

given to the proposed change by the department or agency.

**§ 219.120 Evaluation and disposition of applications and proposals for research to be conducted or supported by a Federal Department or Agency.**

(a) The department or agency head will evaluate all applications and proposals involving human subjects submitted to the department or agency through such officers and employees of the department or agency and such experts and consultants as the department or agency head determines to be appropriate. This evaluation will take into consideration the risks to the subjects, the adequacy of protection against these risks, the potential benefits of the research to the subjects and others, and the importance of the knowledge gained or to be gained.

(b) On the basis of this evaluation, the department or agency head may approve or disapprove the application or proposal, or enter into negotiations to develop an approvable one.

**§ 219.121 [Reserved]**

**§ 219.122 Use of Federal funds.**

Federal funds administered by a department or agency may not be expended for research involving human subjects unless the requirements of this policy have been satisfied.

**§ 219.123 Early termination of research support: Evaluation of applications and proposals.**

(a) The department or agency head may require that department or agency support for any project be terminated or suspended in the manner prescribed in applicable program requirements, when the department or agency head finds an institution has materially 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 paragraph (a) of this section and whether the ap-

plicant 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 COSTS OF HEALTHCARE SERVICES**

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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.**

This part implements the provisions of 10 U.S.C. 1095. In general, 10 U.S.C. 1095 establishes the statutory obligation of third party payers to reimburse the United States the reasonable costs

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of healthcare services provided by facilities of the Uniformed Services to most Uniformed Services medical care beneficiaries who are also covered by a third party payer's plan. This part establishes the Department of Defense interpretations and requirements applicable to all healthcare services subject to 10 U.S.C. 1095.

[57 FR 41100, Sept. 9, 1992]

### § 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 costs of health care services provided in or through any facility of the Uniformed Services to a Uniformed Services 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 of 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 cost of 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]

### § 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

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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 costs 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]

## § 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 costs.

(a) *Diagnosis related group (DRG)-based method for calculating reasonable costs for inpatient services*—(1) *In general.* As authorized by 10 U.S.C. 1095(f)(3), the calculation of reasonable costs for purposes of collections for inpatient hospital care under 10 U.S.C. 1095 and this part shall be 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 cost 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 the Civilian Health and Medicare Program of the Uniformed Services (CHAMPUS) pursuant to 32 CFR 199.14(a)(1).

(2) *Standardized amount.* The standardized amount shall be determined by dividing the total costs of all inpatient care in all military treatment facilities by the total number of discharges. This will produce 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 areas, 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 (a)(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 cost 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 costs.* For purposes of billing

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third party payers other than automobile liability and no-fault insurance carriers, inpatient billings will be 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).

(6) *Outpatient billings*. Outpatient billings (including those for ambulatory procedure visits) may, but are not required by this part, to be subdivided into two categories:

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

(ii) Outpatient services (which refers to overhead and ancillary, diagnostic and treatment services, other than professional services provided in connection with the outpatient visit).

(b) *Unified per diem rates for care provided prior to October 1, 1992*. For inpatient hospital care provided prior to October 1, 1992, the computation of reasonable costs shall be based on the unified per diem full reimbursement rate for all clinical categories of hospital care. For purposes of this paragraph (and paragraph (c) of this section), charges for patients hospitalized before and after the October 1 start date shall be based on the determination method in effect for the respective periods of hospitalization.

(c) *Clinical groups per diem rates for care provided on or after October 1, 1992, and prior to October 1, 1994*. For inpatient hospital care provided on or after October 1, 1992, and prior to October 1, 1994, the computation of reasonable costs shall be based on the per diem full reimbursement rate applicable to the clinical category of services involved. Patients treated in an intensive care unit any time during the 24 hour nursing period shall be charged the intensive care per diem charge in lieu of a charge to the clinical service to which the patient is currently assigned. For this purpose, 12 clinical groups are established, as follows:

(1) Medical Care Services. This includes internal medicine, cardiology,

dermatology, endocrinology, gastroenterology, hematology, nephrology, neurology, oncology, pulmonary and upper respiratory disease, rheumatology, physical medicine, clinical immunology, HIV III—Acquired Immune Deficiency Syndrome (AIDS), infectious disease, allergy, and medical care not elsewhere classified.

(2) Surgical Care Services. This includes general surgery, cardiovascular and thoracic surgery, neurosurgery, ophthalmology, oral surgery, otolaryngology, pediatric surgery, plastic surgery, proctology, urology, peripheral vascular, trauma service, head and neck service and surgical care not elsewhere classified.

(3) Obstetrical and Gynecological Care.

