AUTHENTICATED
U.S. GOVERNMENT
INFORMATION
GPO

failed to comply with the terms of this policy.

(b) In making decisions about supporting or approving applications or proposals covered by this policy the department or agency head may take into account, in addition to all other eligibility requirements and program criteria, factors such as whether the applicant has been subject to a termination or suspension under paragarph (a) of this section and whether the applicant or the person or persons who would direct or has have directed the scientific and technical aspects of an activity has have, in the judgment of the department or agency head, materially failed to discharge responsibility for the protection of the rights and welfare of human subjects (whether or not the research was subject to federal regulation).

§ 219.124 Conditions.

With respect to any research project or any class of research projects the department or agency head may impose additional conditions prior to or at the time of approval when in the judgment of the department or agency head additional conditions are necessary for the protection of human subjects.

PART 220—COLLECTION FROM THIRD PARTY PAYERS OF REASONABLE CHARGES FOR HEALTHCARE SERVICES

Sec.

220.1 Purpose and applicability.
220.2 Statutory obligation of third party payer to pay.
220.3 Exclusions impermissible.
220.4 Reasonable terms and conditions of health plan permissible.
220.5 Records available.
220.6 Certain payers excluded.
220.7 Remedies and procedures.
220.8 Reasonable charges.
220.9 Rights and obligations of beneficiaries.
220.10 Special rules for Medicare supplemental plans.
220.11 Special rules for automobile liability insurance and no-fault automobile insurance.
220.12 [Reserved]
220.13 Special rules for workers' compensation programs.
220.14 Definitions.

AUTHORITY: 5 U.S.C. 301; 10 U.S.C. 1095.

SOURCE: 55 FR 21748, May 29, 1990, unless otherwise noted.

§ 220.1 Purpose and applicability.

(a) This part implements the provisions of 10 U.S.C. 1095, 1097b(b), and 1079b. In general, 10 U.S.C. 1095 establishes the statutory obligation of third party payers to reimburse the United States the reasonable charges of healthcare services provided by facilities of the Uniformed Services to covered beneficiaries who are also covered by a third party payer's plan. Section 1097b(b) elaborates on the methods for computation of reasonable charges. Section 1079b addresses charges for civilian patients who are not normally beneficiaries of the Military Health System. This part establishes the Department of Defense interpretations and requirements applicable to all healthcare services subject to 10 U.S.C. 1095, 1097b(b), and 1079b.

(b) This part applies to all facilities of the Uniformed Services; the Department of Transportation administers this part with respect to facilities to the Coast Guard, not the Department of Defense.

(c) This part applies to pathology services provided by the Armed Forces Institute of Pathology. However, in lieu of the rules and procedures otherwise applicable under this part, the Assistant Secretary of Defense (Health Affairs) may establish special rules and procedures under the authority of 10 U.S.C. 176 and 177 in relation to cooperative enterprises between the Armed Forces Institute of Pathology and the American Registry of Pathology.

[67 FR 57740, Sept. 12, 2002]

§ 220.2 Statutory obligation of third party payer to pay.

(a) *Basic rule.* Pursuant to 10 U.S.C. 1095(a)(1), a third party payer has an obligation to pay the United States the reasonable charges for healthcare services provided in or through any facility of the Uniformed Services to a covered beneficiary who is also a beneficiary under the third party payer's plan. The obligation to pay is to the extent that the beneficiary would be eligible to receive reimbursement or indemnification from the third party payer if the

beneficiary were to incur the costs on the beneficiary's own behalf.

(b) *Application of cost shares.* If the third party payer's plan includes a requirement for a deductible or copayment by the beneficiary of the plan, then the amount the United States may collect from the third party payer is the reasonable charge for the care provided less the appropriate deductible or copayment amount.

(c) *Claim from United States exclusive.* The only way for a third party payer to satisfy its obligation under 10 U.S.C. 1095 is to pay the facility of the uniformed service or other authorized representative of the United States. Payment by a third party payer to the beneficiary does not satisfy 10 U.S.C. 1095.

(d) *Assignment of benefits or other submission by beneficiary not necessary.* The obligation of the third party payer to pay is not dependent upon the beneficiary executing an assignment of benefits to the United States. Nor is the obligation to pay dependent upon any other submission by the beneficiary to the third party payer, including any claim or appeal. In any case in which a facility of the Uniformed Services makes a claim, appeal, representation, or other filing under the authority of this part, any procedural requirement in any third party payer plan for the beneficiary of such plan to make the claim, appeal, representation, or other filing must be deemed to be satisfied. A copy of the completed and signed DoD insurance declaration form will be provided to payers upon request, in lieu of a claimant's statement or coordination of benefits form.

(e) *Preemption of conflicting State laws.* Any provision of a law or regulation of a State or political subdivision thereof that purports to establish any requirement on a third party payer that would have the effect of excluding from coverage or limiting payment, for any health care services for which payment by the third party payer under 10 U.S.C. 1095 or this part is required, is preempted by 10 U.S.C. 1095 and shall have no force or effect in connection with the third party payer's obligations under 10 U.S.C. 1095 or this part.

[55 FR 21748, May 29, 1990, as amended at 57 FR 41101, Sept. 9, 1992; 65 FR 7727, Feb. 16, 2000; 67 FR 57740, Sept. 12, 2002]

§ 220.3 Exclusions impermissible.

(a) *Statutory requirement.* Under 10 U.S.C. 1095(b), no provision of any third party payer's plan having the effect of excluding from coverage or limiting payment for certain care if that care is provided in a facility of the uniformed services shall operate to prevent collection by the United States.

