not required, be accredited by a qualified accreditation organization, as defined in §199.2; and

(vi) Has entered into a participation agreement approved by the Director, OCHAMPUS, or designee, which at least complies with the minimum participation agreement requirements of this section.

(3) *Transfer of participation agreement.* In order to provide continuity of care for beneficiaries when there is a change of provider ownership, the provider agreement is automatically assigned to the new owner, subject to all the terms and conditions under which the original agreement was made.

(i) The merger of the provider corporation or foundation into another corporation or foundation, or the consolidation of two or more corporations or foundations resulting in the creation of a new corporation or foundation, constitutes a change of ownership.

(ii) Transfer of corporate stock or the merger of another corporation or foundation into the provider corporation or foundation does not constitute change of ownership.

(iii) The surviving corporation or foundation shall notify the Director, OCHAMPUS, or designee, in writing of the change of ownership promptly after the effective date of the transfer or change in ownership.

(4) *Pricing and payment methodology:* The pricing and payment of procedures rendered by a provider authorized under this paragraph (f) shall be limited to those methods for pricing and payment allowed by this part which the Director, OCHAMPUS, or designee, determines contribute to the efficient management of CHAMPUS.

(5) *Termination of participation agreement.* A provider may terminate a participation agreement upon 45 days written notice to the Director, OCHAMPUS, or designee, and to the public.

[51 FR 24008, July 1, 1986]

EDITORIAL NOTE: For FEDERAL REGISTER citations affecting §199.6, see the List of CFR Sections Affected, which appears in the Finding Aids section of the printed volume and at *www.fdsys.gov*.

§199.7 Claims submission, review, and payment.

(a) *General.* The Director, OCHAMPUS, or a designee, is responsible for ensuring that benefits under CHAMPUS are paid only to the extent described in this part. Before benefits can be paid, an appropriate claim must be submitted that includes sufficient information as to beneficiary identification, the medical services and supplies provided, and double coverage information, to permit proper, accurate, and timely adjudication of the claim by the CHAMPUS contractor or OCHAMPUS. Providers must be able to document that the care or service shown on the claim was rendered. This section sets forth minimum medical record requirements for verification of services. Subject to such definitions, conditions, limitations, exclusions, and requirements as may be set forth in this part, the following are the CHAMPUS claim filing requirements:

(1) *CHAMPUS identification card required.* A patient shall present his or her applicable CHAMPUS identification card (that is, Uniformed Services identification card) to the authorized provider of care that identifies the patient as an eligible CHAMPUS beneficiary (refer to §199.3 of this part).

(2) *Claim required.* No benefit may be extended under the Basic Program or Extended Care Health Option (ECHO) without submission of an appropriate, complete and properly executed claim form.

(3) *Responsibility for perfecting claim.* It is the responsibility of the CHAMPUS beneficiary or sponsor or the authorized provider acting on behalf of the CHAMPUS beneficiary to perfect a claim for submission to the appropriate CHAMPUS fiscal intermediary. Neither a CHAMPUS fiscal intermediary nor OCHAMPUS is authorized to prepare a claim on behalf of a CHAMPUS beneficiary.

(4) *Obtaining appropriate claim form.* CHAMPUS provides specific CHAMPUS forms appropriate for making a claim for benefits for various types of medical services and supplies (such as hospital, physician, or prescription drugs). Claim forms may be obtained from the appropriate CHAMPUS fiscal intermediary who processes claims for the

beneficiary's state of residence, from the Director, OCHAMPUS, or a designee, or from CHAMPUS health benefits advisors (HBAs) located at all Uniformed Services medical facilities.

(5) *Prepayment not required.* A CHAMPUS beneficiary or sponsor is not required to pay for the medical services or supplies before submitting a claim for benefits.

