

adversely affect in a material way the economy; a section of the economy; productivity; competition; jobs; the environment; public health or safety; or State, local, or tribunal governments or communities;

(2) Create a serious inconsistency or otherwise interfere with an action taken or planned by another Agency;

(3) Materially alter the budgetary impact of entitlements, grants, user fees, or loan programs, or the rights and obligations of recipients thereof; or

(4) Raise novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in these Executive Orders.

*Unfunded Mandates Reform Act (Sec. 202, Pub. L. 104-4)*

It has been determined that this final rule does not contain a Federal mandate that may result in the expenditure by State, local and tribal governments, in aggregate, or by the private sector, of \$100 million or more in any one year.

*Public Law 96-354, "Regulatory Flexibility Act" (5 U.S.C. 601)*

It has been certified that this final rule is not subject to the Regulatory Flexibility Act (5 U.S.C. 601) because it would not, if promulgated, have a significant economic impact on a substantial number of small entities. Set forth in the final rule are minor revisions to the existing regulation. The DoD does not anticipate a significant impact on the Program.

*Public Law 96-511, "Paperwork Reduction Act" (44 U.S.C. Chapter 35)*

It has been determined that this final rule does not impose reporting or recordkeeping requirements under the Paperwork Act of 1995.

*Executive Order 13132, Federalism*

It has been determined that this final rule does not have federalism implications, as set forth in Executive Order 13132. This rule does not have substantial direct effects on:

- (1) The States;
- (2) The relationship between the National Government and the States; or
- (3) The distribution of power and responsibilities among the various levels of Government.

**List of Subjects in 32 CFR Part 199**

Claims, Dental health, Health care, Health insurance, Individuals with disabilities, and Military personnel.

Accordingly, 32 CFR part 199 is amended to read as follows:

**PART 199—[AMENDED]**

■ 1. The authority citation for part 199 continues to read as follows:

**Authority:** 5 U.S.C. 301; 10 U.S.C. chapter 55.

■ 2. Section 199.4 is amended by revising paragraphs (e)(9) and (g)(63) to read as follows:

**§ 199.4 Basic program benefits.**

\* \* \* \* \*

(e) \* \* \*

(9) *Care related to non-covered initial surgery or treatment.* (i) Benefits are available for otherwise covered services and supplies required in the treatment of complications resulting from a non-covered incident of treatment (such as nonadjunctive dental care or cosmetic surgery) but only if the later complication represents a separate medical condition such as a systemic infection, cardiac arrest, and acute drug reaction. Benefits may not be extended for any later care or a procedure related to the complication that essentially is similar to the initial non-covered care. Examples of complications similar to the initial episode of care (and thus not covered) would be repair of facial scarring resulting from dermabrasion for acne.

(ii) Benefits are available for otherwise covered services and supplies required in the treatment of complications (unfortunate sequelae) and any necessary follow-on care resulting from a non-covered incident of treatment provided in an MTF, when the initial non-covered service has been authorized by the MTF Commander and the MTF is unable to provide the necessary treatment of the complications or required follow-on care, according to the guidelines adopted by the Director, DHA, or a designee.

(iii) Benefits are available for otherwise covered services and supplies required in the treatment of complications (unfortunate sequelae) and any necessary follow-on care resulting from a non-covered incident of treatment provided in the private sector pursuant to a properly granted waiver under § 199.16(f). The Director, DHA, or designee, shall issue guidelines for implementing this provision.

\* \* \* \* \*

(g) \* \* \*

(63) *Non-covered condition/ treatment, unauthorized provider.* All services and supplies (including inpatient institutional costs) related to a non-covered condition or treatment, including any necessary follow-on care or the treatment of complications, are

excluded from coverage except as provided under paragraph (e)(9) of this section. In addition, all services and supplies provided by an unauthorized provider are excluded.

\* \* \* \* \*

Dated: December 22, 2014.

**Aaron Siegel,**

*Alternate OSD Federal Register Liaison Officer, Department of Defense.*

[FR Doc. 2014-30307 Filed 12-30-14; 8:45 am]

**BILLING CODE 5001-06-P**

**DEPARTMENT OF DEFENSE**

**Office of the Secretary**

**32 CFR Part 199**

[DOD-2013-HA-0053]

RIN 0720-AB59

**TRICARE Program; Clarification of Benefit Coverage of Durable Equipment and Ordering or Prescribing Durable Equipment; Clarification of Benefit Coverage of Assistive Technology Devices Under the Extended Care Health Option Program**

**AGENCY:** Office of the Secretary, DoD.

**ACTION:** Final rule.

**SUMMARY:** This final rule modifies the TRICARE regulation to add a definition of assistive technology (AT) devices for purposes of benefit coverage under the TRICARE Extended Care Health Option (ECHO) Program and to amend the definitions of durable equipment (DE) and durable medical equipment (DME) to better conform the language in the regulation to the statute. The final rule amends the language that specifically limits ordering or prescribing of DME to only a physician under the Basic Program, as this amendment will allow certain other TRICARE authorized individual professional providers, acting within the scope of their licensure, to order or prescribe DME. This final rule also incorporates a policy clarification relating to luxury, deluxe, or immaterial features of equipment or devices. That is, TRICARE cannot reimburse for the luxury, deluxe, or immaterial features of equipment or devices, but can reimburse for the base or basic equipment or device that meet the beneficiary's needs. Beneficiaries may choose to pay the provider for the luxury, deluxe, or immaterial features if they desire their equipment or device to have these "extra features."