(b) *General rules.* Based on the statutory requirement, the following are general rules for the administration of 10 U.S.C. 1095 and this part.

(1) Express exclusions or limitations in third party payer plans that are inconsistent with 10 U.S.C. 1095(b) are inoperative.

(2) No objection, precondition or limitation may be asserted that defeats the statutory purpose of collecting from third party payers.

(3) Third party payers may not treat claims arising from services provided in facilities of the uniformed services less favorably than they treat claims arising from services provided in other hospitals.

(4) No objection, precondition or limitation may be asserted that is contrary to the basic nature of facilities of the uniformed services.

(c) *Specific examples of impermissible exclusion.* The following are several specific examples of impermissible exclusions, limitations or preconditions. These examples are not all inclusive.

(1) *Care provided by a government entity.* A provision in a third party payer's plan that purports to disallow or limit payment for services provided by a government entity or paid for by a government program (or similar exclusion) is not a permissible ground for refusing or reducing third party payment.

(2) *No obligation to pay.* A provision in a third party payer's plan that purports to disallow or limit payment for services for which the patient has no obligation to pay (or similar exclusion) is not a permissible ground for refusing or reducing third party payment.

(3) *Exclusion of military beneficiaries.* No provision of an employer sponsored program or plan that purports to make ineligible for coverage individuals who are uniformed services health care beneficiaries shall be permissible.

(4) *No participation agreement.* The lack of a participation agreement or

the absence of privity of contract between a third party payer and a facility of the uniformed services is not a permissible ground for refusing or reducing third party payment.

(5) *Medicare carve-out and Medicare secondary payer provisions.* A provision in a third party payer plan, other than a Medicare supplemental plan under § 220.10, that seeks to make Medicare the primary payer and the plan the secondary payer or that would operate to carve out of the plan's coverage an amount equivalent to the Medicare payment that would be made if the services were provided by a provider to whom payment would be made under Part A or Part B of Medicare is not a permissible ground for refusing or reducing payment as the primary payer to the facility of the Uniformed Services by the third party payer unless the provision:

(i) Expressly disallows payment as the primary payer to all providers to whom payment would not be made under Medicare (including payment under Part A, Part B, a Medicare HMO, or a Medicare+Choice plan); and

(ii) Is otherwise in accordance with applicable law.

[55 FR 21748, May 29, 1990, as amended at 57 FR 41101, Sept. 9, 1992; 65 FR 7728, Feb. 16, 2000]

§ 220.4 Reasonable terms and conditions of health plan permissible.

(a) *Statutory requirement.* The statutory obligation of the third party to pay is not unqualified. Under 10 U.S.C. 1095(a)(1) (as noted in § 220.2 of this part), the obligation to pay is to the extent the third party payer would be obliged to pay if the beneficiary incurred the costs personally.

(b) *General rules.* (1) Based on the statutory requirement, after any impermissible exclusions have been made inoperative (see § 220.3 of this part), reasonable terms and conditions of the third party payer's plan that apply generally and uniformly to services provided in facilities other than facilities of the uniformed services may also be applied to services provided in facilities of the uniformed services.

(2) Except as provided by 10 U.S.C. 1095, this part, or other applicable law, third party payers are not required to treat claims arising from services provided in or through facilities of the Uniformed Services more favorably than they treat claims arising from services provided in other facilities or by other health care providers.

(c) *Specific examples of permissible terms and conditions.* The following are several specific examples of permissible terms and conditions of third party payer plans. These examples are not all inclusive.

(1) *Generally applicable coverage provisions.* Generally applicable provisions regarding particular types of medical care or medical conditions covered by the third party payer's plan are permissible grounds to refuse or limit third party payment.

(2) *Generally applicable utilization review provisions.* (i) Reasonable and generally applicable provisions of a third party payer's plan requiring pre-admission screening, second surgical opinions, retrospective review or other similar utilization management activities may be permissible grounds to refuse or reduce third party payment if such refusal or reduction is required by the third party payer's plan.

(ii) Such provisions are not permissible if they are applied in a manner that would result in claims arising from services provided by or through facilities of the Uniformed Services being treated less favorably than claims arising from services provided by other hospitals or providers.

(iii) Such provisions are not permissible if they would not affect a third party payer's obligation under this part. For example, concurrent review of an inpatient hospitalization would generally not affect the third party payer's obligation because of the DRG-based, per-admission basis for calculating reasonable charges under § 220.8(a) (except in long stay outlier cases, noted in § 220.8(a)(4)).

(3) *Restrictions in HMO plans.* Generally applicable exclusions in Health Maintenance Organization (HMO) plans of non-emergency or non-urgent services provided outside the HMO (or similar exclusions) are permissible. However, HMOs may not exclude claims or refuse to certify emergent and urgent services provided within the HMO's service area or otherwise covered non-

emergency services provided out of the HMO's service area. In addition, opt-out or point-of-service options available under an HMO plan may not exclude services otherwise payable under 10 U.S.C. 1095 or this part.

(d) *Procedures for establishing reasonable terms and conditions.* In order to establish that a term or condition of a third party payer's plan is permissible, the third party payer must provide appropriate documentation to the facility of the Uniformed Services. This includes, when applicable, copies of explanation of benefits (EOBs), remittance advice, or payment to provider forms. It also includes copies of policies, employee certificates, booklets, or handbooks, or other documentation detailing the plan's health care benefits, exclusions, limitations, deductibles, co-insurance, and other pertinent policy or plan coverage and benefit information.

[55 FR 21748, May 29, 1990, as amended at 65 FR 7728, Feb. 16, 2000; 67 FR 57740, Sept. 12, 2002]

§ 220.5 Records available.