(6) *Deductible certificate.* If the fiscal year outpatient deductible, as defined in §199.4(f)(2) has been met by a beneficiary or a family through the submission of a claim or claims to a CHAMPUS fiscal intermediary in a geographic location different from the location where a current claim is being submitted, the beneficiary or sponsor must obtain a deductible certificate from the CHAMPUS fiscal intermediary where the applicable individual or family fiscal year deductible was met. Such deductible certificate must be attached to the current claim being submitted for benefits. Failure to obtain a deductible certificate under such circumstances will result in a second individual or family fiscal year deductible being applied. However, this second deductible may be reimbursed once appropriate documentation, as described in this paragraph is supplied to the CHAMPUS fiscal intermediary applying the second deductible (refer to §199.4 (f)(2)(i)(F)).

(7) *Nonavailability Statement (DD Form 1251).* In some geographic locations or under certain circumstances, it is necessary for a CHAMPUS beneficiary to determine whether the required medical care can be provided through a Uniformed Services facility. If the required medical care cannot be provided by the Uniformed Services facility, a Nonavailability Statement will be issued. When required (except for emergencies), this Nonavailability Statement must be issued before medical care is obtained from civilian sources. Failure to secure such a statement will waive the beneficiary's rights to benefits under CHAMPUS, subject to appeal to the appropriate hospital commander (or higher medical authority).

(i) *Rules applicable to issuance of Nonavailability Statement.* Appropriate policy guidance may be issued as necessary to prescribe the conditions for issuance and use of a Nonavailability Statement.

(ii) *Beneficiary responsibility.* The beneficiary shall ascertain whether or not he or she resides in a geographic area that requires obtaining a Nonavailability Statement. Information concerning current rules may be obtained from the CHAMPUS fiscal intermediary concerned, a CHAMPUS HBA or the Director, OCHAMPUS, or a designee.

(iii) *Rules in effect at time civilian care is provided apply.* The applicable rules regarding Nonavailability Statements in effect at the time the civilian care is rendered apply in determining whether a Nonavailability Statement is required.

(iv) *Nonavailability Statement must be filed with applicable claim.* When a claim is submitted for CHAMPUS benefits that includes services for which a Nonavailability Statement is required, such statement must be submitted along with the claim form.

(b) *Information required to adjudicate a CHAMPUS claim.* Claims received that are not completed fully and that do not provide the following minimum information may be returned. If enough space is not available on the appropriate claim form, the required information must be attached separately and include the patient's name and address, be dated, and signed.

(1) *Patient's identification information.* The following patient identification information must be completed on every CHAMPUS claim form submitted for benefits before a claim will be adjudicated and processed:

(i) *Patient's full name.*

(ii) *Patient's residence address.*

(iii) *Patient's date of birth.*

(iv) *Patient's relationship to sponsor.*

NOTE: If name of patient is different from sponsor, explain (for example, stepchild or illegitimate child).

(v) *Patient's identification number (from DD Form 1173).*

(vi) *Patient's identification card effective date and expiration date (from DD Form 1173).*

(vii) *Sponsor's full name.*

(viii) *Sponsor's service or social security number.*

(ix) *Sponsor's grade.*

(x) *Sponsor's organization and duty station.* Home port for ships; home address for retiree.

(xi) *Sponsor's branch of service or deceased or retiree's former branch of service.*

(xii) *Sponsor's current status.* Active duty, retired, or deceased.

(2) *Patient treatment information.* The following patient treatment information routinely is required relative to the medical services and supplies for which a claim for benefits is being made before a claim will be adjudicated and processed:

(i) *Diagnosis.* All applicable diagnoses are required; standard nomenclature is acceptable. In the absence of a diagnosis, a narrative description of the definitive set of symptoms for which the medical care was rendered must be provided.

(ii) *Source of care.* Full name of source of care (such as hospital or physician) providing the specific medical services being claimed.

(iii) *Full address of source of care.* This address must be where the care actually was provided, not a billing address.

(iv) *Attending physician.* Name of attending physician (or other authorized individual professional provider).

(v) *Referring physician.* Name and address of ordering, prescribing, or referring physician.

(vi) *Status of patient.* Status of patient at the time the medical services and supplies were rendered (that is, inpatient or outpatient).

(vii) *Dates of service.* Specific and inclusive dates of service.

(viii) *Inpatient stay.* Source and dates of related inpatient stay (if applicable).