**DATES:** This rule is effective January 30, 2015.

**FOR FURTHER INFORMATION CONTACT:** Gail L. Jones, (303) 676-3401.

**SUPPLEMENTARY INFORMATION:**

**I. Executive Summary**

*A. Purpose of the Final Rule*

1. Coverage for DE, DME and AT Devices.

The National Defense Authorization Act for Fiscal Year 2002 revised the coverage of DE under TRICARE. Those revisions resulted in final amendments to the TRICARE regulation regarding the TRICARE Basic Program, effective December 13, 2004, as published in the **Federal Register** on October 12, 2004 (69 FR 60547), and regarding the TRICARE Extended Health Care Option (ECHO) Program, effective September 20, 2004, as published in the **Federal Register** on August 20, 2004 (69 FR 51559). The original implementing regulations made a potentially confusing technical distinction between “DE” and “DME”; that is, “DE” was defined as an item that did not qualify as “DME” that otherwise might be available under the TRICARE ECHO Program. This final rule provides clarification by correcting the definitions and adding a definition of AT devices, which conforms to existing policy covering devices not otherwise qualifying as DE.

2. Ordering and Prescribing DE and DME

The current regulation in § 199.4(d)(3)(ii)(A)(1) does not allow coverage of DME ordered by a TRICARE-authorized individual professional provider of care, with the exception of a doctor of medicine (MD) or a doctor of osteopathy (DO), even though it is permitted by his or her licensure. Paragraph (d)(3)(ii)(A)(1) specifically states, “Subject to the exceptions in paragraph (d)(3)(ii)(C) of this same section, only DME which is ordered by a physician for the specific use of the beneficiary shall be covered.” Paragraph (d)(1) also states that only a physician can order DME. This restriction causes two problems:

- Certain other TRICARE authorized individual professional providers such as doctors of podiatric medicine (DPMs), doctors of optometry (ODs), doctors of dental surgery (DDSs), doctors of dental medicine (DMDs), certified nurse midwives (CNMs), certified nurse practitioners (CNP), including certified clinical nurse specialists (CCNSs), certified registered nurse anesthetists (CRNAs), and certified psychiatric nurse specialists (CPNSs) cannot prescribe DME, even

when acting within the scope of their licensure.

- Beneficiaries cannot fill a prescription for DME prescribed by other non-physician professional providers, even when they act as a primary care provider, such as a CNP.

State governments generally regulate the licensure and practice of specific types of health care professionals, and DoD limits TRICARE benefit coverage to services and supplies furnished by otherwise authorized TRICARE individual professional providers performing within the scope of their state licenses or certifications. State scope of practice laws vary about the range of services and some include the authority to prescribe DME. DoD determines that it is unnecessarily restrictive to not cover DE (including DME) merely because it is ordered by an otherwise authorized non-physician allied health care professional and certain other authorized individual professional providers. Therefore, this final rule amends the regulation to allow TRICARE coverage of DE (except for cardiorespiratory monitor) when ordered by a physician, dentist, or any other TRICARE authorized non-physician allied health care professional. This includes CNMs, CNPs/CCNSs, CRNAs, CPNSs, and certified physician assistants (CPAs), and certain other TRICARE authorized individual professional providers, namely DPMs, ODs, DDSs, and DMDs, when acting within the scope of their state license or certificate.

Following further review of the applicable regulation, in proposing to expand the category of TRICARE authorized providers allowed to prescribe DE, the proposed amendment was not specific enough to include only physicians, dentists and other allied health care professionals consistent with the stated purpose of the proposed rule. Therefore, this final rule amends § 199.4(d)(3)(ii)(A)(1) to limit those individual professional providers allowed to order DE to those listed in § 199.6(c)(3)(i), (ii), or (iii).

In addition, DoD must clarify that when the proposed rule referred to clinical nurse specialists (CNSs) as being able to prescribe DE for TRICARE beneficiaries, the reference should have been to certified clinical nurse specialists (CCNSs) and only those CCNSs that are recognized by TRICARE either as CNPs, CPNSs, or CNMs. Further, the proposed rule did not mention certified physician assistants (CPAs) as allied health care professionals authorized to prescribe DE. The applicable regulation includes CPAs as TRICARE authorized allied

health care professionals at § 199.6(c)(3)(iii)(H), and this final rule clarifies that CPAs are authorized to order DE for TRICARE beneficiaries. See the *Public Comments* section for additional information on both CCNSs and CPAs.

The legal authorities for this final rule are 10 U.S.C. 1073, 1077(a)(12), 1077(f)(1) and (2), 1077, 1079, and 1086 respectively. Authority for the ECHO Program: 10 U.S.C. 1079(d) through (f); authority for TRICARE benefit coverage: 10 U.S.C. 1079(a)(13), 1079(o), and 32 CFR part 199; authority regarding specific categories of TRICARE authorized individual professional providers: § 199.6(c)(1)(iii) and (2)(i); authority for other allied health professionals as TRICARE authorized providers: § 199.6(c)(3)(iii).

*B. Summary of the Major Provisions of the Final Rule*

In this final rule, the regulatory language more appropriately conforms to that of the statutory language, which identifies “DME” as a subset of “DE” for purposes of the TRICARE Basic Program. Therefore, the final rule amends the TRICARE regulation on DE and clarifies that the policies applicable to DME (*e.g.*, exclusion of luxury features and pricing methods) have been and are applicable to DE. DoD’s interpretation of the statute and regulation has been, and continues to be, that all DE authorized under the TRICARE Basic Program must be determined to be medically necessary for the treatment of an illness, injury or bodily malfunction before the equipment can be cost shared by TRICARE. Consequently, this technical revision does not change current policies for coverage of DE.

This final rule clarifies that the TRICARE ECHO Program includes coverage of AT devices that do not otherwise qualify as DE, and adds a definition and specific criteria for coverage of AT devices for individuals qualified to receive benefits under the ECHO Program.

This final rule also provides further clarification that if a beneficiary wishes to obtain an item of DE that has deluxe, luxury, or immaterial features, the beneficiary shall be responsible for the difference between the price of the item and the TRICARE allowable cost for an otherwise authorized item of DE without such features.

Finally, the final rule emphasizes that certain other TRICARE authorized individual professional providers who are listed in the regulation as physicians, dentists or allied health care professionals, who are legally

authorized to practice by the state, and when they are practicing within the scope of the license permitted by the state licensing authorities, may prescribe or order DE under the TRICARE Program.