Pursuant to 10 U.S.C. 1095(c), facilities of the uniformed services, when requested, shall make available to representatives of any third party payer from which the United States seeks payment under 10 U.S.C. 1095 for inspection and review appropriate health care records (or copies of such records) of individuals for whose care payment is sought. Appropriate records which will be made available are records which document that the services which are the subject of the claims for payment under 10 U.S.C. 1095 were provided as claimed and were provided in a manner consistent with permissible terms and conditions of the third party payer's plan. This is the sole purpose for which patient care records will be made available. Records not needed for this purpose will not be made available.

§ 220.6 Certain payers excluded.

(a) *Medicare and Medicaid.* Under 10 U.S.C. 1095(d), claims for payment from the Medicare or Medicaid programs (titles XVIII and XIX of the Social Security Act) are not authorized.

(b) *Supplemental plans.* CHAMPUS (see 32 CFR part 199) supplemental plans and income supplemental plans are excluded from any obligation to pay under 10 U.S.C. 1095.

(c) *Third party payer plans prior to April 7, 1986.* 10 U.S.C. 1095 is not applicable to third party payer plans which have been in continuous effect without amendment or renewal since prior to April 7, 1986. Plans entered into, amended or renewed on or after April 7, 1986, are subject to 10 U.S.C. 1095.

(d) *Third party payer plans prior to November 5, 1990, in connection with outpatient care.* The provisions of 10 U.S.C. 1095 and this section concerning outpatient services are not applicable to third party payer plans:

(1) That have been in continuous effect without amendment or renewal since prior to November 5, 1990; and

(2) For which the facility of the Uniformed Services or other authorized representative for the United States makes a determination, based on documentation provided by the third party payer, that the policy or plan clearly excludes payment for such services. Plans entered into, amended or renewed on or after November 5, 1990, are subject to this section, as are prior plans that do not clearly exclude payment for services covered by this section.

[55 FR 21748, May 29, 1990, as amended at 57 FR 41101, Sept. 9, 1992]

§ 220.7 Remedies and procedures.

(a) Pursuant to 10 U.S.C. 1095(e)(1), the United States may institute and prosecute legal proceedings against a third party payer to enforce a right of the United States under 10 U.S.C. 1095 and this part.

(b) Pursuant to 10 U.S.C. 1095(e)(2), an authorized representative of the United States may compromise, settle or waive a claim of the United States under 10 U.S.C. 1095 and this part.

(c) The authorities provided by 31 U.S.C. 3701, *et seq.*, 28 CFR part 11, and 4 CFR parts 101–104 regarding collection of indebtedness due the United States shall be available to effect collections pursuant to 10 U.S.C. 1095 and this part.

(d) A third party payer may not, without the consent of a U.S. Government official authorized to take action under 10 U.S.C. 1095 and this part, offset or reduce any payment due under 10 U.S.C. 1095 or this part on the grounds that the payer considers itself due a refund from a facility of the Uniformed Services. A request for refund must be submitted and adjudicated separately from any other claims submitted to the third party payer under 10 U.S.C. 1095 or this part.

[55 FR 21748, May 29, 1990, as amended at 65 FR 7728, Feb. 16, 2000]

§ 220.8 Reasonable charges.

(a) *In general.* (1) Section 1095(f) and section 1097b(b) both address the issue of computation of rates. Between them, the effect is to authorize the calculation of all third party payer collections on the basis of reasonable charges and the computation of reasonable charges on the basis of per diem rates, all-inclusive per-visit rates, diagnosis related groups rates, rates used by the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) program to reimburse authorized providers, or any other method the Assistant Secretary of Defense (Health Affairs) considers appropriate and establishes in this part. Such rates, representative of costs, are also endorsed by section 1079(a).

(2) The general rule is that reasonable charges under this part are based on the rates used by CHAMPUS under 32 CFR 199.14 to reimburse authorized providers. There are some exceptions to this general rule, as outlined in this section.

(b) *Inpatient hospital and professional services on or after April 1, 2003.* Reasonable charges for inpatient hospital services provided on or after April 1, 2003, are based on the CHAMPUS Diagnosis Related Group (DRG) payment system rates under 32 CFR 199.14(a)(1). Certain adjustments are made to reflect differences between the CHAMPUS payment system and the Third Party Collection Program billing system. Among these are to include in the inpatient hospital service charges adjustments related to direct medical education and capital costs (which in the CHAMPUS system are handled as annual pass through payments). Additional adjustments are made for long stay outlier cases. Like the CHAMPUS system, inpatient professional services are not included in the inpatient hospital services charges, but are billed separately in accordance with paragraph (e) of this section. In lieu of the method described in this paragraph (b), the method in effect prior to April 1, 2003 (described in paragraph (c) of this section), may continue to be used for a period of time after April 1, 2003, if the Assistant Secretary of Defense (Health Affairs) determines that effective implementation requires a temporary deferral.

(c) *Inpatient hospital and inpatient professional services before April 1, 2003*—(1) *In general.* Prior to April 1, 2003, the computation of reasonable charges for inpatient hospital and professional services is reasonable costs based on diagnosis related groups (DRGs). Costs shall be based on the inpatient full reimbursement rate per hospital discharge, weighted to reflect the intensity of the principal diagnosis involved. The average charge per case shall be published annually as an inpatient standardized amount. A relative weight for each DRG shall be the same as the DRG weights published annually for hospital reimbursement rates under CHAMPUS pursuant to 32 CFR 199.14(a)(1). The method in effect prior to April 1, 2003 (as described in this paragraph (c)), may continue to be used for a period of time after April 1, 2003, if the Assistant Secretary of Defense (Health Affairs) determines that effective implementation requires a temporary deferral of the method described in paragraph (b) of this section.