(ix) *Physicians or other authorized individual professional providers.* The claims must give the name of the individual actually rendering the care, along with the individual's professional status (e.g., M.D., Ph.D., R.N., etc.) and provider number, if the individual signing the claim is not the provider who actually rendered the service. The following information must also be included:

(A) Date each service was rendered.

(B) Procedure code or narrative description of each procedure or service for each date of service.

(C) Individual charge for each item of service or each supply for each date.

(D) Detailed description of any unusual complicating circumstances related to the medical care provided that the physician or other individual professional provider may choose to submit separately.

(x) *Hospitals or other authorized institutional providers.* For care provided by hospitals (or other authorized institutional providers), the following information also must be provided before a claim will be adjudicated and processed:

(A) An itemized billing showing each item of service or supply provided for each day covered by the claim.

NOTE: The Director, OCHAMPUS, or a designee, may approve, in writing, an alternative billing procedure for RTCs or other special institutions, in which case the itemized billing requirement may be waived. The particular facility will be aware of such approved alternate billing procedure.

(B) Any absences from a hospital or other authorized institution during a period for which inpatient benefits are being claimed must be identified specifically as to date or dates and provide details on the purpose of the absence. Failure to provide such information will result in denial of benefits and, in an ongoing case, termination of benefits for the inpatient stay at least back to the date of the absence.

(C) For hospitals subject to the CHAMPUS DRG-based payment system (see paragraph (a)(1)(ii)(D) of §199.14), the following information is also required:

(*1*) The principal diagnosis (the diagnosis established, after study, to be chiefly responsible for causing the patient's admission to the hospital).

(*2*) All secondary diagnoses.

(*3*) All significant procedures performed.

(*4*) The discharge status of the beneficiary.

(*5*) The hospital's Medicare provider number.

(*6*) The source of the admission.

(D) Claims submitted by hospitals (or other authorized institutional providers) must include the name of the individual actually rendering the care, along with the individual's professional status (e.g., M.D., Ph.D., R.N., etc.).

(xi) *Prescription drugs and medicines (and insulin).* For prescription drugs and medicines (and insulin, whether or not a prescription is required) receipted bills must be attached and the following additional information provided:

(A) Name of drug.

NOTE: When the physician or pharmacist so requests, the name of the drugs may be submitted to the CHAMPUS fiscal intermediary directly by the physician or pharmacist.

(B) Strength of drug.

(C) Name and address of pharmacy where drug was purchased.

(D) Prescription number of drug being claimed.

(xii) *Other authorized providers.* For items from other authorized providers (such as medical supplies), an explanation as to the medical need must be attached to the appropriate claim form. For purchases of durable equipment under the ECHO it is necessary also to attach a copy of the authorization.

(xiii) *Nonparticipating providers.* When the beneficiary or sponsor submits the claim to the CHAMPUS fiscal intermediary (that is, the provider elects not to participate), an itemized bill from the provider to the beneficiary or sponsor must be attached to the CHAMPUS claim form.

(3) *Medical records/medical documentation.* Medical records are of vital importance in the care and treatment of the patient. Medical records serve as a basis for planning of patient care and for the ongoing evaluation of the patient's treatment and progress. Accurate and timely completion of orders, notes, etc., enable different members of a health care team and subsequent health care providers to have access to relevant data concerning the patient. Appropriate medical records must be maintained in order to accommodate utilization review and to substantiate that billed services were actually rendered.

(i) All care rendered and billed must be appropriately documented in writing. Failure to document the care billed will result in the claim or specific services on the claim being denied CHAMPUS cost-sharing.

(ii) A pattern of failure to adequately document medical care will result in episodes of care being denied CHAMPUS cost-sharing.

(iii) Cursory notes of a generalized nature that do not identify the specific treatment and the patient's response to the treatment are not acceptable.

(iv) The documentation of medical records must be legible and prepared as soon as possible after the care is rendered. Entries should be made when the treatment described is given or the observations to be documented are made. The following are documentation requirements and specific time frames for entry into the medical records:

(A) General requirements for acute medical/surgical services:

(*1*) Admission evaluation report within 24 hours of admission.

(*2*) Completed history and physical examination report within 72 hours of admission.