### C. Summary of Costs and Benefits

This final rule is not anticipated to have an annual effect on the economy of \$100 million or more, making it not economically significant and non-major under the Executive Order and the Congressional Review Act.

The technical revisions for coverage of DE do not change current policies. DoD's interpretation of the statute and regulation has been, and will continue to be, that all equipment authorized under the TRICARE Basic Program must be determined to be medically necessary in the treatment of an illness, injury or bodily malfunction before the equipment can be cost shared by TRICARE. The amendment to remove the restriction that limits ordering or prescribing of DME to only an MD or DO is not expected to increase the amount of DE and DME prescribed because other providers are currently writing prescriptions—it only changes who prescribes it. However, DoD anticipates that there may be a marginal increase in administrative cost to accommodate changes to definitions. More importantly, this change will have no impact on beneficiaries eligible for DE.

## II. Discussion of Final Rule

### A. Final Rule Authority

The legal authority for this final rule is 10 U.S.C. 1073, which authorizes the Secretary of Defense to administer the medical and dental benefits provided in 10 U.S.C. chapter 55. The DoD is also authorized to provide DE under 10 U.S.C. 1077(a)(12), which benefit is further defined in 10 U.S.C. 1077(f)(1) and (2). Although section 1077 defines benefits to be provided in the military treatment facilities (MTFs), these benefits are incorporated by reference for the benefits provided by healthcare providers in the private sector to active duty family members and retirees and their dependents through sections 1079 and 1086 respectively. DoD is further authorized to provide a program, generally referred to as ECHO, for dependents of active duty members, who have a qualifying condition under section 1079(d) through (f). The ECHO Program may include DE not otherwise available under the TRICARE Basic Program and AT devices to assist in the reduction of the disabling effects of a qualifying condition.

The DoD, in general, is only authorized to cover as TRICARE benefits, under section 1079(a)(13), section 1079(o), and 32 CFR part 199, any service or supply that is medically or psychologically necessary to prevent, diagnose or treat a mental or physical illness, injury, or bodily malfunction. Section 1079(a)(13) identifies specific categories of individual professional providers who may make the diagnosis and recommend the treatment. Section 199.6(c)(1)(iii) requires TRICARE-authorized individual professional providers to provide medical service and care within the scope of their licensure and training consistent with the state practice act, or within the scope of the test, which is the basis for an individual's certification by the state where the individual renders the service. Paragraph (2)(i) of this same section specifies that an individual must be currently licensed to render professional health care services in each state in which the individual renders services to TRICARE beneficiaries. Such license is required when a specific state provides, but does not require, license for a specific category of individual professional providers. Under § 199.6(c)(3)(iii) of this part, certain individual professional providers, other than physicians and dentists, are identified as allied health professionals and authorized as TRICARE providers of care for covered services or supplies otherwise authorized by the regulation.

Section 199.4(a)(1)(i) specifies the scope of benefits authorized for TRICARE beneficiaries, including requirements that the care be medically necessary in the diagnosis and treatment of illness or injury and that the care be provided by either authorized institutional providers or authorized individual professional providers or non-institutional providers. As defined in § 199.2(b), "medically necessary" incorporates the concept of "appropriate medical care," which is further defined, in part, as requiring that a TRICARE authorized individual professional provider rendering medical care be qualified to perform such medical services, by reason of his or her training and education, and the provider is licensed, or certified by the state where the service is rendered or by an appropriate national organization, or otherwise meets TRICARE standards.

### B. Provisions of the Final Rule

This final rule incorporates all the provisions set forth in the proposed rule, except that this final rule further amends § 199.4.(d)(3)(ii)(A)(1) to clarify that those individual professional providers allowed to order DE are

limited to physicians, dentists and allied health care professionals listed in § 199.6(c)((3)(i), (ii), or (iii)). In addition, based on public comments received, and after further review of the applicable regulation, DoD clarifies that certified clinical nurse specialists (CCNSs) [when recognized by TRICARE as a CNP, CNM, or CPNS] and certified physician assistants (CPAs) are TRICARE authorized allied health care professionals who may order or prescribe DE under TRICARE when acting within the scope of their license or certification. See the *Public Comments* section for additional information.

The provisions, which amend 32 CFR part 199, are specified as follows:

#### § 199.2 (Definitions)

- "Duplicate Equipment." AT devices are subject to the definition of duplicate equipment.
- "Durable Equipment (DE)." To clarify that DE may be a covered benefit under the TRICARE Basic Program, consistent with 10 U.S.C. 1079(a)(5) and 10 U.S.C. 1077(a)(12) and (f), DoD is revising the definition of DE as "(1) a medically necessary item, which can withstand repeated use; (2) is primarily and customarily used to serve a medical purpose; and, (3) is generally not useful to an individual in the absence of an illness or injury." It includes DME, wheelchairs, iron lungs, and hospital beds.
- "Durable Medical Equipment (DME)." Consistent with 10 U.S.C. 1079(a)(5) and 10 U.S.C. 1077(a)(12) and (f), DoD is revising the definition of DME as "DE, which is medically appropriate to (1) improve, restore, or maintain the function of a malformed, diseased, or injured body part, or can otherwise minimize or prevent the deterioration of the beneficiary's function or condition; or, (2) maximize the beneficiary's function consistent with the beneficiary's physiological or medical needs."
- "Assistive Technology (AT) Devices." AT devices do not treat an underlying injury, illness or disease, or their symptoms. However, to clarify that the TRICARE ECHO Program includes coverage of AT devices, which do not otherwise qualify as DE, DoD is adding a definition of AT devices as "equipment that generally helps overcome or remove a disability and is used to increase, maintain, or improve the functional capabilities of an individual. AT devices may include non-medical devices but do not include any structural alterations (e.g., wheelchair ramps or alterations to street curbs) or service animals (e.g., Seeing

Eye dogs, hearing/handicapped assistance animals, etc.). AT devices are authorized only under coverage criteria to assist in the reduction of the disabling effects of a qualifying condition for individuals eligible to receive benefits under the ECHO program as provided in § 199.5.”