(4) Pediatric Care. This includes pediatrics, nursery, adolescent pediatrics and pediatric care not elsewhere classified.

(5) Orthopaedic Care. This includes orthopaedics, podiatry and hand surgery.

(6) Psychiatric Care and Substance Abuse Rehabilitation.

(7) Family Practice Care.

(8) Burn Unit Care.

(9) Medical Intensive Care/Coronary Care.

(10) Surgical Intensive Care.

(11) Neonatal Intensive Care.

(12) Organ and Bone Marrow Transplants.

(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) *Per visit rates.* (1) As authorized by 10 U.S.C. 1095(f)(2), the computation of reasonable costs for purposes of collections for most outpatient services shall be based on a per visit rate for a clinical specialty or subspecialty. The per visit charge shall be equal to the outpatient full reimbursement rate for that clinical specialty or subspecialty and includes all routine ancillary services. A separate charge will be calculated for cases that are considered ambulatory procedure visits. These rates shall be updated and published annually. As with inpatient billing categories, clinical groups representing selected board certified specialties/subspecialties widely accepted by graduate medical accrediting organizations such as the Accreditation Council for Graduate Medical Education (ACGME) or the American Board of Medical Specialties will be used for ambulatory billing categories. Related clinical groups may be combined for purposes of billing categories.

(2) The following clinical reimbursement categories are representative, but not all-inclusive of the billing category clinical groups referred to in paragraph (e)(1) of this section: Internal Medicine, Allergy, Cardiology, Diabetic, Endocrinology, Gastroenterology, Hematology, Hypertension, Nephrology, Neurology, Nutrition, Oncology, Pulmonary Disease, Rheumatology, Dermatology, Infectious Disease, Physical Medicine, General Surgery, Cardiovascular and Thoracic Surgery, Neurosurgery, Ophthalmology, Organ Transplant, Otolaryngology, Plastic Surgery, Proctology, Urology, Pediatric Surgery, Family Planning, Obstetrics, Gynecology, Pediatrics, Adolescent Pediatrics, Well Baby, Orthopaedics, Cast, Orthotic Laboratory, Hand Surgery, Podiatry, Psychiatry, Psychology, Child Guidance, Mental Health, Social Work, Substance Abuse Rehabilitation, Family Practice, and Occupational and Physical Therapy.

(f) *Ambulatory procedure visit rates.* A separate charge will be calculated for ambulatory procedure visits (APVs). APVs are same day surgery visits and other outpatient visits provided by designated, special treatment units in fa-

cilities of the Uniformed Services. APV rates shall be based on the total cost of immediate (day of procedure) pre-procedure; procedure; and immediate post-procedure care performed in the ambulatory procedure unit setting for care requiring less than 24 hours in the facility. An APV is not inpatient care. The Department of Defense is authorized, but not required by this part, to establish multiple ambulatory procedure visit reimbursement categories based on the clinic or subspecialty performing the ambulatory procedure. The average cost of APVs will be published annually.

(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 ancillary services ordered by outside providers and provided by a facility of the Uniformed Services.* If a Uniformed Services facility provides certain ancillary services, prescription drugs or other procedures requested by a source other than a Uniformed Services facility and are not incident to any outpatient visit or inpatient services, the reasonable cost will not be based on the usual Diagnostic Related Group (DRG) or per visit rate. Rather, a separate standard rate shall be established based on the cost of the particular services, drugs, or procedures provided. Effective April 1, 2000, this special rule applies to all services, drugs or procedures ordered by an outside provider and provided by a facility of the Uniformed Services. For such ancillary services provided prior to April 1, 2000, this special rule applies only to services, drugs or procedures

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having a cost of at least \$25. The reasonable cost for the services, drugs or procedures to which this special rule applies shall be calculated and made available to the public annually.

(i) *Miscellaneous health care services.* Some outpatient services are provided which may not traditionally be provided in hospitals or which are not traditional clinical specialties or subspecialties. This includes, but is not limited to, land ambulance service, air ambulance service, hyperbaric treatments, dental care services and immunizations.

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

(2) For hyperbaric treatments (such as high pressure oxygenation treatments, burn treatments and decompression treatments in response to diving incidents), charges will be based on the full operating costs of the hyperbaric treatment services.

(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) 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, will be based 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.

(j)(1) *Special rule for former Public Health Service facilities.* In connection with the former Public Health Service facilities described in § 220.12(c), the computation of reasonable costs for purposes of collections under 10 U.S.C. 1095 and this part may differ from such computations under § 220.8. Reasonable costs for such facilities shall be determined by the Department of Defense based on approximate government costs for similar services under CHAMPUS.