(*3*) Registered nursing notes at the end of each shift.

(*4*) Daily physician notes.

(B) Requirements specific to mental health services:

(*1*) Psychiatric admission evaluation report within 24 hours of admission.

(*2*) History and physical examination within 24 hours of admission; complete report documented within 72 hours for acute and residential programs and within 3 working days for partial programs.

(*3*) Individual and family therapy notes within 24 hours of procedure for acute, detoxification and Residential Treatment Center (RTC) programs and within 48 hours for partial programs.

(*4*) Preliminary treatment plan within 24 hours of admission.

(*5*) Master treatment plan within 5 calendar days of admission for acute care, 10 days for RTC care, 5 days for full-day partial programs and within 7 days for half-day partial programs.

(*6*) Family assessment report within 72 hours of admission for acute care and 7 days for RTC and partial programs.

(*7*) Nursing assessment report within 24 hours of admission.

(*8*) Nursing notes at the end of each shift for acute and detoxification programs; every ten visits for partial hospitalization; and at least once a week for RTCs.

(*9*) Daily physician notes for intensive treatment, detoxification, and rapid stabilization programs; twice per week for acute programs; and once per week for RTC and partial programs.

(*10*) Group therapy notes once per week.

(*11*) Ancillary service notes once per week.

NOTE: A pattern of failure to meet the above criteria may result in provider sanctions prescribed under §199.9.

(4) *Double coverage information.* When the CHAMPUS beneficiary is eligible for medical benefits coverage through another plan, insurance, or program, either private or Government, the following information must be provided:

(i) *Name of other coverage.* Full name and address of double coverage plan, insurance, or program (such as Blue Cross, Medicare, commercial insurance, and state program).

(ii) *Source of double coverage.* Source of double coverage (such as employment, including retirement, private purchase, membership in a group, and law).

(iii) *Employer information.* If source of double coverage is employment, give name and address of employer.

(iv) *Identification number.* Identification number or group number of other coverage.

(5) *Right to additional information.* (i) As a condition precedent to the cost-sharing of benefits under this part or pursuant to a review or audit, whether the review or audit is prospective, concurrent, or retroactive, OCHAMPUS or CHAMPUS contractors may request, and shall be entitled to receive, information from a physician or hospital or other person, institution, or organization (including a local, state, or Federal Government agency) providing services or supplies to the beneficiary for whom claims or requests for approval for benefits are submitted. Such information and records may relate to the attendance, testing, monitoring, examination, diagnosis, treatment, or services and supplies furnished to a beneficiary and, as such, shall be necessary for the accurate and efficient administration of CHAMPUS benefits. This may include requests for copies of all medical records or documentation related to the episode of care. In addition, before a determination on a request for preauthorization or claim of benefits is made, a beneficiary, or sponsor, shall provide additional information relevant to the requested determination, when necessary. The recipient of such information shall hold such records confidential except when:

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

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

(C) Disclosure is authorized or required specifically under the terms of DoD Directive 5400.7 and 5400.11, the Freedom of Information Act, and the Privacy Act (refer to paragraph (m) of §199.1 of this part).

(ii) For the purposes of determining the applicability of and implementing the provisions of §§199.8 and 199.9, or any provision of similar purpose of any other medical benefits coverage or entitlement, OCHAMPUS or CHAMPUS fiscal intermediaries, without consent or notice to any beneficiary or sponsor, may release to or obtain from any insurance company or other organization, governmental agency, provider, or person, any information with respect to any beneficiary when such release constitutes a routine use duly published in the FEDERAL REGISTER in accordance with the Privacy Act.

(iii) Before a beneficiary's claim of benefits is adjudicated, the beneficiary or the provider(s) must furnish to CHAMPUS that information which is necessary to make the benefit determination. Failure to provide the requested information will result in denial of the claim. A beneficiary, by submitting a CHAMPUS claim(s) (either a participating or nonparticipating claim), is deemed to have given consent to the release of any and all medical records or documentation pertaining to the claims and the episode of care.