#### § 199.4 (Basic Program Benefits)

DoD clarifies the following for purposes of benefit coverage of DE under the TRICARE Basic Program:

- DE is an authorized benefit when medically necessary for the treatment of a covered illness or injury.

- Authorized DE is a benefit when ordered by certain authorized individual professional providers listed in § 199.6(c)(3)(i), (ii), or (iii) of this part for the specific use of the beneficiary and the equipment provides the medically appropriate level of performance and quality for the beneficiary’s condition.

- Unless otherwise excluded under the regulation, items authorized coverage as DE include (1) DME (including a cardiorespiratory monitor under certain conditions), (2) wheelchairs when medically appropriate to provide basic mobility, (3) iron lungs, and (4) hospital beds. An electric wheelchair or a TRICARE-approved alternative to an electric wheelchair may be used in lieu of a manual wheelchair when it is medically indicated and appropriate for the individual patient.

- An item that provides a medically appropriate level of performance or quality for the beneficiary’s condition does not include luxury, deluxe, or immaterial items. Only the base or basic model of equipment shall be covered, unless any customization of the equipment owned by the beneficiary, or an accessory or item of supply for any DE is essential for (1) achieving therapeutic benefit for the beneficiary; (2) making the equipment serviceable; or (3) otherwise assuring the proper functioning of the equipment. If a beneficiary wishes to obtain an item of DE that has deluxe, luxury, or immaterial features, the beneficiary shall be responsible for the difference between the price of the item and the TRICARE allowable cost for an otherwise authorized item of DE without such features.

- DE, which otherwise qualifies as a benefit, is excluded from coverage if (1) the beneficiary is a patient in a type of facility that ordinarily provides the same type of DE item to its patients at no additional charge in the usual course of providing its services; or (2) DE is available to the beneficiary from a

Uniformed Services Medical Treatment Facility.

- DE may be provided on a rental or purchase basis and coverage will be based on the price most advantageous to the government under established procedures.

- Repairs of DE damaged while using the equipment in a manner inconsistent with its common use, and replacement of lost or stolen DE are excluded from Basic Program benefits.

- Repairs of deluxe, luxury or immaterial features of DE are excluded from Basic Program benefits.

#### § 199.5 (TRICARE Extended Care Health Option (ECHO))

DoD clarifies the following for purposes of benefit coverage of DE and AT devices under the ECHO Program:

- An AT device is authorized under certain coverage criteria when necessary to assist in the reduction of the disabling effects of a qualifying condition of the ECHO eligible beneficiary. For beneficiaries eligible for an individual education plan (IEP), AT devices that are recommended as part of the IEP may be covered.

- For those beneficiaries who cease to meet the eligibility requirements for an IEP, AT devices under TRICARE ECHO Program must:

- Be preauthorized;
- Be prescribed by a TRICARE authorized provider;
- Assist in the reduction of the disabling effects of the qualifying ECHO condition; and
- Be an item or educational learning device normally included in an IEP.

Further, the item must not be otherwise covered as a prosthetic, augmentative communication device, or a benefit under the TRICARE Basic Program. The implementing instructions for this provision will be outlined in the TRICARE Policy Manual. As with all aspects of this proposed rule, DoD invites the public’s comments on our approach regarding AT devices for those beneficiaries who cease to be eligible for an IEP.

- Repairs of DE or AT devices damaged while using the equipment in a manner inconsistent with its common use, and replacement of lost or stolen DE or AT devices are excluded from ECHO coverage.

- Repairs of deluxe, luxury or immaterial features of DE or AT devices are excluded from ECHO coverage.

- Wheelchairs may exceed the basic mobility limitation when needed to mitigate the effects of the ECHO qualifying condition of the beneficiary.

- DE may be provided on a rental or purchase basis and coverage will be

based on the price most advantageous to the government under the same procedures established for pricing DE under the TRICARE Basic Program.

### III. Public Comments

On August 8, 2013 (78 FR 48367–48373), the Office of the Secretary of Defense published a proposed rule and provided the public an opportunity to comment on implementing changes to the coverage of DE, ordering or prescribing DE and benefit coverage of AT devices under the ECHO Program. The comment period closed October 7, 2013.

As a result of publication of the proposed rule, DoD received 57 comments. All of the commenters supported the policies we proposed, although there were concerns about physician assistants, nurse practitioners, and clinical nurse specialists not being included on the list of providers authorized to prescribe or order DE under the TRICARE Program. We appreciate all expressions of support and approval for the proposed guidelines.

#### *Response Regarding Physician Assistants*

Generally, the Program policy has been to recognize those authorized individual professional providers identified in 10 U.S.C. 1079(a)(13) when acting within the scope of their licenses and to allow direct reimbursement for authorized services they provide. However, § 199.14(j)(ix) allows an otherwise authorized physician to bill for the services of an authorized “certified” physician assistant (CPA) under § 199.6(c)(3)(iii)(H), provided the CPA is acting within the scope of his or her license and is supervised by an employing physician. Therefore, the final rule will allow CPAs to prescribe or order DE under the supervision of the employing authorized physician who must bill under his or her National Provider Identifier (NPI) for services that a CPA furnishes incident to his or her professional services.

#### *Response Regarding Nurse Practitioners*

Nurse practitioners (NPs), by TRICARE law and regulation, are only recognized as individual professional providers when they qualify as “certified” nurse practitioners (CNPs). For that reason, DoD will authorize only CNPs to prescribe or order DE when acting within the scope of their state license or certificate.

*Response Regarding Clinical Nurse Specialists*

“Certified” clinical nurse specialists (CCNSs) are recognized as advanced practice nurses. They meet the same state requirements and coursework as any other advanced practice nurse (such as a CPN) whose practice similarly extends into the medical field, or for that matter, into any other medical professional area, and may use advanced practice nurse practitioner (APNP) or advanced practice nurse (APN) title when practicing within a CCNS’s scope of practice. Therefore, CCNSs when recognized by TRICARE under one of the existing categories of authorized allied health care professionals as found in § 199.6(c)(3)(iii) are authorized to prescribe DE when acting within the scope of their state license or certificate.

