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PRIORITIES FOR THE VARIOUS CATEGORIES OF PERSONNEL ELIGIBLE FOR CARE IN NAVY MEDICAL DEPARTMENT FACILITIES

Priority	Category	Degree of entitlement
1	A. Members of the uniformed services on active duty (including active duty for training and inactive duty training) and comparable personnel of the NATO nations meeting the conditions prescribed in this part. B. Members of a Reserve Component of the Armed Forces and National Guard personnel under orders.	See subpart B. See subpart C.
2	Dependents of active duty members of the uniformed services, dependents of persons who died while in such a status, and the dependents of active duty members of NATO nations meeting the conditions prescribed in subpart E of this part.	See subparts D and E.
3	Members of the Senior Reserve Officers' Training Corps of the Armed Forces.	See § 728.23.
4	Retired members of the uniformed services and their dependents and dependents of deceased retired members.	See subpart D.
5	Civilian employees of the Federal Government under the limited circumstances covered by the Federal Employees' Health Service program.	See § 728.80.
6	All others, including ex-service maternity eligibles	See subparts F and G.

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(a) *Admissions to closed psychiatric wards.* Admit patients to closed psychiatric wards only when they have a psychiatric or emotional disorder which renders them dangerous to themselves or others, or when a period of careful closed psychiatric observation is necessary to determine whether such a condition exists. When a patient is admitted to a closed psychiatric ward, the reason for admission must be clearly stated in the patient's clinical record by the physician admitting the patient to the ward. These same policies apply equally in those instances when it becomes necessary to place a patient under constant surveillance while in an open ward.

(b) *Absence from the sick list.* See § 728.4 (d), (x), and (y).

(c) *Charges and collection.* Charges for services rendered vary and are set by the Office of the Assistant Secretary of Defense (Comptroller) and published in a yearly NAVMEDCOMNOTE 6320, (Cost elements of medical, dental, subsistence rates, and hospitalization bills). Billing and collection actions also vary according to entitlement or eligibility and are governed by the provisions of NAVMED P-5020, Resource Management Handbook. See subpart J on the initiation of collection action on pay patients.

(d) *Convalescent leave.* Convalescent leave, a period of authorized absence of

active duty members under medical care when such persons are not yet fit for duty, may be granted by a member's commanding officer (CO) or the hospital's CO per the following:

(1) Unless otherwise indicated, grant such leave only when recommended by COMNAVMEDCOM through action taken upon a report by a medical board, or the recommended findings of a physical evaluation board or higher authority.

(2) Member's commanding officer (upon advice of attending physician); commanding officers of Navy, Army, or Air Force medical facilities; commanders of regional medical commands for persons hospitalized in designated USTFs or in civilian facilities within their respective areas of authority; and managers of Veterans Administration hospitals within the 50 United States or in Puerto Rico may grant convalescent leave to active duty naval patients, with or without reference to a medical board, physical evaluation board, or higher authority provided the:

(i) Convalescent leave is being granted subsequent to a period of hospitalization.

(ii) Member is not awaiting disciplinary action or separation from the service for medical or administrative reasons.

(iii) Medical officer in charge:

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(A) Considers the convalescent leave beneficial to the patient's health.

(B) Certifies that the patient is not fit for duty, will not need hospital treatment during the contemplated convalescent leave period, and that such leave will not delay final disposition of the patient.

(3) When considered necessary by the attending physician and approved on an individual basis by the commander of the respective geographic regional medical command, convalescent leave in excess of 30 days may be granted. The authority to grant convalescent leave in excess of 30 days may not be redelegated to hospital commanding officers. Member's permanent command must be notified of such extensions (see MILPERSMAN 3020360).

(4) Exercise care in granting convalescent leave to limit the duration of such leave to that which is essential in relation to diagnosis, prognosis, estimated duration of treatment, and patient's probable final disposition.

(5) Upon return from convalescent leave;

(i) Forward one copy of original orders of officers, bearing all endorsements, to the Commander, Naval Military Personnel Command (COMNAV MILPERSCOM) (NMPC-4) or the Commandant of the Marine Corps (CMC), as appropriate.

(ii) Make an entry on the administrative remarks page (page 13 for Navy personnel) of the service records of enlisted personnel indicating that convalescent leave was granted and the dates of departure and return.

(6) If considered beneficial to the patient's health, commanding officers of hospitals may grant convalescent leave as a delay in reporting back to the parent command.

(e) *Cosmetic surgery.* (1) Defined as that surgery which is done to revise or change the texture, configuration, or relationship of contiguous structures of any feature of the human body which would be considered by the average prudent observer to be within the broad range of "normal" and acceptable variation for age or ethnic origin, and in addition, is performed for a condition which is judged by competent medical opinion to be without poten-

tial for jeopardy to physical or mental health of an individual.

(2) Commanding officers will monitor, control, and assure compliance with the following cosmetic surgery policy:

(i) Certain cosmetic procedures are a necessary part of training and retention of skills to meet the requirements of certification and recertification.

(ii) Insofar as they meet minimum requirements and serve to improve the skills and techniques needed for reconstructive surgery, the following cosmetic procedures may be performed as low priority surgery on active duty members only when time and space are available.

(A) Cosmetic facial rhytidectomies (face lifts) will be a part of all training programs required by certifying boards.

(B) Cosmetic augmentation mammoplasties will be done only by properly credentialed surgeons and residents within surgical training programs to meet requirements of certifying boards.

(f) *Cross-utilization of uniformed services facilities.* To provide effective cross-utilization of medical and dental facilities of the uniformed services, eligible persons, regardless of service affiliation, will be given equal opportunity for health benefits. Catchment areas have been established by the Department of Defense for each USMTF (see §728.2(d)). Eligible beneficiaries residing within such a catchment area are expected to use that inpatient facility for care. Make provisions to assure that:

(1) Eligible beneficiaries residing in a catchment area served by a USMTF not of the sponsor's own service may obtain care at that facility or at a facility of the sponsor's service located in another catchment area.

(2) If the facility to which an eligible beneficiary applies cannot furnish needed care, the other facility or facilities in overlapping catchment areas are contacted to determine whether care can be provided thereat.

(g) *Disengagement.* Discontinuance of medical management by a naval MTF for only a specific episode of care.

(1) *General.* Disengagement is accomplished only after alternative sources

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of care (*i.e.*, transfer to another USMTF, a USTF, or other Federal source via the aeromedical evacuation system, if appropriate) and attendant costs, if applicable, have been fully explained to patient or responsible family member. Counselors may arrange for counseling by other appropriate sources when the patient is or may be eligible for VA, Medicare, MEDICAID, etc. benefits. With the individual's permission, counselors may also contact State programs, local health organizations, or health foundations to determine if care is available for the condition upon which disengagement is based. After the disengagement decision is made, the patient to be disengaged or the responsible family member should be advised to return to the naval MTF for any care required subsequent to receiving the care that necessitated disengagement.

(2) *CHAMPUS-eligible individuals.* (i) Issue a Nonavailability Statement (DD 1251) per § 728.33, when appropriate, to patients released to civilian sources for total care (disengaged) under CHAMPUS. CHAMPUS-eligible patients disengaged for total care, who do not otherwise require a DD 1251 (released for outpatient care or those released whose residence is outside the inpatient catchment area of all USMTFs and USTFs) will be given the original of a properly completed DD 2161, Referral For Civilian Medical Care, which clearly indicates that the patient is released for total care under CHAMPUS. CHAMPUS-eligible beneficiaries will be disengaged for services under CHAMPUS when:

(A) Required services are beyond your capability and these services cannot be appropriately provided through one of the alternatives listed in § 728.4(z), or

(B) You cannot effectively provide required services or manage the overall course of care even if augmented by services procured from other Government or civilian sources using naval MTF operation and maintenance funds as authorized in subpart § 728.4(z).