(c) *Signature on CHAMPUS Claim Form*—(1) *Beneficiary signature.* CHAMPUS claim forms must be signed by the beneficiary except under the conditions identified in paragraph (c)(1)(v) of this section. The parent or

guardian may sign for any beneficiary under 18 years.

(i) *Certification of identity*. This signature certifies that the patient identification information provided is correct.

(ii) *Certification of medical care provided*. This signature certifies that the specific medical care for which benefits are being claimed actually were rendered to the beneficiary on the dates indicated.

(iii) *Authorization to obtain or release information*. Before requesting additional information necessary to process a claim or releasing medical information, the signature of the beneficiary who is 18 years old or older must be recorded on or obtained on the CHAMPUS claim form or on a separate release form. The signature of the beneficiary, parent, or guardian will be requested when the beneficiary is under 18 years.

NOTE: If the care was rendered to a minor and a custodial parent or legal guardian requests information prior to the minor turning 18 years of age, medical records may still be released pursuant to the signature of the parent or guardian, and claims information may still be released to the parent or guardian in response to the request, even though the beneficiary has turned 18 between the time of the request and the response. However, any follow-up request or subsequent request from the parent or guardian, after the beneficiary turns 18 years of age, will necessitate the authorization of the beneficiary (or the beneficiary's legal guardian as appointed by a cognizant court), before records and information can be released to the parent or guardian.

(iv) *Certification of accuracy and authorization to release double coverage information*. This signature certifies to the accuracy of the double coverage information and authorizes the release of any information related to double coverage. (Refer to § 199.8 of this part).

(v) *Exceptions to beneficiary signature requirement*. (A) Except as required by paragraph (c)(1)(iii) of this section, the signature of a spouse, parent, or guardian will be accepted on a claim submitted for a beneficiary who is 18 years old or older.

(B) When the institutional provider obtains the signature of the beneficiary (or the signature of the parent or guardian when the beneficiary is under 18 years) on a CHAMPUS claim form at admission, the following participating claims may be submitted without the beneficiary's signature.

(*1*) Claims for laboratory and diagnostic tests and test interpretations from radiologists, pathologists, neurologists, and cardiologists.

(*2*) Claims from anesthesiologists.

(C) Claims filed by providers using CHAMPUS-approved signature-on-file and claims submission procedures.

(2) *Provider's signature*. A participating provider (see paragraph (a)(8) of § 199.6) is required to sign the CHAMPUS claim form.

(i) *Certification*. A participating provider's signature on a CHAMPUS claim form:

(A) Certifies that the specific medical care listed on the claim form was, in fact, rendered to the specific beneficiary for which benefits are being claimed, on the specific date or dates indicated, at the level indicated and by the provider signing the claim unless the claim otherwise indicates another individual provided the care. For example, if the claim is signed by a psychiatrist and the care billed was rendered by a psychologist or licensed social worker, the claim must indicate both the name and profession of the individual who rendered the care.

(B) Certifies that the provider has agreed to participate (providing this agreement has been indicated on the claim form) and that the CHAMPUS-determined allowable charge or cost will constitute the full charge or cost for the medical care listed on the specific claim form; and further agrees to accept the amount paid by CHAMPUS or the CHAMPUS payment combined with the cost-shared amount paid by, or on behalf of the beneficiary, as full payment for the covered medical services or supplies.

(*1*) Thus, neither CHAMPUS nor the sponsor is responsible for any additional charges, whether or not the CHAMPUS-determined charge or cost is less than the billed amount.

(*2*) Any provider who signs and submits a CHAMPUS claim form and then violates this agreement by billing the beneficiary or sponsor for any difference between the CHAMPUS-determined charge or cost and the amount

billed is acting in bad faith and is subject to penalties including withdrawal of CHAMPUS approval as a CHAMPUS provider by administrative action of the Director, OCHAMPUS, or a designee, and possible legal action on the part of CHAMPUS, either directly or as a part of a beneficiary action, to recover monies improperly obtained from CHAMPUS beneficiaries or sponsors (refer to §199.6 of this part.)