In this final rule, DoD considered all comments received during the comment period and responses to those comments are included in the above section of this final rule.

**IV. Regulatory Procedure**

*Executive Order 12866, “Regulatory Planning and Review” and Executive Order 13563, “Improving Regulation and Regulatory Review”*

It has been determined that this final rule is not a significant regulatory action. This rule does not:

- (1) Have an annual effect on the economy of \$100 million or more or adversely affect in a material way the economy; a section of the economy; productivity; competition; jobs; the environment; public health or safety; or State, local, or tribal governments or communities;
- (2) Create a serious inconsistency or otherwise interfere with an action taken or planned by another Agency;
- (3) Materially alter the budgetary impact of entitlements, grants, user fees, or loan programs, or the rights and obligations of recipients thereof; or
- (4) Raise novel legal or policy issues arising out of legal mandates, the President’s priorities, or the principles set forth in these Executive Orders.

*Unfunded Mandates Reform Act (Sec. 202, Pub. L. 104-4)*

It has been determined that this final rule does not contain a Federal mandate that may result in the expenditure by State, local and tribal governments, in aggregate, or by the private sector, of \$100 million or more in any one year.

*Public Law 96-354, “Regulatory Flexibility Act” (5 U.S.C. 601)*

It has been certified that this final rule is not subject to the Regulatory Flexibility Act (5 U.S.C. 601) because it would not, if promulgated, have a significant economic impact on a substantial number of small entities. Set forth in the final rule are minor revisions to the existing regulation. The DoD does not anticipate a significant impact on the Program.

*Public Law 96-511, “Paperwork Reduction Act” (44 U.S.C. Chapter 35)*

It has been determined that this final rule does not impose reporting or recordkeeping requirements under the Paperwork Act of 1995.

*Executive Order 13132, Federalism*

It has been determined that this final rule does not have federalism implications, as set forth in Executive Order 13132. This rule does not have substantial direct effects on:

- (1) The States;
- (2) The relationship between the National Government and the States; or
- (3) The distribution of power and responsibilities among the various levels of Government.

**List of Subjects in 32 CFR Part 199**

Claims, Dental health, Health care, Health insurance, Individuals with disabilities, and Military personnel.

Accordingly, 32 CFR part 199 is amended to read as follows:

**PART 199—[AMENDED]**

■ 1. The authority citation for part 199 continues to read as follows:

**Authority:** 5 U.S.C. 301; 10 U.S.C. chapter 55.

■ 2. Section 199.2, paragraph (b) is amended by adding the definition of “Assistive technology devices” in alphabetical order and revising the definitions of “Duplicate equipment,” “Durable equipment,” and “Durable medical equipment” to read as follows:

**§ 199.2 Definitions.**

\* \* \* \* \*

(b) \* \* \*

*Assistive technology devices.*

Equipment that generally does not treat an underlying injury, illness, disease or their symptoms. Assistive technology devices are authorized only under the Extended Care Health Option (ECHO). Assistive technology devices help an ECHO beneficiary overcome or remove a disability and are used to increase, maintain, or improve the functional capabilities of an individual. Assistive

technology devices may include non-medical devices but do not include any structural alterations (e.g., permanent structure of wheelchair ramps or alterations to street curbs) service animals (e.g., Seeing Eye dogs, hearing/handicapped assistance animals, etc.) or specialized equipment and devices whose primary purpose is to enable the individual to engage in sports or recreational events. Assistive technology devices are authorized only under coverage criteria determined by the Director, TRICARE Management Activity to assist in the reduction of the disabling effects of a qualifying condition for individuals eligible to receive benefits under the ECHO program, as provided in § 199.5.

\* \* \* \* \*

*Duplicate equipment.* An item of durable equipment, durable medical equipment, or assistive technology items, as defined in this section that serves the same purpose that is served by an item of durable equipment, durable medical equipment, or assistive technology item previously cost-shared by TRICARE. For example, various models of stationary oxygen concentrators with no essential functional differences are considered duplicate equipment, whereas stationary and portable oxygen concentrators are not considered duplicates of each other because the latter is intended to provide the user with mobility not afforded by the former. Also, a manual wheelchair and electric wheelchair, both of which otherwise meet the definition of durable equipment or durable medical equipment, would not be considered duplicates of each other if each is found to provide an appropriate level of mobility. For the purpose of this Part, durable equipment, durable medical equipment, or assistive technology items that are essential in providing a fail-safe in-home life support system or that replace in-like-kind an item of equipment that is not serviceable due to normal wear, accidental damage, a change in the beneficiary’s condition, or has been declared adulterated by the U.S. FDA, or is being or has been recalled by the manufacturer is not considered duplicate equipment.

*Durable equipment.* Equipment that—

- (1) Is a medically necessary item, which can withstand repeated use;
- (2) Is primarily and customarily used to serve a medical purpose; and
- (3) Is generally not useful to an individual in the absence of an illness or injury. It includes durable medical equipment as defined in § 199.2, wheelchairs, iron lungs, and hospital

beds. It does not include equipment (including wheelchairs) used or designed primarily for use in sports or recreational activities.

*Durable medical equipment.* Durable equipment that is medically appropriate to—

(1) Improve, restore, or maintain the function of a malformed, diseased, or injured body part or can otherwise minimize or prevent the deterioration of the beneficiary's function or condition; or

(2) Maximize the beneficiary's function consistent with the beneficiary's physiological or medical needs.