(ii) When a decision is made to disengage a CHAMPUS-eligible individual, commanding officers (CO) or officers-in-charge (OIC) are responsible for assuring that counseling and docu-

mentation of counseling are appropriately accomplished. Complete a NAVMED 6320/30. Disengagement for Civilian Medical Care, to document that all appropriate disengagement procedures have been accomplished.

(iii) After obtaining the signature of the patient or responsible family member, the counselor will file a copy of the DD 2161 and the original of the NAVMED 6320/30 in the patient's Health Record.

(3) *Patients other than active duty or CHAMPUS-eligible individuals—(i) Categories of patients.* The following are categories of individuals who also may be disengaged:

(A) Medicare-eligible individuals.

(B) MEDICAID-eligible individuals.

(C) Civilians (U.S. and foreign) admitted or treated as civilian humanitarians.

(D) Secretarial designees.

(E) All other individuals, with or without private insurance, who are not eligible for care at the expense of the Government.

(ii) *Disengagement decision.* Disengage such individuals when:

(A) Required services are beyond the capability of the MTF, and services necessary for continued treatment in the MTF cannot be appropriately provided by another USMTF, a USTF, or another Federal source. (Explore alternative sources, for individuals eligible for care from these sources, before making the disengagement decision.)

(B) The MTF cannot, within the facility's capability, effectively provide required care or manage the overall course of treatment even if augmented by services procured from other Government sources or through procurement from civilian sources using supplemental care funding.

(iii) *Counseling.* The initial step in the disengagement process is appropriate counseling and documentation. In an emergency, or when the individual cannot be appropriately counseled prior to leaving the MTF, establish procedures to ensure counseling and documentation are accomplished during the next working day. Such "follow-up" counseling may be in person or via a witnessed telephone conversation. In either instance, the counselor will document counseling on a

NAVMED 6320/30, Disengagement for Civilian Medical Care. The disengagement decision making authority must assure the accomplishment of counseling by personally initiating this service or by referring the patient or responsible family member to the HBA for counseling. As a minimum, counseling will consist of:

(A) Explaining that the patient is being disengaged from treatment at the facility and the reason therefor. Assure that the individual understands the meaning of "disengagement" by explaining that the MTF is unable to provide for the patient's present needs and must therefore relinquish medical management of the patient to a health care provider of the individual's choice.

(B) Assuring the individual that the disengagement action is taken to provide for the patient's immediate medical needs. Also assure that the individual understands that the disengagement is not indicative of whether care is or will be available in the MTF for other aspects of past, current, or future medical conditions.

(C) Explaining Medicare, MEDICAID, or other known programs as they relate to the particular circumstance of the patient, including cost-sharing, deductibles, allowable charges, participating and authorized providers, physicians accepting assignment, claim filing procedures, etc. Explain that once disengagement is accomplished, the Navy, is not responsible for any costs for care received from a health care provider of the patient's or responsible family member's choice.

(iv) *Documentation.* Commanding officers are responsible for ensuring that proper documentation procedures are started and that providers and counselors under their commands are apprised of their individual responsibilities for counseling and documenting each disengagement. Failure to properly counsel and document counseling may result in the naval MTF having to absorb the cost of the entire episode of care. Document counseling on a NAVMED 6320/30. Disengagement for Civilian Medical Care. Completion of all items on the form assures documentation and written acknowledgment of appropriate disengagement and counseling. If the patient or respon-

sible family member refuses to acknowledge receipt of counseling by signing the form, state this fact on the bottom of the form and have it witnessed by an officer. Give the patient or responsible family member a copy and immediately file the original in the patient's Health Record.

(4) *Active duty members.* When an active duty member seeks care at a USMTF, that USMTF retains some responsibility (e.g., notification, medical cognizance, supplemental care, etc.) for that member even when the member must be transferred to another facility for care. Therefore, relinquishment of total management of an active duty member (disengagement) cannot be accomplished.

(h) *Domiciliary/custodial care.* The type of care designed essentially to assist an individual in meeting the normal activities of daily living, *i.e.*, services which constitute personal care such as help in walking and getting in or out of bed, help in bathing, dressing, feeding, preparation of special diets, and supervision over medications which can usually be self-administered and which does not entail or require the continuing attention of trained medical or paramedical personnel. The essential characteristics to be considered are the level of care and medical supervision that the patient requires, rather than such factors as diagnosis, type of condition, or the degree of functional limitation. Such care will not be provided in naval MTFs except when required for active duty members of the uniformed services.

(i) *Emergency care.* Treat patients authorized only emergency care and those admitted as civilian emergencies only during the period of the emergency. Initiate action to effect appropriate disposition of such patients as soon as the emergency period ends.

(j) *Evaluation after admission.* Evaluate each patient as soon as possible after admission and continue reevaluation until disposition is made. Anticipate each patient's probable type and date of disposition. Necessary processing by the various medical and administrative entities will take place

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concurrently with treatment of the patient. Make the medical disposition decision as early as possible for U.S. military patients inasmuch as immediate transfer to a specialized VA center or to a VA spinal cord injury center may be in their best interest (see NAVMEDCOMINST 6320.1.2). Make disposition decisions for military personnel of NATO nations in conformance with § 728.42(d).

(k) *Extent of care.* Subject to the restrictions and priorities in § 728.3, eligible persons will be provided medical and dental care to the extent authorized, required, and available. When an individual is accepted for care, all care and adjuncts thereto, such as non-standard supplies, as determined by the CO to be necessary, will be provided from resources available to the CO unless specifically prohibited elsewhere in this part. When a patient has been accepted and required care is beyond the capability of the accepting MTF, the CO thereof will arrange for the required care by one of the means shown below. The method of choice will be based upon professional considerations and travel economy.

(1) Transfer the patient per § 728.4(bb).

(2) Procure from civilian sources the necessary material or professional personal services required for the patient's proper care and treatment.

(3) Care authorized in § 728.4(k)(2) will normally be accomplished in the naval MTF. However, when such action is not feasible, supplementation may be obtained outside the facility. Patients may be sent to other Federal or civilian facilities for specific treatment or services under § 728.4(k)(3) *provided* they remain under medical management of the CO of the sending facility during the entire period of care.

(l) *Family planning services.* Provide family planning services following the provisions of SECNAVINST 6300.2A.

(m) *Grouping of patients.* Group hospitalized patients according to their requirements for housing, medical, or dental care. Provide gender identified quarters, facilities, and professional supervision on that basis when appropriate. Individuals who must be retained under limited medical supervision (medical hold) solely for admin-

istrative reasons or for medical conditions which can be treated on a clinic basis will be provided quarters and messing facilities, where practicable, separately from those hospitalized. Provide medical care for such patients on a periodic clinic appointment basis (see § 728.4(p) for handling enlisted convalescent patients). Make maximum use of administrative versus medical personnel in the supervision of such patients.

(n) *Health benefits advising—(1) General.* A Health Benefits Advising program must be started at all shore commands having one or more medical officers. While health benefits advisors are not required aboard every ship with a medical officer, the medical department representative can usually provide services to personnel requiring help. The number of health benefits advisors (HBAs) of a command will be commensurate with counseling and assistance requirements. The program provides health benefits information and counseling to beneficiaries of the Uniformed Services Health Benefits Program (USHBP) and to others who may or may not qualify for care in USMTFs. Office location of HBAs, their names, and telephone numbers will be widely publicized locally. If additional help is required, contact MEDCOM-333 on AUTOVON 294-1127 or commercial (202) 653-1127. In addition to the duties described in § 728.4(n)(2), HBAs will:

(i) Maintain a depository of up-to-date officially supplied health benefits information for availability to all beneficiaries.