(2) *Standard amount.* The standard amount is determined by dividing the total costs of all inpatient care in all military treatment facilities by the total number of discharges. This produces a single national standardized amount. The Department of Defense is authorized, but not required by this part, to calculate three standardized amounts, one for large urban, other urban/rural, and overseas area, utilizing the same distinctions in identifying the first two areas as is used for CHAMPUS under 32 CFR 199.14(a)(1). Using this applicable standardized

amount, the Department of Defense may make adjustments for area wage rates and indirect medical education costs (as identified in paragraph (c)(4) of this section), producing for each inpatient facility of the Uniformed Services a facility-specific "adjusted standardized amount" (ASA).

(3) *DRG relative weights.* Costs for each DRG will be determined by multiplying the standardized amount per discharge by the DRG relative weight. For this purpose, the DRG relative weights used for CHAMPUS pursuant to 32 CFR 199.14(a)(1) shall be used.

(4) *Adjustments for outliers, area wages, and indirect medical education.* The Department of Defense may, but is not required by this part, to adjust charge determinations in particular cases for length-of-stay outliers (long stay and short stay), cost outliers, area wage rates, and indirect medical education. If any such adjustments are used, the method shall be comparable to that used for CHAMPUS hospital reimbursements pursuant to 32 CFR 199.14(a)(1)(iii)(E), and the calculation of the standardized amount under paragraph (a)(2) of this section will reflect that such adjustments will be used.

(5) *Identification of professional and hospital charges.* For purposes of billing third party payers other than automobile liability and no-fault insurance carriers, inpatient billings are subdivided into two categories:

(i) Hospital charges (which refers to routine service charges associated with the hospital stay and ancillary charges).

(ii) Professional charges (which refers to professional services provided by physicians and certain other providers).

(d) *Medical services and subsistence charges included.* Medical services charges pursuant to 10 U.S.C. 1078 or subsistence charges pursuant to 10 U.S.C. 1075 are included in the claim filed with the third party payer pursuant to 10 U.S.C. 1095. For any patient of a facility of the Uniformed Services who indicates that he or she is a beneficiary of a third party payer plan, the usual medical services or subsistence charge will not be collected from the patient to the extent that payment received from the payer exceeds the medical services or subsistence charge. Thus, except in cases covered by § 220.8(k), payment of the claim made pursuant to 10 U.S.C. 1095 which exceeds the medical services or subsistence charge, will satisfy all of the third party payer's obligation arising from the inpatient hospital care provided by the facility of the Uniformed Services on that occasion.

(e) *Reasonable charges for professional services.* The CHAMPUS Maximum Allowable Charge rate table, established under 32 CFR 199.14(h), is used for determining the appropriate charge for professional services in an itemized format, based on Healthcare Common Procedure Coding System (HCPCS) methodology. This applies to outpatient professional charges only prior to implementation of the method described in paragraph (b) of this section, and to all professional charges, both inpatient and outpatient, thereafter.

(f) *Miscellaneous Healthcare services.* Some special services are provided by or through facilities of the Uniformed Services for which reasonable charges are computed based on reasonable costs. Those services are the following:

(1) The charge for ambulance services is based on the full costs of operating the ambulance service.

(2) With respect to inpatient hospital charges in the Burn Center at Brooke Army Medical Center, the Assistant Secretary of Defense for Health Affairs may establish an adjustment to the rate otherwise applicable under the DRG payment methodology under this section to reflect unique attributes of the Burn Center.

(3) Charges for dental services (including oral diagnosis and prevention, periodontics, prosthodontics (fixed and removable), implantology, oral surgery, orthodontics, pediatric dentistry and endodontics) will be based on a full cost of the dental services.

(4) With respect to service provided prior to January 1, 2003, reasonable charges for anesthesia services will be based on an average DoD cost of service in all Military Treatment Facilities. With respect to services provided on or after January 1, 2003, reasonable charges for anesthesia services will be based on an average cost per minute of

service in all Military Treatment Facilities.

(5) The charge for immunizations, allergin extracts, allergic condition tests, and the administration of certain medications when these services are provided in a separate immunizations or shot clinic, are based on CHAMPUS prevailing rates in cases in which such rates are available, and in cases in which such rates are not available, on the average full cost of these services, exclusive of any costs considered for purposes of any outpatient visit. A separate charge shall be made for each immunization, injection or medication administered.

(6) The charges for pharmacy, durable medical equipment and supplies are based on CHAMPUS prevailing rates in cases in which such rates are available, in cases in which such rates are not available, on the average full cost of these items, exclusive of any costs considered for purposes of any outpatient visit. A separate charge shall be made for each item provided.

(7) Charges for aero-medical evacuation will be based on the full cost of the aero-medical evacuation services.

(g) *Special rule for services ordered and paid for by a facility of the Uniformed Services but provided by another provider.* In cases where a facility of the Uniformed Services purchases ancillary services or procedures, from a source other than a Uniformed Services facility, the cost of the purchased services will be added to the standard rate. Examples of ancillary services and other procedures covered by this special rule include (but are not limited to): laboratory, radiology, pharmacy, pulmonary function, cardiac catheterization, hemodialysis, hyperbaric medicine, electrocardiography, electroencephalography, electroneuromyography, pulmonary function, inhalation and respiratory therapy and physical therapy services.