\* \* \* \* \*

■ 3. Section 199.4 is amended by revising paragraphs (a)(1)(i), (d)(1), (d)(3)(ii), and (g)(43) to read as follows:

**§ 199.4 Basic program benefits.**

(a) \* \* \*

(1)(i) *Scope of benefits.* Subject to all applicable definitions, conditions, limitations, or exclusions specified in this part, the CHAMPUS Basic Program will cost share medically necessary services and supplies required in the diagnosis and treatment of illness or injury, including maternity care and well-baby care. Benefits include specified medical services and supplies provided to eligible beneficiaries from authorized civilian sources such as hospitals, other authorized institutional providers, physicians, other authorized individual professional providers, and professional ambulance services, prescription drugs, authorized medical supplies, and rental or purchase of durable equipment.

\* \* \* \* \*

(d) *Other benefits*—(1) General. Benefits may be extended for the allowable charge of those other covered services and supplies described in paragraph (d) of this section, which are provided in accordance with good medical practice and established standards of quality by those other authorized providers described in § 199.6. Such benefits are subject to all applicable definitions, conditions, limitations, or exclusions as otherwise may be set forth in this or other chapters of this Regulation. To be considered for benefits under paragraph (d) of this section, the described services or supplies must be prescribed and ordered by a physician. Other authorized individual professional providers acting within their scope of licensure may also prescribe and order these services and supplies unless

otherwise specified in paragraph (d) of this section.

\* \* \* \* \*

(3) \* \* \*

(ii) *Durable equipment*—(A) Scope of benefit. (1) Durable equipment, which is for the specific use of the beneficiary and is ordered by an authorized individual professional provider listed in § 199.6(c)(3)(i), (ii) or (iii), acting within his or her scope of licensure shall be covered if the durable equipment meets the definition in § 199.2 and—

(i) Provides the medically appropriate level of performance and quality for the medical condition present and

(ii) Is not otherwise excluded by this part.

(2) Items that may be provided to a beneficiary as durable equipment include:

(i) Durable medical equipment as defined in § 199.2;

(ii) Wheelchairs. A wheelchair, which is medically appropriate to provide basic mobility, including reasonable additional costs for medically appropriate modifications to accommodate a particular physiological or medical need, may be covered as durable equipment. An electric wheelchair, or TRICARE approved alternative to an electric wheelchair (e.g., scooter) may be provided in lieu of a manual wheelchair when it is medically indicated and appropriate to provide basic mobility. Luxury or deluxe wheelchairs, as described in paragraph (d)(3)(ii)(A)(3) of this section, include features beyond those required for basic mobility of a particular beneficiary are not authorized.

(iii) Iron lungs.

(iv) Hospital beds.

(v) Cardiorespiratory monitors under conditions specified in paragraph (d)(3)(ii)(B) of this section.

(3) Whether a prescribed item of durable equipment provides the medically appropriate level of performance and quality for the beneficiary's condition must be supported by adequate documentation. Luxury, deluxe, immaterial, or non-essential features, which increase the cost of the item relative to a similar item without those features, based on industry standards for a particular item at the time the equipment is prescribed or replaced for a beneficiary, are not authorized. Only the "base" or "basic" model of equipment (or more cost-effective alternative equipment) shall be covered, unless customization of the equipment, or any accessory or item of supply for any durable equipment, is essential, as determined by the Director (or designee), for—

(i) Achieving therapeutic benefit for the patient;

(ii) Making the equipment serviceable; or

(iii) Otherwise assuring the proper functioning of the equipment.

\* \* \* \* \*

(B) \* \* \*

(C) *Exclusions.* Durable equipment, which is otherwise qualified as a benefit is excluded from coverage under the following circumstances:

(1) Durable equipment for a beneficiary who is a patient in a type of facility that ordinarily provides the same type of durable equipment item to its patients at no additional charge in the usual course of providing its services.

(2) Durable equipment, which is available to the beneficiary from a Uniformed Services Medical Treatment Facility.

(D) *Basis for reimbursement.* (1) Durable equipment may be provided on a rental or purchase basis. Coverage of durable equipment will be based on the price most advantageous to the government taking into consideration the anticipated duration of the medically necessary need for the equipment and current price information for the type of item. The cost analysis must include a comparison of the total price of the item as a monthly rental charge, a lease-purchase price, and a lump-sum purchase price and a provision for the time value of money at the rate determined by the U.S. Department of Treasury. If a beneficiary wishes to obtain an item of durable equipment with deluxe, luxury, immaterial or non-essential features, the beneficiary may agree to accept TRICARE coverage limited to the allowable amount that would have otherwise been authorized for a similar item without those features. In that case, the TRICARE coverage is based upon the allowable amount for the kind of durable equipment normally used to meet the intended purpose (i.e., the standard item least costly). The provider shall not hold the beneficiary liable for deluxe, luxury, immaterial, or non-essential features that cannot be considered in determining the TRICARE allowable costs. However, the beneficiary shall be held liable if the provider has a specific agreement in writing from the beneficiary (or his or her representative) accepting liability for the itemized difference in costs of the durable equipment with deluxe, luxury, or immaterial features and the TRICARE allowable costs for an otherwise authorized item without such features.

(2) In general, repairs of beneficiary owned durable equipment are covered when necessary to make the equipment serviceable and replacement of durable equipment is allowed when the durable equipment is not serviceable because of normal wear, accidental damage or when necessitated by a change in the beneficiary's condition. However, repairs of durable equipment damaged while using the equipment in a manner inconsistent with its common use, and replacement of lost or stolen durable equipment are excluded from coverage. In addition, repairs of deluxe, luxury, or immaterial features of durable equipment are excluded from coverage.

\* \* \* \* \*

(g) \* \* \*

(43) Exercise/relaxation/comfort/sporting items or sporting devices. Exercise equipment, to include items primarily and customarily designed for use in sports or recreational activities, spas, whirlpools, hot tubs, swimming pools health club memberships or other such charges or items.