(ii) Provide information and guidance to beneficiaries and generally support the medical and dental staff by providing help to eligible beneficiaries seeking or obtaining services from USMTFs, civilian facilities, VA facilities, Medicare, MEDICAID, and other health programs.

(iii) Assure that when a referral or disengagement is required, patients or responsible family members are:

(A) Fully informed that such action is taken to provide for their immediate medical or dental requirements and that the disengagement or referral has no bearing on whether care may be available in the naval MTF for other

aspects of current or other future medical conditions.

(B) Provided the services and counseling outlined in §728.4(n)(2) or §728.3(g)(3)(ii), as appropriate, *prior* to their departure from the facility when such beneficiaries are referred or disengaged because care required is beyond the naval MTF's capability. In an emergency, or when the patient or sponsor cannot be seen by the HBA prior to leaving, provide these benefits as soon thereafter as possible.

(2) *Counseling and assisting CHAMPUS-eligible individuals.* HBAs, as a minimum, will:

(i) Explain alternatives available to the patient.

(ii) If appropriate, explain CHAMPUS as it relates to the particular circumstance, including the cost-sharing provisions applicable to the patient, allowable charges, provider participation, and claim filing procedures. Fully inform the patient or responsible family member that when a patient is disengaged for care under CHAMPUS or when cooperative care is to be considered for payment under the provisions of §728.4(z) (5) and (6), the naval MTF is not responsible for monetary amounts above the CHAMPUS-determined allowable charge or for charges CHAMPUS does not allow.

(iii) Explain why the naval MTF is paying for the supplemental care, if appropriate (see §728.4(z) (3) and (4)), and how the bill will be handled. Then:

(A) Complete a DD 2161, Referral For Civilian Medical Care, marking the appropriate source of payment with the concurrence of the naval MTF commanding officer or CO's designee.

(B) If referred for a specified procedure with a consultation report to be returned to the naval MTF retaining medical management, annotate the DD 2161 in the consultation report section to state this requirement. Advise patient or responsible family member to arrange for a completed copy of the DD 2161 to be returned to the naval MTF for payment, if appropriate, and inclusion in patient's medical record.

(iv) Brief patient or responsible family member on the use of the DD 2161 in USMTF payment procedures and CHAMPUS claims processing, as appropriate. Provide sufficient copies of DD

2161 and explain that CHAMPUS contractors will return claims submitted without a required DD 2161. Obtain signature of patient or responsible family member on the form.

(v) Arrange for counseling from appropriate sources when the patient is eligible for VA, Medicare, or MEDICAID benefits.

(vi) Serve as liaison between civilian providers and naval MTF on administrative matters related to the referral and disengagement process.

(vii) Serve as liaison between naval MTF and cooperative care coordinators on matters relating to care provided or recommended by naval MTF providers, as appropriate.

(viii) Explain why the patient is being disengaged and, per §728.4(g)(2), provide a DD 1251, Nonavailability Statement, or DD 2161, Referral For Civilian Medical Care, as appropriate.

(o) *Immunizations.* Administer immunizations per BUMED INST 6230.1H.

(p) *Medical holding companies.* Medical holding companies (MHC) have been established at certain activities to facilitate handling of enlisted convalescent patients whose medical conditions are such that, although they cannot be returned to full duty, they can perform light duty ashore commensurate with their condition while completing their medical care on an outpatient basis. Where feasible, process such patients for transfer.

(q) *Notifications.* The interests of the Navy, Marine Corps, and DOD have been adversely affected by past procedures which emphasized making notifications only when an active duty member's condition was classed as either seriously ill or injured or classed as very seriously ill or injured. However, even temporary disabilities which preclude communication with the next of kin have generated understandable concern and criticism, especially when emergency hospitalization has resulted. Accordingly, naval MTFs will effect procedures to make notifications required in §728.4(q) (2), (3), and (4) upon admission or diagnosis of individuals specified. The provisions of §728.4(q) supplement articles 1810520 and 4210100 of the Naval Military Personnel Manual and chapter 1 of Marine Corps Order

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P3040.4B, Marine Corps Casualty Procedures Manual; they do not supersede them.

(1) *Privacy Act.* The right to privacy of individuals for whom hospitalization reports and other notifications are made will be safeguarded as required by the Privacy Act, implemented in the Department of the Navy by SECNAVINST 5211.5C, U.S. Navy Regulations, the Manual of the Judge Advocate General, the Marine Corps Casualty Procedures Manual, and the Manual of the Medical Department.

(2) *Active duty flag or general officers and retired Marine Corps general officers.* Upon admission of subject officers, make telephonic contact with MEDCOM-33 on AUTOVON 294-1179 or commercial (202) 653-1179 (after duty hours, contact the command duty officer on AUTOVON 294-1327 or commercial (202) 653-1327) to provide the following information:

(i) *Initial.* Include in the initial report:

(A) Officer's name, grade, social security number, and designator.

(B) Duty assignment in ship or station, or other status.

(C) Date of admission.

(D) Present condition, stating if serious or very serious.

(E) Diagnosis, prognosis, and estimated period of hospitalization. To prevent possible invasion of privacy, report the diagnosis only in International Classification of Diseases—9th Edition (ICD-9-CM) code designator.

(ii) *Progress reports.* Call frequency and content will be at the discretion of the commanding officer. However, promptly report changes in condition or status.

(iii) *Termination report.* Make a termination of hospitalization report to provide appropriate details for informational purposes.

(iv) *Additional commands to apprise.* The geographic naval medical region serving the hospital and, if different, the one serving the officer's command will also be apprised of such admissions.

(3) *Active duty members—(i) Notification of member's command.* The commanding officer of naval medical treatment facilities has responsibility for notifying each member's commanding

officer under the conditions listed below. Make COMNAVMILPERS COM or CMC, as appropriate, information addressees on their respective personnel:

(A) *Direct admissions.* Upon direct admission of an active duty member, with or without orders regardless of expected length of stay. The patient administration department (administrative watch officer after hours) is responsible for preparation, per § 728.4(q)(4), and release of these messages. If the patient is attached to a local command (CO's determination), initial notification may be made telephonically. Record the name, grade or rate, and position of the person receiving the call at the member's command on the back of the NAVMED 6300/5, Inpatient Admission/Disposition Record and include the name and telephone number of the MTF's point of contact as given to the patient's command.

(B) *Change in medical condition.* Upon becoming aware of any medical condition, including pregnancy, which will now or in the foreseeable future result in the loss of a member's full duty services in excess of 72 hours. Transmit this information in a message, prepared per § 728.4(q)(4), marked "Commanding Officer's Eyes Only."

(ii) *Notification of next of kin (NOK)—*

(A) *Admitted members.* As part of the admission procedure, encourage all patients to communicate expeditiously and regularly with their NOK. When an active duty member's incapacity makes timely personal communication impractical, *i.e.*, fractures, burns, eye pathology, psychiatric or emotional disorders, etc., MTF personnel will initiate the notification process. Do not start the process if the patient specifically declines such notification or it is clear that the NOK already has knowledge of the admission (commands should develop a local form for such patients to sign attesting their desire or refusal to have their NOK notified). Once notification has been made, the facility will make progress reports, at least weekly, until the patient is again able to communicate with the NOK.

(1) *Navy personnel.* Upon admission of Navy personnel, effect the following notification procedures.

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(i) *In the contiguous 48 states.* Patient administration department personnel will notify the NOK in person, by telephone, telegraph, or by other expeditious means. Included are notifications of the NOK upon arrival of all Navy patients received in the medical air-evacuation system.

(ii) *Outside the contiguous 48 states.* If the next of kin has accompanied the patient on the tour of duty and is in the immediate area, hospital personnel will notify the next of kin in person, by telephone, telegraph, or by other expeditious means. If the next of kin is located in the 48 contiguous United States, use telegraphic means to notify COMNAVMILPERSCOM who will provide notification to the NOK.

(2) *Marine Corps personnel.* When Marine Corps personnel are admitted, effect the following notification procedures.

(i) *In the contiguous 48 states.* The commander of the unit or activity to which the casualty member is assigned is responsible for initiating notification procedures to the NOK of seriously or very seriously ill or injured Marine Corps personnel. Patient administration department personnel will assure that liaison is established with the appropriate command or activity when such personnel are admitted. Patient administration personnel will notify the Marine's command by telephone and request that cognizance be assumed for in-person initial notification of the NOK of Marine Corps patients admitted with an incapacity that makes personal and timely communication impractical and for those arriving via the medical air-evacuation system. If a member's command is unknown or cannot be contacted, inform CMC (MHP-10) on AUTOVON 224-1787 or commercial (202) 694-1787.

(ii) *Outside the contiguous 48 states.* Make casualty notification for Marine Corps personnel hospitalized in naval MTF's outside the contiguous 48 States to the individual's command. If the command is unknown or not located in close proximity to the MTF, notify CMC (MHP-10). When initial notification to the individual's command is made via message, make CMC (MHP-10) an information addressee.

(iii) *In and outside the United States.* In life-threatening situations, the Commandant of the Marine Corps desires and encourages medical officers to communicate with the next of kin. In other circumstances, request that the Marine Corps member communicate with the NOK if able. If unable, the medical officer should communicate with the NOK *after* personal notification has been effected.

(B) *Terminally ill patients.* As soon as a diagnosis is made and confirmed (on inpatients or outpatients) that a Navy member is terminally ill, MILPERSMAN 4210100 requires notification of the primary and secondary next of kin. Accomplish notification the same as for Navy members admitted as seriously or very seriously ill or injured, *i.e.*, by priority message to the Commander, Naval Military Personnel Command and to the Casualty Assistance Calls/Funeral Honors Support Program Coordinator, as appropriate, who has cognizance over the geographical area in which the primary and secondary NOK resides (see OPNAVINST 1770.1). Submit followup reports when appropriate. See MILPERSMAN 4210100 for further amplification and for information addressees.

(1) *In the contiguous 48 states.* Notification responsibility is assigned to the USMTF making the diagnosis and to the member's duty station if diagnosed in a civilian facility.

(2) *Outside the contiguous 48 states.* Notification responsibility is assigned to the naval medical facility making the diagnosis. When diagnosed in nonnaval facilities or aboard deployed naval vessels, notification responsibility belongs to the Commander, Naval Military Personnel Command.

(C) *Other uniformed services patients.* Establish liaison with other uniformed services to assure proper notification upon admission or diagnosis of active duty members of other services.

(D) *Nonactive duty patients.* At the discretion of individual commanding officers, the provisions of § 728.4(q)(3)(ii) on providing notification to the NOK may be extended to admissions or diagnosis of nonactive duty patients; *e.g.*, admission of dependents of members on duty overseas.

(4) *Messages*—(i) *Content*. Phrase contents of messages (and telephonic notifications) in lay terms and provide sufficient details concerning the patient's condition, prognosis, and diagnosis. Messages will also contain the name and telephone number of the facility's point of contact. When appropriate for addressal, psychiatric and other sensitive diagnoses will be related with discretion. When indicated, also include specific comment as to whether the presence of the next of kin is medically warranted. NOTE: In making notification to the NOK of patients diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV), use one of the symptoms of the disease as the diagnosis (e.g., pneumonia) rather than "HIV", "AIDS", or the diagnostic code for AIDS.

(ii) *Information addressees*. Make the commander of the geographic naval medical region servicing the member's command and the one servicing the hospital, if different, information addressees on all messages. For Marine Corps personnel, also include CMC (MHP-10) and the appropriate Marine Corps district headquarters as information addressees, COMNAVMEDCOM WASHINGTON DC requires information copies of messages *only* when a patient has been placed on the seriously ill or injured or very seriously ill or injured list or diagnosed as terminally ill.

(r) *Outpatient care*. Whenever possible, perform diagnostic procedures and provide preoperative and post operative care, surgical care, convalescence, and followup observations and treatment on an outpatient basis.

(s) *Performance of duties while in an inpatient status*. U.S. military patients may be assigned duties in and around naval MTFs when such duties will be, in the judgement of the attending physician, of a therapeutic value. Physical condition, past training, and other acquired skills must all be considered before assigning any patient a given task. Do not assign patients duties which are not within their capabilities or which require more than a very brief period of orientation.

(t) *Prolonged definitive medical care*. Prolonged definitive medical care in

naval MTFs will not be provided for U.S. military patients who are unlikely to return to duty. The time at which a patient should be processed for disability separation must be determined on an individual basis, taking into consideration the interests of the patient as well as those of the Government. A long-term patient roster will be maintained and updated at least once monthly to enable commanding officers and other appropriate staff members to monitor the progress of all patients with 30 or more continuous days of hospitalization. Include on the roster basic patient identification data (name, grade or rate, register number, ward or absent status, clinic service, and whether assigned to a medical holding company), projected disposition (date, type, and profile), diagnosis, and cumulative hospital days (present facility and total).

(u) *Remediable physical defects of active duty members*—(1) *General*. When a medical evaluation reveals that a Navy or Marine Corps patient on active duty has developed a remediable defect while on active duty, the patient will be offered the opportunity of operative repair or other appropriate remediable treatment, if medically indicated.

(2) *Refusal of treatment*. Per MANMED art. 18-15, when a member refuses to submit to recommended therapeutic measures for a remediable defect or condition which has interfered with the member's performance of duty and following prescribed therapy, the member is expected to be fit for full duty, the following procedures will apply:

(i) Transfer the member to a naval MTF for further evaluation and appearance before a medical board. After counseling per MANMED art. 18-15, any member of the naval service who refuses to submit to recommended medical, surgical, dental, or diagnostic measures, other than routine treatment for minor or temporary disabilities, will be asked to sign a completed NAVMED 6100/4, Medical Board Certificate Relative to Counseling on Refusal of Surgery and/or Treatment, attesting to the counseling.

(ii) The board will study all pertinent information, inquire into the merits of the individual's refusal to submit to

treatment, and report the facts with appropriate recommendations.

(iii) As a general rule, refusal of minor surgery should be considered unreasonable in the absence of substantial contraindications. Refusal of major surgical operations may be reasonable or unreasonable, according to the circumstances. The age of the patient, previous unsuccessful operations, existing physical or mental contraindications, and any special risks should all be taken into consideration.

(iv) Where surgical procedures are involved, the board's report will contain answers to the following questions:

(A) Is surgical treatment required to relieve the incapacity and restore the individual to a duty status, and may it be expected to do so?

(B) Is the proposed surgery an established procedure that qualified and experienced surgeons ordinarily would recommend and undertake?

(C) Considering the risks ordinarily associated with surgical treatment, the patient's age and general physical condition, and the member's reason for refusing treatment, is the refusal reasonable or unreasonable? (Fear of surgery or religious scruples may be considered, along with all the other evidence, for whatever weight may appear appropriate.)

(v) If a member needing surgery is mentally competent, do not perform surgery over the member's protestation.

(vi) In medical, dental, or diagnostic situations, the board should show the need and risk of the recommended procedure(s).

(vii) If a medical board decides that a diagnostic, medical, dental, or surgical procedure is indicated, these findings must be made known to the patient. The board's report will show that the patient was afforded an opportunity to submit a written statement explaining the grounds for refusal. Forward any statement with the board's report. Advise the patient that even if the disability originally arose in line of duty, its continuance may be attributable to the member's unreasonable refusal to cooperate in its correction; and that the continuance of the disability might, therefore, result in the member's separation without benefits.

(viii) Also advise the patient that:

(A) Title 10 U.S.C. 1207 precludes disposition under chapter 61 of 10 U.S.C. if such a member's disability is due to intentional misconduct, willful neglect, or if it was incurred during a period of unauthorized absence. A member's refusal to complete a recommended therapy regimen or diagnostic procedure may be interpreted as willful neglect.

(B) Benefits from the Veterans Administration will be dependent upon a finding that the disability was incurred in line of duty and is not due to the member's willful misconduct.

(ix) The Social Security Act contains special provisions relating to benefits for "disabled" persons and certain provisions relating to persons disabled "in line of duty" during service in the Armed Forces. In many instances persons deemed to have "remediable" disorders have been held not "disabled" within the meaning of that term as used in the statute, and Federal courts have upheld that interpretation. One who is deemed unreasonably to have refused to undergo available surgical procedures may be deemed both "not disabled" and to have incurred the condition "not in the line of duty."

(x) Forward the board's report directly to the Central Physical Evaluation Board with a copy to MEDCOM-25 except in those instances when the convening authority desires referral of the medical board report for Departmental review.

(xi) Per MANMED art. 18-15, a member who refuses medical, dental, or surgical treatment for a condition that existed prior to entry into the service (EPTE defect), not aggravated by a period of active service but which interferes with the performance of duties, should be processed for reason of physical disability, convenience to the Government, or enlisted in error rather than under the refusal of treatment provisions. Procedures are delineated in BUMEDINST 1910.2G and SECNAVINST 1910.4A.

(3) *Other uniformed services patients.* When a patient of another service is found to have a remediable physical defect developed in the military service, refer the matter to the nearest headquarters of the service concerned.

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(v) *Responsibilities of the commanding officer.* In connection with the provisions of this part, commanding officers of naval MTFs will:

(1) Determine which persons within the various categories authorized care in a facility will receive treatment in, be admitted to, and be discharged from that specific facility.

(2) Supervise care and treatment, including the employment of recognized professional procedures.

(3) Provide each patient with the best possible care in keeping with accepted professional standards and the assigned primary mission of the facility.

(4) Provide for counseling patients and naval MTF providers when care required is beyond the naval MTF's capability. This includes:

(i) Establishing training programs to acquaint naval MTF providers and HBAs with the uniformed services' referral for supplemental/cooperative care or services policy outlined in § 728.4(z).

(ii) Implementing control measures to ensure that:

(A) Providers requesting care under the provisions § 728.4(z) are qualified to maintain physician case management when required.

(B) Care requested under the supplemental/cooperative care criteria is medically necessary, legitimate, and otherwise permissible under the terms of that part of the USHBP under which it will be considered for payment.

(C) Providers explain to patients the reason for a referral and the type of referral being made.

(D) Attending physicians properly refer beneficiaries to the HBA for counseling and services per § 728.4(n).

(E) Uniform criteria are applied in determining cooperative care situations without consideration of rate, grade, or uniformed service affiliation.

(F) All DD 2161's are properly completed and approved by the commanding officer or designee.

(G) A copy of the completed DD 2161 is returned to the naval MTF for inclusion in the medical record of the patient.

(w) *Sick call.* A regularly scheduled assembly of sick and injured military personnel established to provide routine medical care. Subsequent to exam-

ination, personnel medically unfit for duty will be admitted to an MTF or placed sick in quarters; personnel not admitted or placed sick in quarters will be given such treatment as is deemed necessary. When excused from duty for medical reasons which do not require hospitalization, military personnel may be authorized to remain in quarters, not to exceed 72 hours.

(x) *Sicklist—authorized absence from.* Commanding officers of naval MTFs may authorize absences of up to 72 hours for dependents and retired personnel without formal discharge from the sicklist. When absences are authorized in excess of 24 hours, subsistence charges or dependent's rate, as applicable, for that period will not be collected and the number of reportable occupied bed days will be appropriately reduced. Prior to authorizing such absences, the attending physician will advise patients of their physical limitations and of any necessary safety precautions, and will annotate the clinical record that patients have been so advised. For treatment under the Medical Care Recovery Act, make reporting consistent with § 728.4(aa).

(y) *Subsisting out.* A category in which officer and enlisted patients on the sicklist of a naval MTF may be placed when their daily presence is not required for treatment nor examination, but who are not yet ready for return to duty. As a general rule, patients placed in this category should reside in the area of the facility and should be examined by the attending physician at least weekly. Enlisted personnel in a subsisting out status should be granted commuted rations.

(1) Granting of subsisting out privileges is one of many disposition alternatives; however, recommend that other avenues (medical holding company, convalescent leave, limited duty, etc.) be considered before granting this privilege.

(2) Naval MTF patients in a subsisting out status should not be confused with those enlisted personnel in a rehabilitation program who are granted liberty and are drawing commuted rations, but are required to be present at the treating facility during normal working hours. These personnel are not

subsisting out and must have a bed assigned at the naval MTF.

(3) Naval MTF patients who are required to report for examinations or treatment more often than every 48 hours should not be placed in a subsisting out status.

(z) *Supplemental/cooperative care or services*—(1) *General*. When such services as defined in §728.2(cc) are rendered to other than CHAMPUS-eligible individuals, the cost thereof is chargeable to operation and maintenance funds available for operation of the facility requesting care or services. Cooperative care applies to CHAMPUS-eligible patients receiving inpatient or outpatient care in a USMTF who require care or services beyond the capability of that USMTF. The following general principles apply to such CHAMPUS-eligible patients:

(i) *Cooperation of uniformed services physicians*. USMTF physicians are required to cooperate in providing CHAMPUS contractors and OCHAMPUS additional medical information. SECNAVINST 5211.5C delineates policies, conditions, and procedures that govern safeguarding, using, accessing, and disseminating personal information kept in a system of records. Providing information to CHAMPUS contractors and OCHAMPUS will be governed thereby.

(ii) *Physician case management*. Where required by NAVMEDCOMINST 6320.18 (CHAMPUS Regulation; implementation of), uniformed services physicians are required to provide case management (oversight) as would an attending or supervising civilian physician.

(iii) *CHAMPUS-authorized providers*. CHAMPUS contractors are responsible for determining whether a civilian provider is CHAMPUS-authorized and for providing such information, upon request, to USMTFs.

(iv) *Psychiatric or psychotherapeutic services*. If psychiatric care is being rendered by a psychiatric or clinical social worker, a psychiatric nurse, or a marriage and family counselor, and the uniformed services facility has made a determination that it does not have the professional staff competent to provide required physician case management, the patient may be (partially) disengaged for the psychiatric or psy-

chotherapeutic service, yet have the remainder of required medical care provided by the naval MTF.

(v) *Forms and documentation*. A DD 2161, Referral For Civilian Medical Care, will be provided to each patient who is to receive supplemental or cooperative care or services. When supplemental care is required under the provisions of §728.4(z) (3) and (4), the provisions of §728.4(z)(3)(iii) apply. When cooperative care or services are required under the provisions of §728.4(z) (5) and (6), the provisions of §728.4(z)(5)(iv) apply.