(h) *Special rule for TRICARE Resource Sharing Agreements.* Services provided in facilities of the Uniformed Services in whole or in part through personnel or other resources supplied under a TRICARE Resource Sharing Agreement under 32 CFR 199.17(h) are considered for purposes of this part as services provided by the facility of the Uniformed Services. Thus, third party payers will receive a claim for such services in the same manner and for the same charges as any similar services provided by a facility of the Uniformed Services.

(i) *Alternative determination of reasonable charges.* Any third party payer that can satisfactorily demonstrate a prevailing rate of payment in the same geographic area for the same or similar aggregate groups of services that is less than the charges prescribed under this section may, with the agreement of the facility of the Uniformed Services (or other authorized representatives of the United States), limit payments under 10 U.S.C. 1095 to that prevailing rate for those services. The determination of the third party payer's prevailing rate shall be based on a review of valid contractual arrangements with other facilities or providers constituting a majority of the services for which payment is made under the third party payer's plan. This paragraph does not apply to cases covered by § 220.11.

(j) *Exception authority for extraordinary circumstances.* The Assistant Secretary of Defense (Health Affairs) may authorize exceptions to this section, not inconsistent with law, based on extraordinary circumstances.

[57 FR 41101, Sept. 9, 1992, as amended at 59 FR 49002, Sept. 26, 1994; 61 FR 6542, Feb. 21, 1996; 62 FR 941, Jan. 7, 1997; 65 FR 7728, Feb. 16, 2000; 67 FR 57740, Sept. 12, 2002]

§ 220.9 Rights and obligations of beneficiaries.

(a) *No additional cost share.* Pursuant to 10 U.S.C. 1095(a)(2), uniformed services beneficiaries will not be required to pay to the facility of the uniformed services any amount greater than the normal medical services or subsistence charges (under 10 U.S.C. 1075 or 1078). In every case in which payment from a third party payer is received, it will be considered as satisfying the normal medical services or subsistence charges, and no further payment from the beneficiary will be required.

(b) *Availability of healthcare services unaffected.* The availability of healthcare services in any facility of the Uniformed Services will not be affected by the participation or nonparticipation of a Uniformed Services

beneficiary in a health care plan of a third party payer. Whether or not a Uniformed Services beneficiary is covered by a third party payer's plan will not be considered in determining the availability of healthcare services in a facility of the Uniformed Services.

(c) *Obligation to disclose information and cooperate with collection efforts.* (1) Uniformed Services beneficiaries are required to provide correct information to the facility of the Uniformed Services regarding whether the beneficiary is covered by a third party payer's plan. Such beneficiaries are also required to provide correct information regarding whether particular health care services might be covered by a third party payer's plan, including services arising from an accident or workplace injury or illness. In the event a third party payer's plan might be applicable, a beneficiary has an obligation to provide such information as may be necessary to carry out 10 U.S.C. 1095 and this part, including identification of policy numbers, claim numbers, involved parties and their representatives, and other relevant information.

(2) Uniformed Services beneficiaries are required to take other reasonable steps to cooperate with the efforts of the facility of the Uniformed Services to make collections under 10 U.S.C. 1095 and this part, such as submitting to the third party payer (or other entity involved in adjudicating a claim) any requests or documentation that might be required by the third party payer (or other entity), if consistent with this part, to facilitate payment under this part.

(3) Intentionally providing false information or willfully failing to satisfy a beneficiary's obligations are grounds for disqualification for health care services from facilities of the Uniformed Services.

(d) *Mandatory disclosure of Social Security account numbers.* Pursuant to 10 U.S.C. 1095(k)(2), every covered beneficiary eligible for care in facilities of the Uniformed Services is, as a condition of eligibility, required to disclose to authorized personnel his or her Social Security account number.

[55 FR 21748, May 29, 1990, as amended at 57 FR 41102, Sept. 9, 1992; 63 FR 11600, Mar. 10, 1998; 65 FR 7729, Feb. 16, 2000]

§ 220.10 Special rules for Medicare supplemental plans.

(a) *Statutory obligation of Medicare supplemental plans to pay.* The obligation of a Medicare supplemental plan to pay shall be determined as if the facility of the Uniformed Services were a medicare-eligible provider and the services provided as if they were Medicare-covered services. A Medicare supplemental plan is required to pay only to the extent that the plan would have incurred a payment obligation if the services had been furnished by a Medicare eligible provider.

(b) *Inpatient hospital care charges.* (1) Notwithstanding the provisions of § 220.8, charges to Medicare supplemental plans for inpatient hospital care services provided to beneficiaries of such plans shall not, for any admission, exceed the Medicare inpatient hospital deductible amount.

(2) Only one deductible charge shall be made per hospital admission (or Medicare benefit period), regardless of whether the admission is to a facility of the Uniformed Services or a Medicare certified civilian hospital. To ensure that a Medicare supplemental insurer is not charged the inpatient hospital deductible twice when an individual who is entitled to benefits under both DoD retiree benefits and Medicare, the following payment rules apply:

(i) If a dual beneficiary is first admitted to a Medicare-certified hospital and is later admitted to a facility of the Uniformed Services within the same benefit period initiated by the admission to the Medicare-certified hospital, the facility of the Uniformed Services shall not charge the Medicare supplemental insurance plan an inpatient hospital deductible.

(ii) If a dual beneficiary is admitted first to a facility of the Uniformed Services and secondly to a Medicare-certified hospital within 60 days of discharge from the facility of the Uniformed Services, the facility of the Uniformed Services shall refund to the Medicare supplemental insurer any inpatient hospital deductible that the insurer paid to the facility of the Uniformed Services so that it may pay the deductible to the Medicare-certified hospital.

(c) *Charges for Healthcare services other than inpatient deductible amount.* (1) The Assistant Secretary of Defense (Health Affairs) may establish charge amounts for Medicare supplemental plans to collect reasonable charges for inpatient and outpatient copayments and other services covered by the Medicare supplemental plan. Any such schedule of charge amounts shall:

(i) Be based on percentage amounts of the per diem, per visit and other rates established by § 220.8 comparable to the percentage amounts of beneficiary financial responsibility under Medicare for the service involved;

(ii) Include adjustments, as appropriate, to identify major components of the all inclusive per diem or per visit rates for which Medicare has special rules.

(iii) Provide for offsets and/or refunds to ensure that Medicare supplemental insurers are not required to pay a limited benefit more than one time in cases in which beneficiaries receive similar services from both a facility of the uniformed services and a Medicare certified provider; and

(iv) Otherwise conform with the requirements of this section and this part.

(2) If collections are sought under paragraph (c) of this section, the effective date of such collections will be prospective from the date the Assistant Secretary of Defense (Health Affairs) provides notice of such collections, and will exempt policies in continuous effect without amendment or renewal since the date the Assistant Secretary of Defense (Health Affairs) provides notice of such collections.

(d) *Medicare claim not required.* Notwithstanding any requirement of the Medicare supplemental plan policy, a Medicare supplemental plan may not refuse payment to a claim made pursuant to this section on the grounds that no claim had previously been submitted by the provider or beneficiary for payment under the Medicare program.

(e) *Exclusion of Medicare supplemental plans prior to November 5, 1990.* This section is not applicable to Medicare supplemental plans:

(1) That have been in continuous effect without amendment since prior to November 5, 1990; and

(2) For which the facility of the Uniformed Services (or other authorized representative of the United States) makes a determination, based on documentation provided by the Medicare supplemental plan, that the plan agreement clearly excludes payment for services covered by this section. Plans entered into, amended or renewed on or after November 5, 1990, are subject to this section, as are prior plans that do not clearly exclude payment for services covered by this section.

[57 FR 41102, Sept. 9, 1992, as amended at 59 FR 49003, Sept. 26, 1994; 67 FR 57742, Sept. 12, 2002]

§ 220.11 Special rules for automobile liability insurance and no-fault automobile insurance.

(a) *Active duty members covered.* In addition to Uniformed Services beneficiaries covered by other provisions of this part, this section also applies to active duty members of the Uniformed Services. As used in this section, "beneficiaries" includes active duty members.

(b) *Effect of concurrent applicability of the Federal Medical Care Recovery Act—* (1) *In general.* In many cases covered by this section, the United States has a right to collect under both 10 U.S.C. 1095 and the Federal Medical Care Recovery Act (FMCRA), Pub. L. 87–693 (42 U.S.C. 2651 *et seq.*). In such cases, the authority is concurrent and the United States may pursue collection under both statutory authorities.

(2) *Cases involving tort liability.* In cases in which the right of the United States to collect from the automobile liability insurance carrier is premised on establishing some tort liability on some third person, matters regarding the determination of such tort liability shall be governed by the same substantive standards as would be applied under the FMCRA including reliance on state law for determinations regarding tort liability. In addition, the provisions of 28 CFR part 43 (Department of Justice regulations pertaining to the FMCRA) shall apply to claims made under the concurrent authority of the FMCRA and 10 U.S.C. 1095. All other

matters and procedures concerning the right of the United States to collect shall, if a claim is made under the concurrent authority of the FMCRA and this section, be governed by 10 U.S.C. 1095 and this part.

(c) *Exclusion of automobile liability insurance and no-fault automobile insurance plans prior to November 5, 1990.* This section is not applicable to automobile liability insurance and no-fault automobile insurance plans:

(1) That have been in continuous effect without amendment since prior to November 5, 1990; and

(2) For which the facility of the Uniformed Services (or other authorized representative of the United States) makes a determination, based on documentation provided by the third party payer, that the policy or plan clearly excludes payment for services covered by this section. Plans entered into, amended or renewed on or after November 5, 1990, are subject to this section, as are prior plans that do not clearly exclude payment for services covered by this section.

[57 FR 41103, Sept. 9, 1992]

§ 220.12 [Reserved]

§ 220.13 Special rules for workers' compensation programs.

(a) *Basic rule.* Pursuant to the general duty of third party payers under 10 U.S.C. 1095(a)(1) and the definitions of 10 U.S.C. 1095(h), a workers' compensation program or plan generally has an obligation to pay the United States the reasonable charges for healthcare services provided in or through any facility of the Uniformed Services to a Uniformed Services beneficiary who is also a beneficiary under a workers' compensation program due to an employment related injury, illness, or disease. Except to the extent modified or supplemented by this section, all provisions of this part are applicable to any workers' compensation program or plan in the same manner as they are applicable to any other third party payer.

(b) *Special rules for lump-sum settlements.* In cases in which a lump-sum workers' compensation settlement is made, the special rules established in this paragraph (b) shall apply for purposes of compliance with this section.

(1) *Lump-sum commutation of future benefits.* If a lump-sum worker's compensation award stipulates that the amount paid is intended to compensate the individual for all future medical expenses required because of the work-related injury, illness, or disease, the Uniformed Service health care facility is entitled to reimbursement for injury, illness, or disease related, future health care services or items rendered or provided to the individual up to the amount of the lump-sum payment.