\* \* \* \* \*

■ 4. Section 199.5 is amended by revising paragraphs (c)(2), (c)(8)(ii), and (c)(8)(iii), (d)(3), (d)(7) introductory text, (d)(7)(i), (d)(7)(iv), and (d)(8), (g)(2), and (h)(4), and adding new paragraph (d)(7)(v) to read as follows:

**§ 199.5 TRICARE extended care health option (ECHO).**

\* \* \* \* \*

(c) \* \* \*

(2) Medical, habilitative, rehabilitative services and supplies, durable equipment and assistive technology (AT) devices that assist in the reduction of the disabling effects of a qualifying condition. Benefits shall be provided in the beneficiary's home or another environment, as appropriate. An AT device may be covered only if it is recommended in a beneficiary's Individual Educational Program (IEP) or, if the beneficiary is not eligible for an IEP, the AT device is an item or educational learning device normally included in an IEP and is preauthorized under ECHO as an integral component of the beneficiary's individual comprehensive health care services plan (including rehabilitation) as prescribed by a TRICARE authorized provider.

(i) An AT device may be covered under ECHO only if it is not otherwise covered by TRICARE as durable equipment, a prosthetic, augmentation communication device, or other benefits under § 199.4.

(ii) An AT device may include an educational learning device directly related to the beneficiary's qualifying

condition when recommended by an IEP and not otherwise provided by State or local government programs. If an individual is not eligible for an IEP, an educational learning device normally included in the IEP may be authorized as if directly related to the beneficiary's qualifying condition and prescribed by a TRICARE authorized provider as part of the beneficiary's individual comprehensive health care services plan.

(iii) Electronic learning devices may include the hardware and software as appropriate. The Director, DHA, shall determine the types and (or) platforms of electronic devices and the replacement lifecycle of the hardware and its supporting software. All upgrades or replacements shall require a recommendation from the individual's IEP or the individual's comprehensive health care services plan.

(iv) Duplicative or redundant hardware platforms are not authorized.

Note to paragraph (c)(2)(iv): When one or more electronic platforms such as a desktop computer, laptop, notebook or tablet can perform the same functions in relation to the teaching or educational objective directly related to the qualifying condition, it is the intent of this provision to allow only one electronic platform that may be chosen by the beneficiary. Duplicative or redundant platforms are not allowed; however, a second platform may be obtained, if the individual's IEP recommends one platform such as a computer for the majority of the learning objectives, but there exists another objective, which cannot be performed on that platform. In these limited circumstances, the beneficiary may submit a request with the above justification to the Director, TMA, who may authorize a second device.

(v) AT devices damaged through improper use of the device as well as lost or stolen devices may not be replaced until the device would next be eligible for a lifecycle replacement.

(vi) AT devices do not include equipment or devices whose primary purpose is to assist the individual to engage in sports or recreational activities.

\* \* \* \* \*

(8) \* \* \*

(ii) *Equipment adaptation.* The allowable equipment and an AT device purchase shall include such services and modifications to the equipment as necessary to make the equipment usable for a particular ECHO beneficiary.

(iii) *Equipment maintenance.* Reasonable repairs and maintenance of the beneficiary owned or rented DE or

AT devices provided by this section shall be allowed while a beneficiary is registered in the ECHO Program. Repairs of DE and/or AT devices damaged while using the item in a manner inconsistent with its common use, and replacement of lost or stolen DE and/or AT devices are not authorized coverage as an ECHO benefit. In addition, repairs and maintenance of deluxe, luxury, or immaterial features of DE or AT devices are not authorized coverage as an ECHO benefit.

(d) \* \* \*

(3) *Structural alterations.* Alterations to living space and permanent fixtures attached thereto, including alterations necessary to accommodate installation of equipment or AT devices to facilitate entrance or exit, are excluded.

\* \* \* \* \*

(7) *Equipment.* Purchase or rental of DE and AT devices otherwise allowed by this section is excluded when:

(i) The beneficiary is a patient in an institution or facility that ordinarily provides the same type of equipment or AT devices to its patients at no additional charge in the usual course of providing services; or

\* \* \* \* \*

(iv) The item is a duplicate DE or an AT device, as defined in § 199.2.

(v) The item (or charge for access to such items through health club membership or other activities) is exercise equipment including an item primarily and customarily designed for use in sports or recreational activities, spa, whirlpool, hot tub, swimming pool, an electronic device used to locate or monitor the location of the beneficiary, or other similar items or charges.

(8) *Maintenance agreements.* Maintenance agreements for beneficiary owned or rented equipment or AT device are excluded.

\* \* \* \* \*

(g) \* \* \*

(2) *Equipment.* (i) The TRICARE allowable amount for DE or AT devices shall be calculated in the same manner as DME allowable through section 199.4 of this title, and accrues to the fiscal year benefit limit specified in paragraph (f)(3) of this section.

(ii) *Cost-share.* A cost-share, as provided by paragraph (f)(2) of this section, is required for each month in which equipment or an AT device is purchased under this section. However, in no month shall a sponsor be required to pay more than one cost-share regardless of the number of benefits the sponsor's dependents received under this section.

\* \* \* \* \*

(h) \* \* \*



(4) Repair or maintenance of DE owned by the beneficiary or an AT device is exempt from the public facility-use certification requirements.

\* \* \* \* \*

Dated: December 22, 2014.

**Aaron Siegel,**

*Alternate OSD Federal Register Liaison Officer, Department of Defense.*

[FR Doc. 2014-30337 Filed 12-30-14; 8:45 am]

**BILLING CODE 5001-06-P**

## POSTAL REGULATORY COMMISSION

### 39 CFR Part 3020

[Docket Nos. MC2010-21 and CP2010-36]

#### Update to Product Lists

**AGENCY:** Postal Regulatory Commission.  
**ACTION:** Final rule.

**SUMMARY:** The Commission is updating the product lists. This action reflects a publication policy adopted by Commission order. The referenced policy assumes periodic updates. The updates are identified in the body of this document. The product lists, which is re-published in its entirety, includes these updates.