(vi) *Clarification of unusual circumstances*. Commanding officers of naval MTFs will submit requests for clarification of unusual circumstances to OCHAMPUS or CHAMPUS contractors via the Commander, Naval Medical Command (MEDCOM-33) for consideration.

(2) *Care beyond a naval MTF's capability*. When, either during initial evaluation or during the course of treatment of CHAMPUS-eligible beneficiaries, required services are beyond the capability of the naval MTF, the commanding officer will arrange for the services from an alternate source in the following order, subject to restrictions specified. The provisions of §728.4(z)(2)(i) through (iii) must be followed before either supplemental care, authorized in §728.4(z)(4), is considered for payment from Navy Operations and Maintenance funds, or cooperative care, authorized in §728.4(z)(6), is to be considered for payment under the terms of CHAMPUS.

(i) Obtain from another USMTF or other Federal MTF the authorized care necessary for continued treatment of the patient within the naval MTF, when such action is medically feasible and economically advantageous to the Government.

(ii) When the patient is a retired member or dependent, transfer per §728.4(bb)(3) (i), (ii), (iii), or (iv), in that order. When the patient is a dependent of a member of a NATO nation, transfer per §728.4(bb)(4) (i), (ii), or (iii), in that order.

(iii) With the patient's permission, the naval MTF may contact State programs, local health agencies, or health

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foundations to determine if benefits are available.

(iv) Obtain such supplemental care or services as delineated in § 728.4(z)(4) from a civilian source using local operation and maintenance funds, or

(v) Obtain such cooperative care or services as delineated in § 728.4(z)(6) from a civilian source under the terms of CHAMPUS.

(3) *Operation and maintenance funds.* When local operation and maintenance funds are to be used to obtain supplemental care or services, the following guidelines are applicable:

(i) Care or services must be legitimate, medically necessary, and ordered by a qualified USMTF provider.

(ii) The naval MTF must make the necessary arrangements for obtaining required care or services from a specific source of care.

(iii) Upon approval of the naval MTF commanding officer or designee, provide the patient or sponsor with a properly completed DD 2161, Referral For Civilian Medical Care. The DD 2161 will be marked by the health benefits advisor or other designated individual to show the naval MTF as the source of payment. Forward a copy to the MTF's contracting or supply officer who is the point of contact for coordinating obligations with the comptroller and thus is responsible for assuring proper processing for payment.

(iv) Authorize care on an inpatient or outpatient basis for the minimum period necessary for the civilian provider to perform the specific test, procedure, treatment, or consultation requested. Patients receiving inpatient services in civilian medical facilities will not be counted as an occupied bed in the naval MTF, but will be continued on the naval MTF's inpatient census. Continue to charge pay patients the USMTF inpatient rate appropriate for their patient category.

(v) Naval MTF physicians will maintain professional contact with civilian providers.

(4) *Care and services authorized.* Use local operation and maintenance funds to defray the cost of the following when CHAMPUS-eligible patients are referred to civilian sources for the following types of care or services;

(i) All specialty consultations for the purpose of establishing or confirming diagnoses or recommending a course of treatment.

(ii) All diagnostic tests, diagnostic examinations, and diagnostic procedures (including genetic tests and CAT scans), ordered by qualified USMTF providers.

(iii) Prescription drugs and medical supplies.

(iv) Civilian ambulance service ordered by USMTF personnel.

(5) *CHAMPUS funds.* When payment is to be considered under the terms of CHAMPUS for cooperative care, even though the beneficiary remains under naval MTF control, the following guidelines are applicable:

(i) Process charges for care under the terms of CHAMPUS.

(A) If the charge for a covered service or supply is above the CHAMPUS-determined reasonable charge, the direct care system will not assume any liability on behalf of the patient where a civilian provider is concerned, although a USMTF physician recommended or prescribed the service or supply.

(B) Payment consideration for all care or services meeting cooperative care criteria will be under the terms of CHAMPUS and payment for such care or services will not be made from naval MTF funds. Conversely, any care or services meeting naval MTF supplemental care or services payment criteria will not be considered under the terms of CHAMPUS.

(ii) Care must be legitimate and otherwise permissible under the terms of CHAMPUS and must be ordered by a qualified USMTF provider.

(iii) Provide assistance to beneficiaries referred or disengaged under CHAMPUS. Although USMTF personnel are not authorized to refer beneficiaries to a specific civilian provider for care under CHAMPUS, health benefits advisors are authorized to contact the cooperative care coordinator of the appropriate CHAMPUS contractor for aid in determining authorized providers with the capability of rendering required services. Such information may be given to beneficiaries. Also encourage beneficiaries to obtain required services only from providers willing to participate in CHAMPUS.

Subject to the availability of space, facilities, and capabilities of the staff, USMTFs may provide consultative and such other ancillary aid as required by the civilian provider selected by the beneficiary.

(iv) Provide a properly completed DD 2161, Referral For Civilian Medical Care, to patients who are referred (versus disengaged) to civilian sources under the terms of CHAMPUS for cooperative care. (A Nonavailability Statement (DD 1251) may also be required. Provide this form when required under § 728.33.) The DD 2161 will be marked by the health benefits advisor, or other designated individual, to show CHAMPUS as the source of payment consideration. All such DD 2161's must be approved by the commanding officer or designee. Give the patient sufficient copies to ensure a copy of the DD 2161 accompanies each CHAMPUS claim. Advise patients that CHAMPUS contractors will return claims received without the DD 2161. Also advise patients to arrange for return of a completed copy of the DD 2161 to the naval MTF for inclusion in their medical record.

(v) Such patients receiving inpatient or outpatient care or services will pay the patient's share of the costs as specified under the terms of CHAMPUS for their beneficiary category. Patients receiving inpatient services will not be continued on the naval MTF's census and will not be charged the USMTF inpatient rate.

(vi) Certain ancillary services authorized under CHAMPUS require physician case management during the course of treatment. USMTF physicians will manage the provision of ancillary services by civilian providers when such services are obtained under the terms of CHAMPUS. Examples include physical therapy, private duty (special) nursing, rental or lease/purchase of durable medical equipment, and services under the CHAMPUS Program for the Handicapped. USMTF providers exercising physician case management responsibility for ancillary services under CHAMPUS are subject to the same benefit limitations and certification of need requirements applicable to civilian providers under the terms of CHAMPUS for the same types

of care. USMTF physicians exercising physician case management responsibility will maintain professional contact with civilian providers of care.

(6) *Care and services authorized.* Refer CHAMPUS-eligible patients to civilian sources for the following under the terms of CHAMPUS:

(i) Authorized nondiagnostic medical services such as physical therapy, speech therapy, radiation therapy, and private duty (special) nursing.

(ii) Preauthorized (by OCHAMPUS) adjunctive dental care, including orthodontia related to surgical correction of cleft palate.

(iii) Durable medical equipment. (CHAMPUS payment will be considered only if the equipment is not available on a loan basis from the naval MTF.)

(iv) Prosthetic devices (limited benefit), orthopedic braces and appliances.

(v) Optical devices (limited benefit).

(vi) Civilian ambulance service to a USMTF when service is ordered by other than direct care personnel.

(vii) All CHAMPUS Program for the Handicapped care.

(viii) Psychotherapeutic or psychiatric care.

(ix) Except for those types of care or services delineated in § 728.4(z)(4), all other CHAMPUS authorized medical services not available in the naval MTF (for example, neonatal intensive care).