(2) The special rule set forth in paragraph (j)(1) of this section expires Sep-

tember 30, 1997. Effective October 1, 1997, collections for health care services provided by these facilities are no longer covered by this part, but are covered by 32 CFR 199.8 (CHAMPUS Double Coverage).

(k) *Special rules for TRICARE Resource Sharing Agreements and Partnership Program providers—(1) In general.* Paragraph (k) establishes special Third Party Collection program rules for TRICARE Resource Sharing Agreements and Partnership Program providers.

(i) TRICARE Resource Sharing Agreements are agreements under the authority of 10 U.S.C. 1096 and 1097 between uniformed services treatment facilities and TRICARE managed care support contractors under which the TRICARE managed care support contractor provides personnel and other resources to the uniformed services treatment facility concerned in order to help the facility increase the availability of health care services for beneficiaries. TRICARE is the managed care program authorized by 10 U.S.C. 1097 (and several other statutory provisions) and established by regulation at 32 CFR 199.17.

(ii) Partnership Program providers provide services in facilities of the uniformed services under the authority of 10 U.S.C. 1096 and the CHAMPUS program. They are similar to providers providing services under TRICARE Resource Sharing Agreements, except that payment arrangements are different. Those functioning under TRICARE Resource Sharing Agreements are under special payment arrangements with the TRICARE managed care contractor; those under the Partnership Program file claims under the standard CHAMPUS program on a fee-for-service basis.

(2) *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 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 costs as any similar

services provided by a facility of the uniformed services. This paragraph (k)(2) becomes effective April 1, 1997.

(3) *Special rule for Partnership Program providers.* For inpatient services for which the professional provider services were provided by a Partnership Program participant, the professional charges component of the bill will be deleted from the claim from the facility of the uniformed services. In these cases, the uniformed service facility's claim shall not be considered solely a "facility charge." As an all-inclusive bill, room and board, nursing services and all ancillary services (radiology, pharmaceuticals, respiratory therapy, etc.) are factored into the bill. The third party payer will receive a separate claim for professional services directly from the individual health care provider. The same is true for the professional services provided on an outpatient basis under the Partnership Program. Claims from Partnership Program providers are not covered by 10 U.S.C. 1095 or this part, but are governed by statutory and regulatory requirements of the CHAMPUS program.

(1) *Alternative determination of reasonable costs.* 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 standard rate (or other amount as determined under paragraphs (f) through (k) of this section) of the facility of the Uniformed Services 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 that aggregate category of 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.

[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]

### § 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 non-participation 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 health care services other than the inpatient hospital deductible amount.* (1) The Assistant Secretary of Defense (Health Affairs) may establish special charge amounts for Medicare supplemental plans to collect reasonable costs 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]

**§ 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 Special rules for preferred provider organizations.**

(a) *Statutory requirement.* (1) Pursuant to the general duty of third party payers to pay under 10 U.S.C. 1095(a)(1) and the definitions of 10 U.S.C. 1095(h), a

plan with a preferred provider organization (PPO) provision or option generally has an obligation to pay the United States the reasonable costs of health care services provided through any facility of the Uniformed Services to a Uniformed Services beneficiary who is also a beneficiary under the plan.

(2) This section provides specific rules for applying 10 U.S.C. 1095 and this part in the context of plans with a PPO provision or option.

(b) *PPO plan exclusions and limitations impermissible.* Under 10 U.S.C. 1095(b), no provision of any plan with a PPO provision or option having the effect of excluding from coverage or limiting payment for certain care if that care is provided through a facility of the Uniformed Services shall operate to prevent collection under this part.

(c) *PPO agreement not required.* The lack of a PPO agreement or the absence of privity of contract between a plan with a preferred provider organization provision or option and a facility of the Uniformed Services is not a permissible ground for refusing or reducing payment by the plan. The lack of a contractual relationship between the plan and the facility of the Uniformed Services may not be a basis for the plan to treat a facility of the Uniformed Services as a non-PPO provider for purposes of the plan's PPO payment amount, if the facility of the Uniformed Services accommodates the plan's fundamental price and utilization management standards for its PPO provision or option, as provided in this section.

(d) *Accommodation of PPO's fundamental price and utilization review standards.* A plan's duty to pay under this section is premised on the accommodation by the facility of the Uniformed Services of the plan's fundamental price and utilization review standards for its PPO provision or option, as provided in this paragraph.

(1) A facility of the Uniformed Services accommodates a plan's fundamental PPO price standards by accepting, in lieu of the rates established under § 220.8, the plan's demonstrated PPO prevailing rates of payment paid to preferred providers in the same geographic area for the same or similar

aggregate groups of services, if such rates are, in the aggregate, less than the rates established under § 220.8. The determination of the plan's PPO prevailing rates shall be based on a review of all rates, including the professional and technical components, contained in all valid contractual arrangements with facilities and providers in the PPO network for the year in which the services were rendered. The rates for any specific ancillary procedure must include both professional and technical components.

(2) A facility of the Uniformed Services accommodates a plan's fundamental PPO utilization review standards by complying with the reasonable pretreatment, concurrent, or retrospective review procedures that are required of all preferred providers under the plan and by accepting denials or reductions of requested payment that are consistent with prevailing standards in the geographic area for medical necessity and proper level of care for the services involved.

(e) *Examples of impermissible PPO requirements.* PPO requirements unnecessary for the achievement of the PPO's fundamental price and utilization review standards and would have the effect of excluding or limiting payment to a facility of the Uniformed Services are impermissible. Examples of such impermissible PPO requirements follow:

(1) A requirement that a PPO provider accept all beneficiaries of the PPO's plan. A facility of the Uniformed Services may provide health care services only to persons with eligibility established pursuant to 10 U.S.C. Chapter 55.

(2) A requirement that a PPO provider meet particular credentialing, licensing, certification, or other provider selection requirements intended to promote good quality of care. Facilities of the Uniformed Services comply with federal quality standards and a comprehensive system of provider credentialing and quality assurance.

(3) A requirement that PPO providers restrict patient referrals to particular providers in the PPO network or order ancillary services only from particular providers. Facilities of the Uniformed Services carry out patient referrals and

the ordering of ancillary services in accordance with applicable Department of Defense rules and procedures.

(4) Any other PPO requirement that would purport to require a facility of the Uniformed Services, in order to effectuate the legislative purpose of 10 U.S.C. 1095, to act in a manner inconsistent with the basic nature of facilities of the Uniformed Services.

(f) *Sunset of section.* The special rules established by this § 220.12 shall no longer be in effect as of October 1, 2004.

[65 FR 7729, Feb. 16, 2000]

EFFECTIVE DATE NOTE: At 65 FR 7729, Feb. 16, 2000, § 220.12 was added, effective Mar. 17, 2000, through Oct. 1, 2004.

**§ 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 costs of health care 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

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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]

### § 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 health care beneficiaries under chapter 55 of title 10, United States Code, except members of the Uniformed Services on active duty.

*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 supple-

mental 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 co-payments) 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 an 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.

*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]

## PART 221—DEPARTMENT OF DEFENSE PARTICIPATION IN THE NATIONAL PRACTITIONER DATA BANK (NPDB)

Sec.

- 221.1 Purpose.
- 221.2 Applicability and scope.
- 221.3 Definitions.
- 221.4 Policy.
- 221.5 Responsibilities.
- 221.6 Procedures.
- 221.7 Information requirements.

AUTHORITY: Public Law 99-660, title IV (44 U.S.C. 11131-11152).

SOURCE: 55 FR 50321, Dec. 6, 1990, unless otherwise noted.

### § 221.1 Purpose.

This part:

(a) Establishes DoD policy, assigns responsibilities, and prescribes procedure for implementing Public Law 99-660, title IV and the objectives of the Memorandum of Understanding (MOU) between the Department of Health and Human Services (DHHS) and the Department of Defense, September 21, 1987, which outlines the DoD's participation in the National Practitioner Data Bank (NPDB).

(b) Specifies the content of confidential reports to the NPDB established under part B of Public Law 99-660, and reporting responsibilities.

### § 221.2 Applicability and scope.

This part applies to:

(a) The Office of the Secretary of Defense (OSD) and the Military Departments (including their National Guard and Reserve components). The term, "Military Departments," as used herein, refers to the Army, the Navy, and the Air Force.

(b) Healthcare personnel who are in professions required to possess a license under DoD Directive 6025.6<sup>1</sup> and/or who are granted individual clinical privileges.

### § 221.3 Definitions.

(a) *Healthcare entity.* A hospital, ambulatory health clinic, or dental clinic with an independent healthcare practitioner staff that carries out professional staff review and provides healthcare to medical or dental patients; and applicable professional staff components of each Service, as designated by the respective Surgeon General, which also perform peer review as part of the quality assurance program.

(b) *Licensed healthcare practitioner.* Any healthcare practitioner of one of the professions required to possess a professional license, as prescribed in DoD Directive 6025.6.

<sup>1</sup>Copies may be obtained, at cost, from the National Technical Information Service, 5285 Port Royal Road, Springfield, VA 22161.