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

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

(d) *Claims filing deadline*. For all services provided on or after January 1, 1993, to be considered for benefits, all claims submitted for benefits must, except as provided in paragraph (d)(2) of this section, be filed with the appropriate CHAMPUS contractor no later than one year after the services are provided. Unless the requirement is waived, failure to file a claim within this deadline waives all rights to benefits for such services or supplies.

(1) *Claims returned for additional information*. When a claim is submitted initially within the claim filing time limit, but is returned in whole or in part for additional information to be considered for benefits, the returned claim, along with the requested information, must be resubmitted and received by the appropriate CHAMPUS contractor no later than the later of:

(i) One year after the services are provided; or

(ii) 90 days from the date the claim was returned to the provider or beneficiary.

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

(i) *Types of exception*. (A) *Retroactive eligibility*. Retroactive CHAMPUS eligibility determinations.

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

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

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

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

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

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

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

(e) *Other claims filing requirements.* Notwithstanding the claims filing deadline described in paragraph (d) of this section, to lessen any potential adverse impact on a CHAMPUS beneficiary or sponsor that could result from a retroactive denial, the following additional claims filing procedures are recommended or required.

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

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

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

(f) *Preauthorization.* When specifically required in other sections of this part, preauthorization requires the following:

(1) *Preauthorization must be granted before benefits can be extended.* In those situations requiring preauthorization, the request for such preauthorization shall be submitted and approved before benefits may be extended, except as provided in §199.4(a)(11). If a claim for services or supplies is submitted without the required preauthorization, no benefits shall be paid, unless the Director, OCHAMPUS, or a designee, has granted an exception to the requirement for preauthorization.

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

(ii) *Time limit on preauthorization.* Approved preauthorizations are valid for specific periods of time, appropriate for the circumstances presented and specified at the time the preauthorization is approved. In general, preauthorizations are valid for 30 days. If the preauthorized service or supplies are not obtained or commenced within the specified time limit, a new preauthorization is required before benefits may be extended. For organ and stem cell transplants, the preauthorization shall remain in effect as long as the beneficiary continues to meet the specific transplant criteria set forth in the TRICARE/CHAMPUS Policy Manual, or until the approved transplant occurs.

(2) *Treatment plan.* Each preauthorization request shall be accompanied by a proposed medical treatment plan (for inpatient stays under the Basic Program) which shall

include generally a diagnosis; a detailed summary of complete history and physical; a detailed statement of the problem; the proposed treatment modality, including anticipated length of time the proposed modality will be required; any available test results; consultant's reports; and the prognosis. When the preauthorization request involves transfer from a hospital to another inpatient facility, medical records related to the inpatient stay also must be provided.

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

(4) *Advance payment prohibited.* No CHAMPUS payment shall be made for otherwise authorized services or items not yet rendered or delivered to the beneficiary.

(g) *Claims review.* It is the responsibility of the CHAMPUS fiscal intermediary (or OCHAMPUS, including OCHAMPUSEUR) to review each CHAMPUS claim submitted for benefit consideration to ensure compliance with all applicable definitions, conditions, limitations, or exclusions specified or enumerated in this part. It is also required that before any CHAMPUS benefits may be extended, claims for medical services and supplies will be subject to utilization review and quality assurance standards, norms, and criteria issued by the Director, OCHAMPUS, or a designee (see paragraph (a)(1)(v) of §199.14 for review standards for claims subject to the CHAMPUS DRG-based payment system).

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

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

(2) *Benefit payments made to participating provider.* When the authorized provider elects to participate by signing a CHAMPUS claim form, indicating participation in the appropriate space on the claim form, and submitting a specific claim on behalf of the beneficiary to the appropriate CHAMPUS fiscal intermediary, any CHAMPUS benefit payments due as a result of that claim submission will be made in the name of and mailed to the participating provider. Thus, by signing the claim form, the authorized provider agrees to abide by the CHAMPUS-determined allowable charge or cost, whether or not lower than the amount billed. Therefore, the beneficiary or sponsor is responsible only for any required deductible amount and any cost-sharing portion of the CHAMPUS-determined allowable charge or cost as may be required under the terms and conditions set forth in §§199.4 and 199.5 of this part.

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

(i) Name and address of beneficiary.

(ii) Name and address of provider.

(iii) Services or supplies covered by claim for which CEOB applies.

(iv) Dates services or supplies provided.

(v) Amount billed; CHAMPUS-determined allowable charge or cost; and amount of CHAMPUS payment.

(vi) To whom payment, if any, was made.

(vii) Reasons for any denial.

(viii) Recourse available to beneficiary for review of claim decision (refer to §199.10 of this part).

NOTE: The Director, OCHAMPUS, or a designee, may authorize a CHAMPUS fiscal

intermediary to waive a CEOB to protect the privacy of a CHAMPUS beneficiary.

(4) *Benefit under $1.* If the CHAMPUS benefit is determined to be under $1, payment is waived.

(i) *Extension of the Active Duty Dependents Dental Plan to areas outside the United States.* The Assistant Secretary of Defense (Health Affairs) (ASD(HA) may, under the authority of 10 U.S.C. 1076a(h), extend the Active Duty Dependents Dental Plan to areas other than those areas specified in paragraph (a)(2)(i) of this section for the eligible beneficiaries of members of the Uniformed Services. In extending the program outside the Continental United States, the ASD(HA), or designee, is authorized to establish program elements, methods of administration and payment rates and procedures to providers that are different from those in effect under this section in the Continental United States to the extent the ASD(HA), or designee, determines necessary for the effective and efficient operation of the plan outside the Continental United States. This includes provisions for preauthorization of care if the needed services are not available in a Uniformed Service overseas dental treatment facility and payment by the Department of certain cost-shares and other portions of a provider's billed charges. Other differences may occur based on limitations in the availability and capabilities of the Uniformed Services overseas dental treatment facility and a particular nation's civilian sector providers in certain areas. Otherwise, rules pertaining to services covered under the plan and quality of care standards for providers shall be comparable to those in effect under this section in the Continental United States and available military guidelines. In addition, all provisions of 10 U.S.C. 1076a shall remain in effect.

(j) *General assignment of benefits not recognized.* CHAMPUS does not recognize any general assignment of CHAMPUS benefits to another person. All CHAMPUS benefits are payable as described in this and other Sections of this part.

[51 FR 24008, July 1, 1986]

EDITORIAL NOTE: For FEDERAL REGISTER citations affecting §199.7, see the List of CFR Sections Affected, which appears in the Finding Aids section of the printed volume and at *www.fdsys.gov*.

§ 199.8 Double coverage.

(a) *Introduction.* (1) In enacting TRICARE legislation, Congress clearly has intended that TRICARE be the secondary payer to all health benefit, insurance and third-party payer plans. 10 U.S.C. 1079(j)(1) specifically provides that a benefit may not be paid under a plan (CHAMPUS) covered by this section in the case of a person enrolled in, or covered by, any other insurance, medical service, or health plan, including any plan offered by a third-party payer (as defined in 10 U.S.C. 1095(h)(1)) to the extent that the benefit is also a benefit under the other plan, except in the case of a plan administered under title XIX of the Social Security Act (42 U.S.C. 1396 *et seq.*).

(2) The provision in paragraph (a)(1) of this section is made applicable specifically to retired members, dependents, and survivors by 10 U.S.C. 1086(g). The underlying intent, in addition to preventing waste of Federal resources, is to ensure that TRICARE beneficiaries receive maximum benefits while ensuring that the combined payments of TRICARE and other health and insurance plans do not exceed the total charges.

(b) *Double coverage plan.* A double coverage plan is one of the following:

(1) *Insurance plan.* An insurance plan is any plan or program that is designed to provide compensation or coverage for expenses incurred by a beneficiary for medical services and supplies. It includes plans or programs for which the beneficiary pays a premium to an issuing agent as well as those plans or programs to which the beneficiary is entitled as a result of employment or membership in, or association with, an organization or group.

(2) *Medical service or health plan.* A medical service or health plan is any plan or program of an organized health care group, corporation, or other entity for the provision of health care to an individual from plan providers, both professional and institutional. It includes plans or programs for which the beneficiary pays a premium to an issuing agent as well as those plans or