(aa) *Third party liability case.* Per chapter 24, section 2403, JAG Manual, use the following guidelines to complete and submit a NAVJAG 5890/12, Hospital and Medical Care, 3rd Party Liability Case, when a third party may be liable for the injury or disease being treated:

(1) *Preparation.* All naval MTFs will use the front of NAVJAG 5890/12 to report the value of medical care furnished to any patient when (i) a third party may be legally liable for causing the injury or disease, or (ii) when a Government claim is possible under workmen's compensation, no-fault insurance (see responsibilities for appraising the insurance carrier in § 728.4(aa)(5)), uninsured motorist insurance, or under medical payments insurance (e.g., in all automobile accident cases). Block 4 of this form requires an appended statement of the patient or

an accident report, if available. Prior to requesting such a statement from a patient, the person preparing the front side of NAVJAG 5890/12 will show the patient the Privacy Act statement printed at the bottom of the form and have the patient sign his or her name beneath the statement.

(2) *Submission*—(i) *Naval patients*. For naval patients, submit the completed front side of the NAVJAG 5890/12 to the appropriate action JAG designee listed in section 2401 of the JAG Manual at the following times:

(A) *Initial*. Make an initial submission as soon as practicable after a patient is admitted for any period of inpatient care, or if it appears that more than 7 outpatient treatments will be furnished. This submission should not be delayed pending the accumulation of all potential charges from the treating facility. This submission need not be based upon an extensive investigation of the cause of the injury or disease, but it should include all known facts. Statements by the patient, police reports, and similar information (if available), should be appended to the form.

(B) *Interim*. Make an interim submission every 4 months after the initial submission until the patient is transferred or released from the facility, or changed from an inpatient status to an outpatient status.

(C) *Final*. Make a final submission upon completion of treatment or upon transfer of the patient to another facility. The facility to which the patient is transferred should be noted on the form. Report control symbol NAVJAG 5890-1 is assigned to this report.

(ii) *Nonnaval patients*. When care is provided to personnel of another Federal agency or department, that agency or department generally will assert any claim in behalf of the United States. In such instances, submit the NAVJAG 5890/12's (initial, interim, and final) directly to the appropriate of the following:

(A) *U.S. Army*. Commanding general of the Army or comparable area commander in which the incident occurred.

(B) *U.S. Air Force*. Staff judge advocate of the Air Force installation nearest the location where the initial medical care was provided.

(C) *U.S. Coast Guard*. Commandant (G-K-2). U.S. Coast Guard, Washington, DC 20593-0001.

(D) *Department of Labor*. The appropriate Office of Workers' Compensation Programs (OWCP).

(E) *Veterans Administration*. Director of the Veterans Administration hospital responsible for medical care of the patient being provided treatment.

(F) *Department of Health and Human Services (DHHS)*. Regional attorney's office in the area where the incident occurred.

(3) *Supplementary documents*. An SF 502 should accompany the final submission in all cases involving inpatient care. Additionally, when Government care exceeds \$1,000, inpatient facilities should complete and submit the back side of NAVJAG 5890/12 to the action JAG designee. On this side of the form, the determination of "patient status" may be used on local hospital usage.

(4) *Health record entries*. Retain copies of all NAVJAG 5890/12's in the Health Record of the patient. Immediately notify action JAG designees when a patient receives additional treatment subsequent to the issuance of a final NAVJAG 5890/12 if the subsequent treatment is related to the condition which gave rise to the claim.

(5) *No-fault insurance*. When no-fault insurance is or may be involved, the naval legal service office at which the JAG designee is located is responsible for apprising the insurance carrier that the Federal payment for the benefits of this part is secondary to any no-fault insurance coverage available to the injured individual.

(6) *Additional guidance*. Chapter 24 of the JAG Manual and BUMEDINST 5890.1A contain supplemental information.

(bb) *Transfer of patients*—(1) *General*. Treat all patients at the lowest echelon equipped and staffed to provide necessary care; however, when transfer to another MTF is considered necessary, use Government transportation when available. Accomplish medical regulating per the provisions of OPNAVINST 4630.25B and BUMEDINST 6320.1D.

(2) *U.S. military patients*. Do not retain U.S. military patients in acute care MTFs longer than the minimum

time necessary to attain the mental or physical state required for return to duty or separation from the service. When required care is not available at the facility providing area inpatient care, transfer patients to the most readily accessible USMTF or designated USTF possessing the required capability. Transportation of the patient and a medical attendant or attendants, if required, is authorized at Government expense. Since the VA is staffed and equipped to provide care in the most expeditious manner, follow the administrative procedures outlined in NAVMEDCOMINST 6320.12 when:

(i) A patient has received the maximum benefit of hospitalization in a naval MTF but requires a protracted period of nursing home type care. The VA can provide this type care or arrange for it from a civilian source for individuals so entitled.

(ii) Determined that there is or may be spinal cord injury necessitating immediate medical and psychological attention.

(iii) A patient has sustained an apparently severe head injury or has been blinded necessitating immediate intervention beyond the capabilities of naval MTFs.

(iv) A determination has been made by the Secretary concerned that a member on active duty has an alcohol or drug dependency or drug abuse disability.

(3) *Retired members and dependents.* When a retired member of a dependent requires care beyond the capabilities of a facility and a transfer is necessary, the commanding officer of that facility may:

(i) Arrange for transfer to another USMTF or designated USTF located in an overlapping inpatient catchment area of the transferring facility if either has the required capability.

(ii) If the patient or sponsor agrees, arrange for transfer to the nearest USMTF or designated USTF with required capability, regardless of its location.

(iii) Arrange for transfer of retired members to the Veterans Administration MTF nearest the patient's residence.

(iv) Provide aid in releasing the patient to a civilian provider of the pa-

tient's choice under the terms of Medicare, if the patient is entitled. Beneficiaries entitled to Medicare, Part A, because they are 65 years of age or older or because of a disability or chronic renal disease, lose CHAMPUS eligibility but remain eligible for care in USMTFs and designated USTFs.

(v) If the patient is authorized benefits under CHAMPUS, disengage from medical management and issue a Non-availability Statement (DD 1251) per the provisions of § 728.33, for care under CHAMPUS. This step should only be taken after due consideration is made of the supplemental/cooperative care policy addressed in § 728.4(z).

(4) *Dependents of members of NATO nations.* When a dependent, as defined in § 728.41, of a member of a NATO nation requires care beyond the capabilities of a facility and a transfer is necessary, the commanding officer of that facility may:

(i) Arrange for transfer to another USMTF or designated USTF with required capability if either is located in an overlapping inpatient catchment area of the transferring facility.

(ii) If the patient or sponsor agrees, arrange for transfer to the nearest USMTF or designated USTF with required capability, regardless of its location.

(iii) Effect disposition per § 728.42(d).

(5) *Others—(i) Medical care.* Section 34 of title 24, United States Code, provides that hospitalization and outpatient services may be provided outside the continental limits of the United States and in Alaska to officers and employees of any department or agency of the Federal Government, to employees of a contractor with the United States or the contractor's subcontractor, to dependents of such persons, and in emergencies to such other persons as the Secretary of the Navy may prescribe: *Provided*, such services are not otherwise available in reasonably accessible and appropriate non-Federal facilities. Hospitalization of such persons in a naval MTF is further limited by 24 U.S.C. 35 to the treatment of acute medical and surgical conditions, exclusive of nervous, mental, or contagious diseases, or those requiring domiciliary care.

(ii) *Dental care.* Section 35 of title 24 provides for space available routine dental care, other than dental prosthesis and orthodontia, for the categories of individuals enumerated in § 728.4(bb)(5)(i). *Provided*, that such services are not otherwise available in reasonably accessible and appropriate non-Federal facilities.

(iii) *Transfer.* Accomplish transfer and subsequent treatment of individuals in § 728.4(bb)(5)(i) per the provisions of law enumerated in § 728.4(bb)(5)(i) and (ii).