(2) *Lump-sum compromise settlement.* (i) A lump sum compromise settlement, unless otherwise stipulated by an official authorized to take action under 10 U.S.C. 1095 and this part, is deemed to be a workers' compensation payment for the purpose of reimbursement to the facility of the Uniformed Services for services and items provided, even if the settlement agreement stipulates that there is no liability under the workers' compensation law, program, or plan.

(ii) If a settlement appears to represent an attempt to shift to the facility of the Uniformed Services the responsibility of providing uncompensated services or items for the treatment of the work-related condition, the settlement will not be recognized and reimbursement to the uniformed health care facility will be required. For example, if the parties to a settlement attempt to maximize the amount of disability benefits paid under workers' compensation by releasing the employer or workers' compensation carrier from liability for medical expenses for a particular condition even though the facts show that the condition is work-related, the facility of the Uniformed Services must be reimbursed.

(iii) Except as specified in paragraph (b)(2)(iv) of this section, if a lump-sum compromise settlement forecloses the possibility of future payment or workers' compensation benefits, medical expenses incurred by a facility of the Uniformed Services after the date of the settlement are not reimbursable under this section.

(iv) As an exception to the rule of paragraph (b)(2)(iii) of this section, if the settlement agreement allocates

certain amounts for specific future medical services, the facility of the Uniformed Services is entitled to reimbursement for those specific services and items provided resulting from the work-related injury, illness, or disease up to the amount of the lump-sum settlement allocated to future expenses.

(3) *Apportionment of a lump-sum compromise settlement of a workers' compensation claim.* If a compromise settlement allocates a portion of the payment for medical expenses and also gives reasonable recognition to the income replacement element, that apportionment may be accepted as a basis for determining the payment obligation of a workers' compensation program or plan under this section to a facility of the Uniformed Services. If the settlement does not give reasonable recognition to both elements of a workers' compensation award or does not apportion the sum granted, the portion to be considered as payment for medical expenses is computed as follows: determine the ratio of the amount awarded (less the reasonable and necessary costs incurred in procuring the settlement) to the total amount that would have been payable under workers' compensation if the claim had not been compromised; multiply that ratio by the total medical expenses incurred as a result of the injury or disease up to the date of settlement. The product is the amount of workers' compensation settlement to be considered as payment or reimbursement for medical expenses.

[65 FR 7730, Feb. 16, 2000, as amended at 67 FR 57742, Sept. 12, 2002]

§ 220.14 Definitions.

Ambulatory procedure visit. An ambulatory procedure visit is a type of outpatient visit in which immediate (day of procedure) pre-procedure and immediate post-procedure care require an unusual degree of intensity and are provided in an ambulatory procedure unit (APU) of the facility of the Uniformed Services. Care is required in the facility for less than 24 hours. An APU is specially designated and is accounted for separately from any outpatient clinic.

Assistant Secretary of Defense (Health Affairs). This term includes any authorized designee of the Assistant Secretary of Defense (Health Affairs).

Automobile liability insurance. Automobile liability insurance means insurance against legal liability for health and medical expenses resulting from personal injuries arising from operation of a motor vehicle. Automobile liability insurance includes:

(1) Circumstances in which liability benefits are paid to an injured party only when the insured party's tortious acts are the cause of the injuries; and

(2) Uninsured and underinsured coverage, in which there is a third party tortfeasor who caused the injuries (i.e., benefits are not paid on a no-fault basis), but the insured party is not the tortfeasor.

CHAMPUS supplemental plan. A CHAMPUS supplemental plan is an insurance, medical service or health plan exclusively for the purpose of supplementing an eligible person's benefit under CHAMPUS. (For information concerning CHAMPUS, see 32 CFR part 199.) The term has the same meaning as set forth in the CHAMPUS regulation (32 CFR 199.2).

Covered beneficiaries. Covered beneficiaries are all healthcare beneficiaries under chapter 55 of title 10, United States Code, except members of the Uniformed Services on active duty (as specified in 10 U.S.C. 1074(a)). However, for purposes of § 220.11 of this part, such members of the Uniformed Services are included as covered beneficiaries.

Facility of the Uniformed Services. A facility of the Uniformed Services means any medical or dental treatment facility of the Uniformed Services (as that term is defined in 10 U.S.C. 101(43)). Contract facilities such as Navy NAVCARE clinics and Army and Air Force PRIMUS clinics that are funded by a facility of the Uniformed Services are considered to operate as an extension of the local military treatment facility and are included within the scope of this program. Facilities of the Uniformed Services also include several former Public Health Services facilities that are deemed to be facilities of the Uniformed Services pursuant to section 911 of Pub. L. 97–99 (often referred to as "Uniformed Services Treatment Facilities" or "USTFs").

Healthcare services. Healthcare services include inpatient, outpatient, and designated high-cost ancillary services.

Inpatient hospital care. Treatment provided to an individual other than a transient patient, who is admitted (i.e., placed under treatment or observation) to a bed in a facility of the uniformed services that has authorized beds for inpatient medical or dental care.

Insurance, medical service or health plan. Any plan (including any plan, policy, program, contract, or liability arrangement) that provides compensation, coverage, or indemnification for expenses incurred by a beneficiary for health or medical services, items, products, and supplies. It includes but is not limited to:

(1) Any plan offered by an insurer, reinsurer, employer, corporation, organization, trust, organized health care group or other entity.

(2) Any plan for which the beneficiary pays a premium to an issuing agent as well as any plan to which the beneficiary is entitled as a result of employment or membership in or association with an organization or group.

(3) Any Employee Retirement Income and Security Act (ERISA) plan.

(4) Any Multiple Employer Trust (MET).

(5) Any Multiple Employer Welfare Arrangement (MEWA).