**DATES:** *Effective Date:* December 31, 2014.

*Applicability Dates:* See the

#### SUPPLEMENTARY INFORMATION.

**FOR FURTHER INFORMATION CONTACT:** David A. Trissell, General Counsel, at 202-789-6800.

**SUPPLEMENTARY INFORMATION:** This document identifies updates to the product lists, which appear as Appendix A to Subpart A of 39 CFR part 3020—Mail Classification Schedule. Publication of the updated product lists in the **Federal Register** is addressed in the Postal Accountability and Enhancement Act (PAEA) of 2006.

*Applicability Dates:* August 29, 2014, Priority Mail Contract 89 (MC2014-39 and CP2014-72); September 10, 2014, Priority Mail Express Contract 19 (MC2014-41 and CP2014-74); September 10, 2014, First-Class Package Service Contract 37 (MC2014-42 and CP2014-75); September 15, 2014, Priority Mail Express, Priority Mail & First-Class Package Service Contract 4 (MC2014-43 and CP2014-76); October 1, 2014, Priority Mail Contract 92 (MC2014-46 and CP2014-82); October 1, 2014, Priority Mail Contract 93 (MC2014-47 and CP2014-83); October 3, 2014, Priority Mail Contract 91 (MC2014-45 and CP2014-81); October 8, 2014, Priority Mail Contract 94 (MC2014-48 and CP2014-84); October

8, 2014, Priority Mail Contract 95 (MC2014-49 and CP2014-85); October 23, 2014, Market Test Customized Delivery (MT2014-1); October 24, 2014, Outbound Competitive International Merchandise Return Service Agreement with Royal Mail Group, Ltd. (CP2015-1); October 30, 2014, Priority Mail Express & Priority Mail Contract 16 (MC2015-2 and CP2015-4); November 5, 2014, Priority Mail Contract 97 (MC2015-5 and CP2015-6); November 5, 2014, Priority Mail Contract 98 (MC2015-6 and CP2015-7); November 5, 2014, Parcel Select Contract 8 (MC2015-1 and CP2015-3); November 10, 2014, Priority Mail Contract 96 (MC2015-4 and CP2015-5); December 5, 2014, Priority Mail Contract 101 (MC2015-11 and CP2015-14); December 5, 2014, Priority Mail Express Contract 20 (MC2015-12 and CP2015-15); December 5, 2014, Priority Mail Contract 100 (MC2015-10 and CP2015-13); December 5, 2014, Priority Mail Contract 99 (MC2015-9 and CP2015-2); December 11, 2014, Priority Mail Express Contract 21 (MC2015-14 and CP2015-17); December 12, 2014, Priority Mail Contract 102 (MC2015-13 and CP2015-16); December 19, 2014, Priority Mail Express Contract 23 (MC2015-16 and CP2015-20).

*Authorization.* The Commission process for periodic publication of updates was established in Docket Nos. MC2010-21 and CP2010-36, Order No. 445, April 22, 2010, at 8.

*Changes.* The product lists are being updated by publishing a replacement in its entirety of Appendix A to Subpart A of 39 CFR part 3020—Mail Classification Schedule. The following products are being added, removed, or moved within the product lists:

1. Priority Mail Contract 89 (MC2014-39 and CP2014-72) (Order No. 2175), added August 29, 2014.

2. Priority Mail Express Contract 19 (MC2014-41 and CP2014-74) (Order No. 2178), added September 10, 2014.

3. First-Class Package Service Contract 37 (MC2014-42 and CP2014-75) (Order No. 2179), added September 10, 2014.

4. Priority Mail Express, Priority Mail & First-Class Package Service Contract 4 (MC2014-43 and CP2014-76), added September 15, 2014.

5. Priority Mail Contract 92 (MC2014-46 and CP2014-82), added October 1, 2014.

6. Priority Mail Contract 93 (MC2014-47 and CP2014-83), added October 1, 2014.

7. Priority Mail Contract 91 (MC2014-45 and CP2014-81), added October 3, 2014.

8. Priority Mail Contract 94 (MC2014-48 and CP2014-84), added October 8, 2014.

9. Priority Mail Contract 95 (MC2014-49 and CP2014-85), added October 8, 2014.

10. Market Test Customized Delivery (MT2014-1), authorizing test October 23, 2014.

11. Outbound Competitive International Merchandise Return Service Agreement with Royal Mail Group, Ltd. (CP2015-1), added October 24, 2014.

12. Priority Mail Express & Priority Mail Contract 16 (MC2015-2 and CP2015-4), added October 30, 2014.

13. Priority Mail Contract 97 (MC2015-5 and CP2015-6), added November 5, 2014.

14. Priority Mail Contract 98 (MC2015-6 and CP2015-7), added November 5, 2014.

15. Parcel Select Contract 8 (MC2015-1 and CP2015-3), added November 5, 2014.

16. Priority Mail Contract 96 (MC2015-4 and CP2015-5), added November 10, 2014.

17. Priority Mail Contract 101 (MC2015-11 and CP2015-14), added December 5, 2014.

18. Priority Mail Express Contract 20 (MC2015-12 and CP2015-15), added December 5, 2014.

19. Priority Mail Contract 100 (MC2015-10 and CP2015-13), added December 5, 2014.

20. Priority Mail Contract 99 (MC2015-9 and CP2015-12), added December 5, 2014.

21. Priority Mail Express Contract 21 (MC2015-14 and CP2015-17), added December 11, 2014.

22. Priority Mail Contract 102 (MC2015-13 and CP2015-16), added December 12, 2014.

23. Priority Mail Express Contract 23 (MC2015-16 and CP2015-20), added December 19, 2014.

*Updated product lists.* The referenced changes to the product lists are incorporated into Appendix A to Subpart A of 39 CFR part 3020—Mail Classification Schedule.

#### List of Subjects in 39 CFR Part 3020

Administrative practice and procedure, Postal Service.

For the reasons discussed in the preamble, the Postal Regulatory Commission amends chapter III of title 39 of the Code of Federal Regulations as follows:

#### PART 3020—PRODUCT LISTS

■ 1. The authority citation for part 3020 continues to read as follows: