chiefly responsible for causing the patient's admission to the hospital), secondary diagnoses, procedures performed and discharge status. In addition, for neonatal cases (other than normal newborns) the classification shall also account for birthweight, surgery and the presence of multiple, major and other neonatal problems, and shall incorporate annual updates to these classification features.

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

(3) Basis of payment.

(a) Hospital billing. Under the CHAMPUS **DRG-based** payment system, hospitals are required to submit claims (including itemized charges) in accordance with Chapter 7, paragraph B. The CHAMPUS fiscal intermediary will assign the appropriate DRG to the claim based on the information contained on the claim. Any request from a hospital for reclassification of a claim to a higher weighted DRG must be submitted, within 60 days from the date of the initial payment, in a manner prescribed by the Director, OCHAMPUS. I

(b) Payment on a per-discharge basis. Under the CHAMPUS **DRG-based** payment system, hospitals are paid a predetermined amount per discharge for inpatient hospital services furnished to CHAMPUS beneficiaries.

(c) Claims priced as of date of admission. Except for interim claims submitted for qualifying **outlier** cases, all claims reimbursed under the CHAMPUS **DRG-based** payment system are to be priced as of the date of admission, regardless of when the claim is submitted.

(d) Payment in full. The **DRG-based** amount paid for inpatient hospital services is the total CHAMPUS payment for the inpatient operating costs (as described in subparagraph **A.1.a.** (3)(e)) incurred in furnishing services covered by the CHAMPUS. The full prospective payment amount is payable for each stay during which there is **at least one covered day of care**, except as provided in subparagraph **A.1.c. (5)(a)1a.**

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

- 1 Operating costs for routine services; such as the costs of room, board, and routine nursing services;
- 2 Operating costs for ancillary services, **such as** hospital radiology and laboratory services (other than physicians' services) furnished to hospital inpatients;
- 3 Special care unit operating costs; and
- 4 Malpractice insurance costs related to services furnished to inpatients.

(f) Discharges and transfers.

1 Discharges. A hospital inpatient is discharged when:

a The patient is formally released from the hospital (release of the **patient** to another hospital as described in subparagraph 2 of this subparagraph, or a leave of absence from the hospital, will not be recognized as a discharge for the purpose of determining payment under the CHAMPUS **DRG-based** payment system);

b The patient dies in the hospital; or

c The patient is transferred from the care of a hospital included under the CHAMPUS **DRG-based** payment system to a hospital or unit that is excluded from the prospective payment system.

2 Transfers. Except as provided under subparagraph **A.1.a. (3)(f)1**, a discharge of a hospital inpatient is not counted for purposes of the CHAMPUS **DRG-based** payment system when the patient is transferred:

a From one inpatient area or unit of the hospital to another area or **unit** of the same hospital;

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

c From the care of a hospital included under the CHAMPUS **DRG-based** payment system to the care of another hospital that is excluded from the CHAMPUS **DRG-based** payment system because of participation in a statewide cost control program which is exempt from the CHAMPUS **DRG-based** payment system under subparagraph **A.1.b.** (1) of this chapter; or

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

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

4 Payment to a hospital transferring an inpatient to another hospital. If a hospital subject to the CHAMPUS **DRG-based** payment system transfers an inpatient to another such hospital, the transferring hospital shall be paid a per diem rate (except that in neonatal cases, other than normal newborns, the hospital will **be** paid at 125 percent of that per diem rate), as determined under instructions issued by **OCHAMPUS**, for each day of the patient's stay in that hospital, not to exceed the **DRG-based** payment that would have been paid if the patient had been discharged to another setting. However, if a discharge is classified into DRG No. 456 (Burns, transferred to another acute care facility) or DRG 601 (neonate, transferred less than or equal to 4 days old), the transferring hospital shall be paid in full .

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

(4) DRG system updates. The CHAMPUS **DRG-based** payment system is modeled on the Medicare Prospective Payment System (**PPS**) and uses annually updated items and numbers from the Medicare PPS as provided for in this Part and in instructions issued by the Director, **OCHAMPUS**. The effective date of these items and numbers shall correspond to that under the Medicare PPS except where distinctions are made in this chapter.

b. Applicability of the DRG system.

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

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

(3) Services exempt from the DRG-based payment system. The following hospital services, even when provided in a hospital subject to the CHAMPUS DRG-based payment system, are exempt from the CHAMPUS DRG-based payment system. The services in subparagraphs A.1.b. (3)(a) through (d) and (g) through (i) shall be reimbursed under the procedures in subsection A.3. of this chapter, and the services in subparagraphs A.1.b. (3)(e) and (f) shall be reimbursed under the procedures in section G. of this chapter.

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

(b) All services related to kidney acquisition by Renal Transplantation Centers.

(c) All services related to a heart transplantation which would otherwise be paid under DRG 103.

(d) All services related to liver transplantation when the transplant is performed in a CHAMPUS-authorized liver transplantation center.

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

(f) All services provided by nurse anesthetists.

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

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

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

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

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

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

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

(c) Psychiatric and rehabilitation units (distinct parts). A psychiatric or rehabilitation unit which is exempt from the Medicare prospective payment system is also exempt from the CHAMPUS **DRG-based** payment system. In order for a distinct unit which does not participate in Medicare to be exempt from the CHAMPUS **DRG-based** payment system, it must meet the same criteria (as determined by the Director, **OCHAMPUS**, or a designee) as required for exemption from the Medicare Prospective Payment System as contained in Section 412.23 of Title 42 **CFR**.

(d) Long-term hospitals. A long-term hospital which is exempt from the Medicare prospective payment system is also exempt from the CHAMPUS **DRG-based** payment system. In order for a long-term hospital which does not participate in Medicare to be exempt from the CHAMPUS **DRG-based** payment system, it must have an average length of inpatient stay greater than 25 days:

1 As computed by dividing the number of total inpatient days (less leave **or** pass days) by the total number of discharges for the hospital's most recent **fiscal** year; or

2 As computed by the same method for the immediately preceding six-month period, if a change in the hospital's average length of stay is indicated.