(6) Any Health Maintenance Organization (HMO) plan, including any such plan with a point-of-service provision or option.

(7) Any individual practice association (IPA) plan.

(8) Any exclusive provider organization (EPO) plan.

(9) Any physician hospital organization (PHO) plan.

(10) Any integrated delivery system (IDS) plan.

(11) Any management service organization (MSO) plan.

(12) Any group or individual medical services account.

(13) Any preferred provider organization (PPO) plan or any PPO provision or option of any third party payer plan.

(14) Any Medicare supplemental insurance plan.

(15) Any automobile liability insurance plan.

(16) Any no fault insurance plan, including any personal injury protection plan or medical payments benefit plan for personal injuries arising from the operation of a motor vehicle.

Medicare eligible provider. Medicare participating (institutional) providers and physicians, suppliers and other individual providers eligible to participate in the Medicare program.

Medicare supplemental insurance plan. A Medicare supplemental insurance plan is an insurance, medical service or health plan primarily for the purpose of supplementing an eligible person's benefit under Medicare. The term has the same meaning as "Medicare supplemental policy" in section 1882(g)(1) of the Social Security Act (42 U.S.C. 1395ss) and 42 CFR part 403, subpart B.

No-fault insurance. No-fault insurance means an insurance contract providing compensation for health and medical expenses relating to personal injury arising from the operation of a motor vehicle in which the compensation is not premised on who may have been responsible for causing such injury. No-fault insurance includes personal injury protection and medical payments benefits in cases involving personal injuries resulting from operation of a motor vehicle.

Preferred provider organization. A preferred provider organization (PPO) is any arrangement in a third party payer plan under which coverage is limited to services provided by a select group of providers who are members of the PPO or incentives (for example, reduced copayments) are provided for beneficiaries under the plan to receive health care services from the members of the PPO rather than from other providers who, although authorized to be paid, are not included in the PPO. However, a PPO does not include any organization that is recognized as a health maintenance organization.

Third party payer. A third party payer is any entity that provides an insurance, medical service, or health plan by contract or agreement. It includes but is not limited to:

(1) State and local governments that provide such plans other than Medicaid.

(2) Insurance underwriters or carriers.

(3) Private employers or employer groups offering self-insured or partially self-insured medical service or health plans.

(4) Automobile liability insurance underwriter or carrier.

(5) No fault insurance underwriter or carrier.

(6) Workers' compensation program or plan sponsor, underwriter, carrier, or self-insurer.

(7) Any other plan or program that is designed to provide compensation or coverage for expenses incurred by a beneficiary for healthcare services or products.

Third party payer plan. A third party payer plan is any plan or program provided by a third party payer, but not including an income or wage supplemental plan.

Uniformed Services beneficiary. For purposes of this part, a Uniformed Services beneficiary is any person who is covered by 10 U.S.C. 1074(b), 1076(a), or 1076(b). For purposes of § 220.11 (but not for other sections), a Uniformed Services beneficiary also includes active duty members of the Uniformed Services.

Workers' compensation program or plan. A workers' compensation program or plan is any program or plan that provides compensation for loss, to employees or their dependents, resulting from the injury, disablement, or death of an employee due to an employment related accident, casualty or disease. The common characteristic of such a plan or program is the provision of compensation regardless of fault, in accordance with a delineated schedule based upon loss or impairment of the worker's wage earning capacity, as well as indemnification or compensation for medical expenses relating to the employment related injury or disease. A workers' compensation program or plan includes any such program or plan:

(1) Operated by or under the authority of any law of any State (or the District of Columbia, American Samoa, Guam, Puerto Rico, and the Virgin Islands).

(2) Operated through an insurance arrangement or on a self-insured basis by an employer.

(3) Operated under the authority of the Federal Employees Compensation Act or the Longshoremen's and Harbor Workers' Compensation Act.

[57 FR 41103, Sept. 9, 1992. Redesignated and amended at 65 FR 7729, 7731, Feb. 16, 2000; 67 FR 57742, Sept. 12, 2002]

PART 223—DEPARTMENT OF DEFENSE UNCLASSIFIED CONTROLLED NUCLEAR INFORMATION (DOD UCNI)

Sec.

223.1 Purpose.
223.2 Applicability and scope.
223.3 Definitions.
223.4 Policy.
223.5 Responsibilities.
223.6 Procedures.
223.7 Information requirements.
APPENDIX A TO PART 223—PROCEDURES FOR IDENTIFYING AND CONTROLLING DOD UCNI
APPENDIX B TO PART 223—GUIDELINES FOR THE DETERMINATION OF DOD UCNI

AUTHORITY: 10 U.S.C. 128 and 5 U.S.C. 552(b)(3).

SOURCE: 56 FR 64554, Dec. 11, 1991, unless otherwise noted.

§ 223.1 Purpose.

This part implements 10 U.S.C. 128 by establishing policy, assigning responsibilities, and prescribing procedures for identifying, controlling, and limiting the dissemination of unclassified information on the physical protection of DoD special nuclear material (SNM), equipment, and facilities. That information shall be referred to as "the Department of Defense Unclassified Controlled Nuclear Information (DoD UCNI)," to distinguish it from a similar Department of Energy (DoE) program.

§ 223.2 Applicability and scope.

This part:

(a) Applies to the Office of the Secretary of Defense (OSD), the Military Departments, the Chairman of the Joint Chiefs of Staff and the Joint Staff, the Unified and Specified Commands, the Defense Agencies, and the DoD Field Activities (hereafter referred to collectively as "the DoD Components").

(b) Implements 10 U.S.C. 128, which is the statutory basis for controlling the