(e) Sole community hospitals. Any hospital which has qualified for special treatment under the Medicare prospective payment system as a sole community hospital and has not given up that classification is exempt from **the** CHAMPUS **DRG-based** payment system. (See Subpart G of 42 CFR Part 412.)

(f) Christian Science sanatoriums. All Christian Science **sanatoriums** (as defined in paragraph B.4.h. of Chapter 6) are exempt from the CHAMPUS **DRG-based** payment system.

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

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

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

(6) Substance Use Disorder Rehabilitation facilities. With admissions on or **after** July 1, 1995, substance use disorder rehabilitation facilities, authorized under chapter 6, section **B.4.n.**, are subject to the **DRG-based** payment system.

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

(1) Calculation of DRG Weights.

(a) Grouping of charges. All discharge records in the database shall be grouped by DRG.

(b) Remove DRGs 469 and 470. Records from DRGs 469 and 470 shall be removed from the database.

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

$$1.43 \times \left[\left\{ 1.0 + \frac{\text{number of interns + residents}}{\text{number of beds}} \right\}^{.5795} - 1.0 \right]$$

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

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

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

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

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

(2) Empty and low-volume DRGs. The Medicare weight shall be used for any DRG with less than ten (10) occurrences in the CHAMPUS database. The short-stay thresholds shall be set at one day for these DRGs and the long-stay thresholds shall be set at the FY 87 Medicare thresholds.

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

(a) DRG weights shall be recalculated annually using CHAMPUS charge data and the methodology described in subparagraph **A.1.c.** (1) of this chapter.

(b) When a new DRG is created, CHAMPUS will, if practical, calculate a weight for it using an appropriate charge sample (if available) and the methodology described in subparagraph **A.1.c.** (1) of this chapter.

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

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

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

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

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

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

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

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

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

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

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

(5) Adjustments to the DRG-based payment amounts. The following **adjustments** to the **DRG-based** amounts (the weight multiplied by the adjusted standardized amount) will be made.

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

1 Length-of-stay outliers. Length-of-stay **outliers** shall be identified and paid by the fiscal intermediary when the claims are processed.

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

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

2 Cost outliers. Additional payment for cost **outliers** shall be made only upon request by the hospital.

a Cost outliers except those in children's hospitals or for neonatal services. Any discharge which has standardized costs that exceed a threshold established in accordance with the criteria used for the Medicare Prospective Payment System as contained in 42 CFR 412.84 shall qualify as a cost **outlier**. The standardized costs shall be calculated by multiplying the total charges by the factor described in subparagraph **A.1.c.** (4)(d) and adjusting this **amount** for indirect medical education costs. Cost **outliers** shall be reimbursed the **DRG-based** amount plus a percentage (as established for the Medicare Prospective Payment System) of all costs exceeding the threshold.

b Cost outliers in children's hospitals and for neonatal services. Any discharge for services in a children's hospital or for neonatal services which has standardized costs that exceed a threshold of the greater of two times the DRG-based amount or \$13,500 shall qualify as a cost **outlier**. The standardized costs shall **be** calculated by multiplying the total charges by the factor described in subparagraph **A.1.c.(4)(d)** (adjusted to include average capital and direct medical education costs) and adjusting this amount for indirect-medical education costs. Cost **outliers** for services in **children's** hospitals and for neonatal services shall be reimbursed the **DRG-based** amount plus a percentage (as established for the Medicare Prospective Payment System) of all costs exceeding the threshold.

c Cost outliers for burn cases. All cost **outliers** for DRGs related to **burn** cases shall be reimbursed the DRG-based amount plus a percentage (as established for the Medicare Prospective Payment System) of all costs exceeding the threshold. The standardized costs and thresholds for these cases **shall** be calculated in accordance with subparagraph **A.1.c.(5)(a)2 a** and subparagraph **A.1.c.(5)(a)2 b**.

(b) Wage Adjustment. CHAMPUS will adjust the labor portion of the standardized amounts according to the hospital's area wage index.

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

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

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

2 Calculation of differential. The differential shall be equal to the difference between a specially calculated children's hospital adjusted standardized amount and the adjusted standardized amount for fiscal year 1988. The specially calculated children's hospital adjusted standardized amount shall **be** calculated in the same manner as set forth in subparagraph **A.1.c.(4)**, except that:

a The base period shall be fiscal year **1988** and shall represent total **estimated** charges for discharges that occurred during fiscal year 1988.

b No cost to charge ratio shall be applied.

c Capital costs and direct medical education costs will be included in the-calculation.

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

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

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

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

6 Administrative corrections. In connection with determinations pursuant to subparagraph **A.1.c. (5)(d)3** of this chapter, any children's hospital that believes **OCHAMPUS** erroneously failed to classify the hospital as a high volume hospital or incorrectly calculated (in the case of a high volume hospital) the hospital's differential may obtain administrative corrections by submitting appropriate documentation to the Director, **OCHAMPUS** (or designee).

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

(7) Annual Cost Pass-Throughs.

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

1 Costs included as capital costs. Allowable capital costs are those specified in Medicare Regulation Section 413.130, as modified by Section 412.72.

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

a The capital-related equipment is leased or rented by the provider;

b The capital-related equipment is located on the provider's premises; and

c The capital-related portion of the charge is separately specified in the charge to the provider.

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

(c) Information necessary for payment of capital and direct medical education costs. All hospitals subject to the **CHAMPUS DRG-based** payment system, except for children's hospitals, may be reimbursed for allowed capital-and direct medical education costs **by** submitting a request to the CHAMPUS contractor. Such request shall cover the one-year period corresponding to the hospital's Medicare cost-reporting period. The first such request may cover a period of less than a full year--from the effective date of the CHAMPUS **DRG-based** payment system to the end of the hospital's Medicare cost-reporting period. All costs reported to the CHAMPUS contractor must correspond to the costs reported on the hospital's Medicare cost report. In the case of children's hospitals that request reimbursement under this clause for capital and/or direct medical education costs, the hospital must submit appropriate base period cost information, as determined by the Director, **OCHAMPUS** (or designee). (If these costs change as a result of a **subsequent** audit by Medicare, the revised costs are to be reported to

the hospital's CHAMPUS contractor within 30 days of the date the hospital is notified of the change.) The request must be signed by the hospital official responsible for verifying the amounts and shall **contain** the following information.

- 1 The hospital's name.
- 2 The hospital's address.
- 3 The hospital's CHAMPUS provider number.
- 4 The hospital's Medicare provider number.
- 5 The period covered-- this must correspond to the hospital's Medicare cost-reporting period.
- 6 **Total** inpatient days provided to all patients in units subject to **DRG-based** payment.
- 7 Total allowed CHAMPUS inpatient days provided in units subject to **DRG-based** payment.
- 8 Total allowable capital costs.
- 9 Total allowable direct medical education costs.
- 10 Total full-time equivalents for:
 - a Residents.
 - b Interns
- 11 Total inpatient beds as of the end of the cost-reporting period. **If** this has changed during the reporting period, an explanation of the change must be provided.
- 12 Title of official signing the report.
- 13 Reporting date.
- 14 The report shall contain a certification statement that any **changes** to the items in subparagraphs 6, 7, 8, 9, or 10, which are a result of an audit of the hospital's Medicare cost-report, **shall be** reported to CHAMPUS within thirty (30) days of the date the hospital is notified of the change.

2. CHAMPUS mental health per diem payment system. The CHAMPUS mental health per diem payment system shall be used to reimburse for inpatient mental health hospital care in specialty psychiatric hospitals and units. Payment is made on the basis of prospectively determined rates and paid on a

per diem basis. The system uses two sets of per diems. One set of per diems applies to hospitals and units that have a relatively higher number of CHAMPUS discharges. For these hospitals and units, the system uses hospital-specific per diem rates. The other set of per diems applies to hospitals and units with a relatively lower number of CHAMPUS discharges. For these hospitals and units, the system uses regional per diems, and further provides for adjustments for area wage differences and indirect medical education costs and additional pass-through payments for direct medical education costs.

a. Applicability of the mental health per diem payment system.

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

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

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

(1) Per diem amount.

(a) A hospital-specific per diem amount shall be calculated for each hospital and unit with a higher volume of CHAMPUS discharges. The base period per diem amount shall be equal to the hospital's average daily charge in the base period. The base period amount, however, may not exceed the cap described in subparagraph **A.2.b.** (2), below. The base period amount shall be updated in accord with paragraph A.2.d. of this chapter.

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

(2) Cap.

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

(b) Applicable to payments for care provided to patients on or after April 6, 1995, the base period per diem amount may not exceed the 70th percentile of the average daily charge weighted for all discharges throughout the United States from all higher volume hospitals. For this purpose, base year charges shall be deemed to be charges during the period of July 1, 1991 to June 30, 1992, adjusted to correspond to base year (**FY1988**) charges by the percentage change in average daily charges for all higher volume hospitals and units between the period of July 1, 1991 to June 30, 1992 and the base year.

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

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

(1) Per diem amounts. Hospitals and units with a lower volume of CHAMPUS patients shall be paid on the basis of a regional per diem amount, adjusted for area wages and indirect medical education. Base period regional per diems shall be calculated based upon all CHAMPUS lower volume hospitals' claims paid during the base period. Each regional per diem amount shall be the quotient of all covered charges divided by all covered days of care, reported on all CHAMPUS claims from lower volume hospitals in the region paid during the base period, after having standardized for indirect medical education costs and area wage indexes and subtracted direct medical education costs. Regional per diem amounts are adjusted in accordance with subparagraph **A.2.c.** (3), below. Additional pass-through payments to lower volume hospitals are made in accordance with subparagraph **A.2.c.** (4), below. The regions shall be the same as the federal census regions.

(2) Review of per diem amount. Any hospital that believes the regional per diem amount applicable to that hospital has been erroneously calculated by **OCHAMPUS** by more than \$5.00 may submit to the Director, **OCHAMPUS**, or a designee, evidence supporting a different regional per diem. The burden of **proof** shall be on the hospital.

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

(a) Area wage index. The same area wage indexes used for the CHAMPUS **DRG-based** payment system (see subparagraph **A.1.c.** (5)(b) of this chapter) shall be applied to the wage portion of the applicable regional per diem rate for each day of the admission. The wage portion shall be the same as that used for the CHAMPUS **DRG-based** payment system.

(b) Indirect medical education. The indirect medical education adjustment factors shall be calculated for teaching hospitals in the same manner as is used in the CHAMPUS **DRG-based** payment system (see subparagraph **A.1.c.** (5)(c) of this chapter) and applied to the applicable regional per diem rate for each day of the admission.

(4) Annual cost pass-through for direct medical education. In addition to payments made to lower volume hospitals under paragraph A.2.c., CHAMPUS shall annually reimburse hospitals for actual direct medical education costs associated with services to CHAMPUS beneficiaries. This reimbursement shall be done pursuant to the same procedures as are applicable to the CHAMPUS **DRG-based** payment system (see subparagraph **A.1.c.** (7) of this chapter).

d. Base period and update factors.

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

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

(3) Update factors.

(a) The hospital-specific per diems and the regional per diems calculated for the base period pursuant to paragraph A.2.b. of this chapter shall remain in effect for federal fiscal year 1989; there **will** be no additional update for fiscal year 1989.

(b) Except as provided in paragraph A.2.d. (3)(c) of this chapter, for subsequent federal **fiscal** years, each per diem shall be updated **by** the Medicare update factor for hospitals and units exempt from the Medicare prospective payment system.

(c) As an exception to the update required by paragraph A.2.d. (3)(b) of this chapter, **all** per diems in effect at the end of fiscal year 1995 shall remain in effect, with no additional update, throughout fiscal years 1996 and 1997. For fiscal year 1998 and thereafter, the per diems in effect at the end of fiscal year 1997 will be updated in accordance with paragraph A.2.d. (3)(b).

(d) Hospitals and units with hospital-specific rates will be notified of their respective rates prior to the beginning of each Federal fiscal year. New hospitals shall be notified at such time as the hospital rate is determined. The actual amounts of each regional per diem that will apply in any Federal fiscal year shall be published in the Federal Register at approximately the start of that fiscal year.

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

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

(2) Hospitals that subsequently become higher volume hospitals. In any federal fiscal year in which a hospital, including a new hospital (see subparagraph A.2.e. (3) below), not previously classified as a higher volume hospital has 25 or more CHAMPUS discharges, that hospital shall be considered to be a higher volume hospital during the next federal fiscal year and all subsequent fiscal years. The hospital specific per diem amount shall be calculated in accordance with the provisions of paragraph A.2.b. of this chapter, except that the base period average daily charge shall be deemed to be the hospital's average daily charge in the year in which the hospital had 25 or more discharges, adjusted by the percentage change in average daily charges for all higher volume hospitals and units between the year in which the hospital had 25 or more CHAMPUS discharges and the base period. The base period amount, however, may not exceed the cap described in subparagraph A.2.b. (2) of this chapter.

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

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

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

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

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

(1) Non-specialty providers. Providers of inpatient care which are not either psychiatric hospitals or psychiatric specialty units as described in subparagraph **A.2.a. (1)** of this chapter are exempt from the CHAMPUS mental health per diem payment system. Such providers should refer to subsection A1. of this chapter for provisions pertinent to the CHAMPUS **DRG-based** payment system.

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

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

(4) Sole community hospitals. Any hospital which has qualified for special treatment under the Medicare prospective payment system as a sole community hospital and has not given up that classification is exempt.

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

i. Per diem payment for psychiatric and substance use disorder rehabilitation partial hospitalization services.

(1) In general. Psychiatric and substance use disorder rehabilitation partial hospitalization services authorized by chapter 4, sections B.10. and E.4. and provided by institutional providers authorized under chapter 6, sections **B.4.1.** and B.4.n. are reimbursed on the basis of prospectively determined, all-inclusive per diem rates. The per diem payment amount must be accepted as payment in full for all institutional services provided, including board, routine nursing services, ancillary services (includes art, music, dance, occupational and other such therapies), psychological testing and assessments, overhead and any other services for which the customary practice among similar providers is included as part of the institutional charges.

(2) Services which may be billed separately. The following services are not considered as included within the per diem payment amount and may be separately billed when provided **by** an authorized independent professional provider:

(a) Psychotherapy sessions not included. Professional services provided by an authorized professional provider (who is not employed by or under contract with the partial hospitalization program) for purposes of providing clinical patient care to a patient in the partial hospitalization program are not included in the per diem rate. They may be separately billed. Professional mental health benefits are limited to a maximum of one session (60 minutes individual, 90 minutes family, etc.) per authorized treatment day **not** to exceed five sessions in any calendar week.

(b) Non-mental health related medical services.

Those services not normally included in the evaluation and assessment of a partial hospitalization program, non-mental health related medical services, may be separately billed when provided by an authorized independent professional provider. This includes ambulance services when medically necessary for emergency transport. .

(3) Per diem rate. For any full day partial hospitalization program (minimum of 6 hours), the maximum per diem payment amount is 40 percent of the average inpatient per diem amount per case established under the CHAMPUS mental health per diem reimbursement system for both high and low volume psychiatric hospitals and units (as defined in chapter 14, section A.Z.) for the fiscal year. A partial hospitalization program of less than 6 hours (with a minimum of three hours) will be paid a per diem rate of 75 percent of the rate for a full-day program.

(4) Other requirements. No payment is due for leave days, for days in which treatment **is not** provided, or for days in which the duration of the program services was less than three hours.

3. Billed charges and set rates-. The allowable costs for authorized care in **all** hospitals not subject **to** the CHAMPUS **DRG-based** payment system or the CHAMPUS mental health per diem payment system shall be determined on the basis of billed charges or set rates. Under this procedure the allowable costs may not exceed the lower of:

- a. The actual charge for such service made to the general public;
or
- b. The allowed charge applicable to the policyholders or subscribers of the CHAMPUS fiscal intermediary for comparable services under comparable circumstances, when extended to CHAMPUS beneficiaries by consent or agreement; or
- c. The allowed charge applicable to the citizens of the community or state as established by local or state regulatory authority, excluding title XIX of the Social Security Act or other welfare program, when extended to CHAMPUS beneficiaries by consent or agreement.

4. CHAMPUS discount rates. The CHAMPUS-determined allowable cost for authorized care in any hospital may be based **on** discount rates established under section I. of this chapter.

B. SKILLED NURSING FACILITIES (SNFs)

The CHAMPUS-determined allowable cost for reimbursement of a SNF shall be determined on the same basis as for hospitals which are not subject to the CHAMPUS **DRG-based** payment system.

C. REIMBURSEMENT FOR OTHER THAN HOSPITALS AND SNFS

The Director, **OCHAMPUS**, or a designee, shall establish such other methods of determining allowable cost or charge reimbursement **for** those institutions, other than hospitals and SNFS, as may be required.

D. Payment of Institutional facility costs for ambulatory surgery.

1. In general. CHAMPUS pays institutional facility costs for ambulatory surgery on the basis of prospectively determined amounts, as provided in this paragraph. This payment method is similar to that used by the Medicare program for ambulatory surgery. This paragraph applies to payment for institutional charges for ambulatory surgery provided in hospitals and freestanding ambulatory surgical centers. It does not apply to professional services. A list of ambulatory surgery procedures subject to the payment method set forth in this paragraph shall be published periodically by the Director **OCHAMPUS**. Payment to freestanding ambulatory surgery centers is limited to these procedures.

2. Payment in full. The payment provided for under this paragraph is the payment in full for services covered by this paragraph. Facilities may not charge beneficiaries for amounts, if any, in excess of the payment amounts determined pursuant to this paragraph.

3. Calculation of standard payment rates. Standard payment rates are calculated for groups of procedures under the following **steps**:

a. Step 1: calculate a-median standardized cost for each procedure. For each ambulatory surgery procedure, a median standardized cost will be calculated on the basis of all ambulatory surgery charges nationally under CHAMPUS during a recent one-year base period. The steps in this calculation include standardizing for local labor costs by reference to the same wage index and labor/non-labor-related cost ratio as applies to the facility under Medicare, applying a cost-to-charge ratio, calculating a median cost for each procedure, and updating to the year for which the payment rates will be in effect by the Consumer Price Index-Urban. In applying a cost-to-charge ratio, the Medicare cost-to-charge ratio for freestanding ambulatory surgery centers (**FASCS**) will be used for all charges from FASCS, **and** the Medicare cost-to-charge ratio for hospital outpatient settings will be used for all charges from hospitals.

b. Step 2: grouping procedures. Procedures will then be placed into one of ten groups by **their** median per procedure cost, starting with \$0 to \$299 for group 1 and ending with \$1000 to \$1299 for group 9 and \$1300 and above for group 10, with groups 2 through 8 set on the basis of \$100 fixed intervals .

c. Step 3: adjustments to groups. The Director, OCHAMPUS may make adjustments to the groupings resulting from step 2 to account for any ambulatory surgery procedures for which there were insufficient data to allow a grouping **or** to correct for any anomalies resulting from data or statistical factors or other special factors that fairness requires be specially recognized. In making any **such** adjustments, the Director may take into consideration the placing of particular procedures in the ambulatory surgery groups under Medicare.

d. Step 4: standard payment amount per group. The standard payment **amount per** group will be the volume weighted median per procedure cost for the procedures in that group.

e. Step 5: actual payments. Actual payment for a procedure will **be** the standard payment amount for the group which covers that procedure, adjusted for local labor costs by reference to the same **labor/non-labor-**related cost ratio and hospital wage index as used for ambulatory surgery centers by Medicare.

4. Multiple procedures. In cases in which authorized multiple procedures are performed during the same operative session, payment shall be based on 100 percent of the payment amount for the procedure with the highest ambulatory surgery payment amount, plus, for each other procedure performed during the session, 50 percent of its payment amount.

5. Annual updates. The standard payment amounts will be updated annually **by** the same update factor as is used in the Medicare annual updates for ambulatory surgery center payments.

6. Recalculation of rates. The Director, **OCHAMPUS**, may periodically recalculate standard payment rates for ambulatory surgery using the steps set forth in paragraph **D.3.**, of this Chapter.

E. REIMBURSEMENT OF BIRTHING CENTERS

1. Reimbursement for maternity care and childbirth services furnished by an authorized birthing center shall **be** limited to the **lower** of the **CHAMPUS** established all-inclusive rate or the center's most-favored all-inclusive rate.

2. The all-inclusive rate shall include the following to the extent that they are usually associated with a normal pregnancy and childbirth: laboratory studies, prenatal management, labor management, delivery, **post-partum** management, newborn care, birth assistant, certified nurse-midwife professional services, physician professional services, and the use of the facility.

3. The CHAMPUS established all-inclusive rate is equal to the sum of the CHAMPUS area prevailing professional charge for total obstetrical care for a normal pregnancy and delivery and the sum of the average CHAMPUS allowable institutional charges for supplies, laboratory, and delivery room

for a hospital inpatient normal delivery. The CHAMPUS established all-inclusive rate areas will coincide with those established for prevailing professional charges and will be updated concurrently with the CHAMPUS area prevailing professional charge database.

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

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

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

F. REIMBURSEMENT OF RESIDENTIAL TREATMENT CENTERS

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

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

a. The CHAMPUS rate paid to the RTC for all-inclusive services as of June 30, 1988, adjusted by the Consumer Price Index - Urban (**CPI-U**) for medical care as **determined** applicable by the Director, **OCHAMPUS**, or designee; or

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

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

c. An **OCHAMPUS** determined capped per diem amount not to exceed the 80th percentile of all established CHAMPUS RTC rates nationally, weighted by total CHAMPUS days provided at each rate during the base period discussed in F.1. above.

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

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

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

a. The RTC shall exclude educational costs from its daily costs.

b. The **RTC's** accounting system must be adequate to assure CHAMPUS is not billed for educational costs.

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

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

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

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

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

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

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

b. For purposes of rates for Federal fiscal years 1996 and 1997:

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

(2) For any RTC whose 1995 rate was below the 30th percentile level determined under paragraph **F.5.b.** (1) of this chapter, the rate shall be adjusted by the lesser of: the **CPI-U** for medical care, or the amount that brings the rate up to that 30th percentile level.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2. Use of Medicare rates. CHAMPUS will use the most current Medicare rates to reimburse hospice programs for services provided to CHAMPUS beneficiaries. It is CHAMPUS' intent to adopt changes in the Medicare reimbursement methodology as they occur; e.g., Medicare's adoption of an updated, more accurate wage index.

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

a. Physicians employed by, or contracted with, the hospice.

(1) Administrative and supervisory activities (i.e., establishment, review and updating of plans of care, supervising care and services, and establishing governing policies) are included in the adjusted national payment rate.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

a. If the number **of** days **of** inpatient care furnished to CHAMPUS beneficiaries exceeds 20 percent of the total days of hospice care to CHAMPUS beneficiaries, the total payment for inpatient care is determined as follows:

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

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

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

(4) Add the amounts calculated in paragraphs **G.6.a.** (2) and (3) of this section.

b. Compare the total payment for inpatient care calculated in paragraph **G.6.a.** (4) above to actual payments made to the hospice for inpatient care during the cap period.

c. Payments in excess of the inpatient limitation must be refunded by the hospice program.

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

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

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

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

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

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

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

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

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

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

8. Reconsideration of cap amount and inpatient limit. A hospice dissatisfied with the contractor's calculation and application of its cap amount and/or inpatient limitation may request and obtain a contractor review if the amount of program reimbursement in controversy -- with respect to matters which the hospice has a right to review -- is at least \$1000. The administrative review by the contractor of the calculation and application" of the cap amount and inpatient limitation is the only administrative review available. These calculations are not subject to the appeal procedures set forth in Chapter 10. The methods and standards for calculation of the hospice payment rates established by CHAMPUS, as well as questions as to the validity of the applicable law, regulations or CHAMPUS decisions, are not subject to administrative review, including the appeal procedures of Chapter 10.

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

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

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

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

H. REIMBURSEMENT OF INDIVIDUAL HEALTH-CARE PROFESSIONALS AND OTHER
NON-INSTITUTIONAL HEALTH-CARE PROVIDERS

The CHAMPUS-determined reasonable charge (the amount allowed by CHAMPUS) for the service of an individual health-care professional or other non-institutional health-care provider (even if employed **by** or under contract to an institutional provider) **shall** be determined by one of the following methodologies, that **is**, whichever is in effect in the specific geographic location **at the** time covered services and supplies are provided to a CHAMPUS beneficiary.

1. Allowable charge method.

a. Introduction

(1) In general. The allowable charge method is the preferred and primary method for reimbursement of individual health care professionals and other non-institutional health care providers (covered by 10 **U.S.C.** 1079(h)(1)). The allowable charge for authorized care shall be the lower of the billed charge or the local CHAMPUS Maximum Allowable Charge (**CMAC**) level.

(2) CHAMPUS Maximum Allowable Charge. Beginning in calendar year 1992, prevailing charge levels and appropriate charge levels will be calculated on a national level. There will then be calculated a national CHAMPUS Maximum Allowable Charge (**CMAC**) level for each procedure, which shall be the lesser of the national prevailing charge level or the national appropriate charge level. The national **CMAC** will then be adjusted for localities in accordance with paragraph **G.1.d.**, of this Chapter.

(3) Differential for Participating Providers. Beginning in calendar year 1994, there shall be a differential in national and local **CMACs** based on **whether** the provider is a participating provider or a nonparticipating provider. The differential shall be calculated so that the **CMAC** for the nonparticipating providers is 95 percent of the **CMAC** for the participating providers. To assure the **effectiveness** of the several phase-in and waiver provisions set forth in paragraphs **G.1.c.**, and **G.1.d.**, of this Chapter, beginning in calendar year 1994, there will first be calculated the national and local **CMACs** for nonparticipating providers. For purposes of this calculation, the identification of overpriced procedures called for in paragraph **G.1.C.a.**, of this Chapter and the calculation of appropriate charge levels for such overpriced procedures called for in paragraph **G.1.D. (2)**, of this Chapter shall use as the Medicare fee component of the comparisons and calculations the fee level applicable to Medicare nonparticipating providers, which is 95 percent of the basic fee level. After nonparticipating provider local **CMACs** are calculated (including consideration of special phase-in rules and waiver rules in paragraph **G.1.d.**, of this Chapter) participating provider local **CMACs** will be calculated so that nonparticipating provider local **CMACs** are 95 percent of participating provider local **CMACs**. (For more information on the Participating Provider Program, see Chapter **6.A.8**).

(4) Limits on balance billing by nonparticipating providers. Nonparticipating providers may not balance bill beneficiary an amount which exceeds the applicable balance billing limit. The balance billing limit shall be the same percentage as the Medicare limiting charge percentage for nonparticipating physicians. The balance billing limit may **be** waived by the Director, **OCHAMPUS** on a case-by-case basis if requested **by the** CHAMPUS beneficiary (or" sponsor) involved. A decision by the Director to waive or not waive the limit in any particular case is not subject to the appeal and hearing procedures **of** Chapter 10., of this regulation.

b. Prevailing charge level.

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

(2) The national prevailing charge level referred **to** in paragraph **G.1.b.** (1) of this section is the level that does not exceed the amount equivalent to the 80th percentile of billed charges made for similar services during the base period. The 80th percentile of charges shall be determined on the basis of statistical data and methodology acceptable to the Director, **OCHAMPUS** (or a designee).

(3) For purposes of paragraph **G.1.b.** (2) of this section, the base period shall be a period of 12" calendar months and shall be adjusted once a year, unless the Director, **OCHAMPUS** determines that a different period for adjustment is appropriate and publishes a notice to that effect in the Federal Register.

c. Appropriate charge level. Beginning in calendar year 1992, the appropriate charge level for each **procedure** is the product of the two-step process set forth in paragraphs **G.1.** (c)(1) and (2) of this Chapter. This process involves comparing the prior year's CMAC with the fully phased in Medicare fee. For years after the Medicare fee has been fully phased in, the comparison shall **be** to the current Medicare fee. For any particular procedure for which comparable Medicare fee and CHAMPUS data are unavailable, but for which alternative data are available that the Director, **OCHAMPUS** (or designee) determines provide a reasonable approximation of relative value or price, the comparison may be based on such alternative data.

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

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

(b) Other procedures. These are procedures subject to the allowable charge method that are not included in either the overpriced procedures group or the underpriced procedures group.

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

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

(a) For overpriced procedures, the appropriate charge **level** for each procedure shall be the prior year's **CMAC**, reduced by the lesser of: the percentage by which it exceeds the Medicare fee or fifteen percent.

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

(c) For underpriced procedures, the appropriate charge level for each procedure shall be the prior year's **CMAC**, increased by the lesser of: the percentage by which it is exceeded by the Medicare fee or the Medicare Economic Index.

c. Special rule for cases in which the CHAMPUS appropriate charge was prematurely reduced. In any case in which a recalculation of the **Medicare** fee results in a Medicare rate higher than the CHAMPUS appropriate charge for a procedure that had been considered an overpriced procedure, the reduction in the CHAMPUS appropriate charge shall be restored up to the level of the recalculated Medicare rate.

d. Calculating CHAMPUS Maximum Allowable Charge levels for localities.

(1) In general. The national CHAMPUS Maximum Allowable Charge level for each procedure will be adjusted for localities using the same (or similar) geographical areas and the same geographic adjustment factors as are used for determining allowable charges under Medicare.

(z) Special locality-based phase-in provision.

(a) In general. Beginning with the recalculation of **CMACs** for calendar year 1993, the CMAC in a locality will not be less than 72.25 percent of **the** maximum charge level in effect for that locality on December 31, 1991. For recalculations of **CMACs** for calendar years after 1993, the CMAC in a locality will not be less than 85 percent of the CMAC in effect for that locality at the end of the prior calendar year.

(b) Exception. The special locality-based phase-in provision **established by** Section **G.1.d.** (2)(a) of this Chapter shall not be applicable in the case of any procedure code for which there were not CHAMPUS claims in the locality accounting for at least 50 services.

(3) Special locality-based waivers of reductions to assure adequate access to care. Beginning with the recalculation of **CMACs** for calendar year 1993, in the case of any procedure classified as an overpriced procedure pursuant to section **G.1.c.** (1)(a) of this Chapter, a reduction in the CMAC in a locality below the level in effect at the end of the previous calendar year that would otherwise occur pursuant to sections **G.1.c.**, and **G.1.d.**, of this Chapter may be waived pursuant to this section **G.1.c.** (3).

(a) Waiver based on balance billing rates. Except as . . . , provided in section **G.1.d.** (3)(b) of this Chapter such a reduction will be waived if there has been excessive balance billing in the locality for the procedure involved. For this purpose, the extent of balance billing will be determined based on a review of all services under the procedure code involved in the prior year (or most recent period for which data are available). If the number of services for which balance billing was not required was less than 60 percent of all services provided, the Director will determine that there was an excessive balance billing with respect to that procedure in that locality and will waive the reduction in the **CMAC** that would otherwise occur. A decision by the Director to waive or not to waive the reduction is not subject to the appeal and hearing procedures of Chapter 10 of this regulation.

(b) Exception. As an exception to section **G.1.d.** (3)(a) of this Chapter, the waiver required by that section shall not be applicable in the case of any procedure code for which there were not CHAMPUS claims in the locality accounting for at least 50 services. A waiver may, however, be granted in such cases pursuant to section **G.1.d.** (3)(c) of this Chapter.

(c) Waiver based on other evidence that adequate access to care would be impaired. The Director, **OCHAMPUS** may waive a reduction that would otherwise occur (or restore a reduction that was already taken) if the Director determines that available evidence shows that the reduction would impair adequate access. For this purpose, such evidence may include consideration of the number of providers in the locality who provide the affected services, the number of such providers who are **CHAMPUS** Participating Providers, the number of CHAMPUS beneficiaries in the area, and other relevant factors. Providers or beneficiaries in a locality may submit to the Director, **OCHAMPUS** a petition, together **with appropriate** documentation regarding relevant factors, for a determination that adequate access would be impaired. The Director, **OCHAMPUS** will consider and respond to all such petitions. Petitions may be filed at any time. Any petition received by the date which is 120 days prior to the implementation of a recalculation of **CMACs** will be assured of consideration prior that implementation. The Director, **OCHAMPUS** may establish procedures for handling petitions. A decision by the Director to waive or not to waive a reduction is not subject to the appeal and hearing procedures of Chapter 10 of this regulation.

e. Special rules for 1991.

(1) Prevailing charge levels for care provided on or after January 1, 1991, and before the 1992 prevailing charge levels take effect shall be the same as those in effect on December 31, 1990, except that prevailing charge levels for care provided on or after October 7, 1991 shall be those established pursuant to this paragraph **G.1.e.** of this section.

(2) Appropriate charge levels will be established for each locality for which a prevailing charge level was in effect immediately prior to **October 7, 1991.** For each procedure, the appropriate charge level shall be the prevailing charge level in effect immediately prior to October 7, 1991, adjusted as provided in **G.1.e.** (2)(a) through (c) of this section.

(a) For each overpriced procedure, the level shall be reduced by fifteen percent. For this purpose, overpriced procedures are the procedures determined by the Physician Payment Review Commission to be overvalued pursuant to the process established under the Medicare program, other procedures considered overvalued in the Medicare program (for which Congress directed reductions in Medicare allowable levels for 1991), radiology procedures and pathology procedures.

(b) For each other procedure, the level shall remain unchanged. For this purpose, other procedures are procedures which are not overpriced procedures or primary care procedures.

(c) For each primary care procedure, the level shall be adjusted by the MEI, as the MEI is applied to Medicare prevailing charge levels. For this purpose, primary care procedures include maternity care and delivery services and well baby care services.

f. Special transition rule for 1992.

(1) For purposes of calculating the national appropriate charge levels for 1992, the prior year's appropriate charge level for each service will be considered to be the level that does not exceed the amount equivalent to the 80th percentile of billed charges made for similar services during the base period of July 1, 1986 to June 30, 1987 (determined as under paragraph G.1.b. (2) of this section), adjusted to calendar year 1991 based on the adjustments made for maximum CHAMPUS prevailing charge levels through 1990 and the application of paragraph G.1.e. of this section for 1991.

(2) The adjustment to calendar year 1991 of the product of paragraph G.1.f. (1) of this section shall be as follows:

(a) For procedures other than those described in paragraph G.1.f. (2)(b) of this section, the adjustment to 1991 shall be on the same basis as that provided under paragraph G.1.e. of this section.

(b) For any procedure that was considered an overpriced procedure for purposes of the 1991 prevailing charge levels under paragraph G.1.e. of this section for which the resulting 1991 prevailing charge level was less than 150 percent of the Medicare converted relative value unit, the adjustment to 1991 for purposes of the special transition rule for 1992 shall be as if the procedure had been treated under paragraph G.1.e. (2)(b) of this section for purposes of the 1991 prevailing charge level.

g. Adjustments and procedural rules.

(1) The Director, OCHAMPUS may make adjustments to the appropriate charge levels calculated pursuant to paragraphs G.1.c. and G.1.e. of this section to correct any anomalies resulting from data or statistical factors, significant differences between Medicare-relevant information and CHAMPUS-relevant considerations or other special factors that fairness requires be specially recognized. However, no such adjustment may result in reducing an appropriate charge level.

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

h. Clinical laboratory services. The allowable charge for clinical diagnostic laboratory test services shall be calculated in the same manner as allowable charges for other individual health care providers are calculated pursuant to paragraphs **G.1.a.** through **G.1.d.** of this Chapter, with the following exceptions and clarifications.

(1) The calculation of national prevailing charge levels, national appropriate charge levels and national **CMACs** for laboratory services shall begin in calendar year 1993. For purposes of the 1993 calculation, the prior year year's national appropriate charge **level** or national prevailing charge level shall be the level that does not exceed the amount equivalent to the 80th percentile of billed charges made for similar services during the period July 1, 1991, through June 30, 1992 (referred to in this paragraph **G.1.h.** of this Chapter as the "base period").

(2) For purposes of comparison to Medicare allowable payment amounts pursuant to paragraph **G.1.c.** of this Chapter, the Medicare national laboratory payment limitation amounts shall **be used.**

(3) For purposes of establishing laboratory service local **CMACS** pursuant to paragraph **G.1.d.** of this Chapter, the adjustment factor shall equal the ratio of the local average charge (standardized for the distribution clinical laboratory services) to the national average charge for **all** clinical laboratory services during the base period.

(4) For purposes of a special locality-based phase-in provision similar to that established by paragraph **G.1.d.** (2) of this Chapter, the **CMAC** in a locality will not be less than 85 percent of the **maximum** charge level in effect for that locality during the base period.

i. The allowable charge for physician assistant services other, than assistant-at-surgery may not exceed 85 percent of the allowable charge for a comparable service rendered by a physician performing the service in a similar location. For cases in which the physician assistant and the physician perform component services of a procedure other than assistant-at-surgery (e.g., home, office or hospital visit), the combined allowable charge for the procedure may not exceed the allowable charge for the procedure rendered by a physician alone. The allowable charge for physician assistant services performed as an assistant-at-surgery may not exceed 65 percent of the allowable charge for a physician serving as an assistant surgeon when authorized as CHAMPUS benefits in accordance with the provisions of Chapter 4 C.3.C. of this Part. Physician assistant services must **be billed** through the employing physician who must be an authorized CHAMPUS provider.

j. A charge that exceeds the CHAMPUS **Maximum Allowable** charge can be determined to be allowable only when unusual circumstances or medical complications justify the higher charge. The allowable charge may not exceed the billed charge under any circumstances.

2. All-inclusive rate. Claims from individual health-care professional providers for services rendered to CHAMPUS beneficiaries residing in an RTC that is either being reimbursed on an all-inclusive per diem rate, or is billing an all-inclusive per diem rate, shall **be** denied; with the exception of independent health-care professionals providing geographically distant family therapy to a family member residing a minimum of 250 miles from the RTC or covered medical services related to a **nonmental** health condition rendered outside the RTC. Reimbursement for individual professional services is included in the rate paid the institutional provider.

3. Alternative method. The Director, OCHAMPUS, **or** a designee, may, subject to the approval of the ASD(HA), establish an alternative method of reimbursement designed to produce reasonable control over health care costs and to ensure a high level of acceptance of the **CHAMPUS-determined** charge by the individual health-care professionals or other noninstitutional health-care providers furnishing services and supplies to CHAMPUS beneficiaries. Alternative methods may not result in reimbursement greater than the allowable charge method above.

I. REIMBURSEMENT UNDER THE MILITARY-CIVILIAN HEALTH SERVICES PARTNERSHIP PROGRAM

The Military-Civilian Health Services Partnership Program, as authorized by Section 1096, Chapter 55, Title 10, provides for the sharing of staff, equipment, and resources between the civilian and military health care system in order to achieve more effective, efficient, or economical health care for authorized beneficiaries. Military treatment facility commanders, based upon the authority provided by their respective Surgeons General of the military departments, are responsible for entering into individual partnership agreements only when they have determined specifically that use of the Partnership Program is more economical overall to the Government than referring the need for health care services to the civilian community under the normal operation of the CHAMPUS Program. (See Section P. of Chapter 1, for general requirements of the Partnership Program.)

1. Reimbursement of institutional health care providers. Reimbursement of institutional health care providers under the Partnership Program shall **be** on the same basis as non-Partnership providers.

2. Reimbursement of individual health-care professionals and other non-institutional health care providers. Reimbursement of individual health care professional and other **non-institutional** health care providers shall be on the same basis as non-Partnership providers as detailed in Section G. of this chapter.

J. ACCOMMODATION OF DISCOUNTS UNDER PROVIDER REIMBURSEMENT METHODS

1. General rule. The Director, OCHAMPUS (or designee) has authority to reimburse a **provider** at an amount below the amount usually paid pursuant to this chapter when, under a program approved by the Director, the provider has agreed to the lower amount.

2. Special applications. The following are examples of applications of . . . the general rule; they are not **all** inclusive.

a. In the case of individual health care professionals and other noninstitutional providers, **if** the discounted fee is below the provider's normal billed charge and the prevailing charge level (see section G. of this chapter), the discounted fee **shall** be the provider's actual billed charge and the CHAMPUS allowable charge.

b. In **the** case of institutional providers normally paid on the basis of a pre-set amount (such as **DRG-based** amount under subsection A1. of this chapter or per-diem amount under subsection A.2. of this chapter), if the discount rate is lower than the pre-set rate, the discounted rate shall **be** the CHAMPUS-determined allowable cost. This is an exception to the usual rule that the **pre-set** rate is paid regardless of the institutional provider's billed charges or other factors.

3. Procedures.

a. This section only applies when both the provider and the Director have agreed to the discounted payment rate. The Director's agreement may be in the context of approval of a program that allows for such discounts.

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

K. OUTSIDE THE UNITED STATES

The Director, **OCHAMPUS**, or a designee, shall determine the appropriate reimbursement method or methods **to be** used in the extension of CHAMPUS benefits for otherwise covered medical services or supplies **provided by** hospitals or other institutional providers, physicians or other individual professional providers, or other providers outside the United States.

L. IMPLEMENTING INSTRUCTIONS

The Director, **OCHAMPUS**, or a designee, shall issue CHAMPUS policies, instructions, procedures, and guidelines, as may be necessary to implement the intent of this chapter.