(cc) *Verification of patient eligibility—*
(1) *DEERS.* (i) The Defense Enrollment Eligibility Reporting System (DEERS) was implemented by OPNAVINST 1750.2. Where DEERS has been started at naval medical and dental treatment facilities, commanding officers will appoint, in writing, a DEERS project officer to perform at the base level. The project officer's responsibilities and functions include coordinating, executing, and maintaining base-level DEERS policies and procedures; providing liaison with line activities, base-level personnel project officers, and base-level public affairs project officers; meeting and helping the contractor field representative on site visits to each facility under the project officer's cognizance; and compiling and submitting reports required within the command and by higher authority.

(ii) Commanding officers of afloat and deployable units are encouraged to appoint a unit DEERS medical project officer as a liaison with the hospital project officer providing services to local medical and dental treatment facilities. Distribute notice of such appointments to all concerned facilities.

(iii) When a DEERS project officer has been appointed by a naval MTF or DTF, submit a message (report control symbol MED 6320-42) to COMNAVMEDCOM, with information copies to appropriate chain of command activities, no later than 10 October annually, and situationally when changes occur. As a minimum, the report will provide:

(A) Name of reporting facility. If the project officer is responsible for more than one facility, list all such facilities.

(B) Mailing address including complete zip code (zip + 4) and unit identification code (UIC). Include this information for all facilities listed in § 728.4(cc)(1)(iii)(A).

(C) Name, grade, and corps of the DEERS project officer designated.

(D) Position title within parent facility.

(E) AUTOVON and commercial telephone numbers.

(2) *DEERS and the identification card.* This subpart includes DEERS procedures for eligibility verification checks to be used in conjunction with the identification card system as a basis for verifying eligibility for medical and dental care in USMTFs and uniformed services dental treatment facilities (USDTFs). For other than emergency care, certain patients are required to have a valid ID card in their possession and, under the circumstances described in § 728.4(cc)(3), are also required to meet DEERS criteria before treatment or services are rendered. Although DEERS and the ID card system are interrelated, there will be instances where a beneficiary is in possession of an apparently valid ID card and the DEERS verification check shows that eligibility has terminated or vice versa. Eligibility verification via an ID card does not override an indication of ineligibility in DEERS without some other collateral documentation. Dependents (in possession of or without ID cards) who undergo DEERS checking will be considered ineligible for the reasons stated in § 728.4(cc)(4)(v) (A) through (G). For problem resolution, refer dependents of active duty members to the personnel support detachment (PSD) servicing the sponsor's command; refer retirees, their dependents, and survivors to the local PSD.

(3) *Identification cards and procedures.* All individuals, including members of uniformed services in uniform, must provide valid identification when requesting health benefits. Although the most widely recognized and acceptable forms of identification are DD 1173, DD 2, Form PHS-1866-1, and Form PHS-1866-3 (Ret), individuals presenting for care without such identification may be rendered care upon presentation of other identification as outlined in this

part. Under the circumstances indicated, the following procedures will be followed when individuals present without the required ID card.

(i) *Children under 10.* Although a DD 1173 (Uniformed Services Identification and Privilege Card) may be issued to children under 10 years of age, under normal circumstances they are not. Accordingly, certification and identification of children under 10 years of age are the responsibility of the member, retired member, accompanying parent, legal guardian, or acting guardian. Either the DD 1173 issued the spouse of a member or former member or the identification card of the member or former member (DD 2, DD 2 (Ret), Form PHS-1866-1, or Form PHS-1866-3 (Ret)) is acceptable for the purpose of verifying eligibility of a child under 10 years of age.

(ii) *Indefinite expiration.* The fact that the word "indefinite" may appear in the space for the expiration date on a member's card does not lessen its acceptability for identification of a child. See § 728.4(cc)(3)(iii) for dependent's cards with an indefinite expiration date.

(iii) *Expiration date.* To be valid, a dependent's DD 1173 must have an expiration date. Do not honor a dependent's DD 1173 with an expiration date of "indefinite". Furthermore, such a card should be confiscated, per NAVMILPERSCOMINST 1750.1A, and forwarded to the local PSD. The PSD may then forward it to the Commander, Naval Military Personnel Command, (NMPC (641D)/Pers 7312), Department of the Navy, Washington, DC 20370-5000 for investigation and final disposition. Render necessary emergency treatment to such a person. The patient administration department must determine such a patient's beneficiary status within 30 calendar days and forward such determination to the fiscal department. If indicated, billing action for treatment will then proceed following NAVMED P-5020.

(iv) *Without cards or with expired cards.* (A) When parents or parents-in-law (including step-parents and step-parents-in-law) request care in naval MTFs or DTFs without a DD 1173 in their possession or with expired DD 1173's, render care if they or their spon-

sor sign a statement that the individual requiring care has a valid ID card or that an application has been submitted for a renewal DD 1173. In the latter instance, include in the statement the allegation that: (1) The beneficiary is dependent upon the service member for over one-half of his or her support, and (2) that there has been no material change in the beneficiary's circumstances since the previous determination of dependency and issuance of the expired card. Place the statement in the beneficiary's medical record. Inform the patient or sponsor that if eligibility is not verified by presentation of a valid ID card to the patient administration department within 30 calendar days, the facility will initiate action to recoup the cost of care. If indicated, billing action for the cost of treatment will then proceed following NAVMED P-5020.

(B) When recent accessions, National Guard, reservists, or Reserve units are called to active duty for a period greater than 30 days and neither the members nor their dependents are at yet in receipt of their identification cards, satisfactory collateral identification may be accepted in lieu thereof, *i.e.*, official documents such as orders, along with a marriage license, or birth certificate which establish the individual's status as a dependent of a member called to duty for a period which is not specified as 30 days or less. For a child, the collateral documentation must include satisfactory evidence that the child is within the age limiting criteria outlined in § 728.31(b)(4). An eligible dependent's entitlement, under the provisions of this subpart, starts on the first day of the sponsor's active service and ends as of midnight on the last day of active service.

(4) *DEERS checking.* Unless otherwise indicated, all DEERS verification procedures will be accomplished in conjunction with possession of a valid ID card.

(i) *Prospective DEERS processing—(A) Appointments.* To minimize difficulties for MTFs, DTFs, and patients, DEERS checks are necessary for prospective patients with future appointments made through a central or clinic appointment desk. Without advance DEERS checking, patients could arrive

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at a facility with valid ID cards but may fail the DEERS check, or may arrive without ID cards but be identified by the DEERS check as eligible. Records, including full social security numbers, of central and clinic appointment systems will be passed daily to the DEERS representative for a prospective DEERS check. This enables appointment clerks to notify individuals with appointments of any apparent problem with the DEERS or ID card system and refer those with problems to appropriate authorities prior to the appointment.

(B) *Prescriptions.* Minimum checking requirements of the program require prospective DEERS checks on all individuals presenting prescriptions of civilian providers (see § 728.4(cc)(4)(iv)(D)).

(ii) *Retrospective DEERS processing.* Pass daily logs (for walk-in patients, patients presenting in emergencies, or patients replacing last minute appointment cancellations) to the DEERS representative for retrospective batch processing if necessary for the facility to meet the minimum checking requirements in § 728.4(cc)(4)(iv). For DEERS processing, the last four digits of a social security number are insufficient. Accordingly, when retrospective processing is necessary, the full social security number of each patient must be included on daily logs.

(iii) *Priorities.* With the following initial priorities, conduct DEERS eligibility checks using a CRT terminal, single-number dialer telephone, or 800 number access provided for the specific purpose of DEERS checking to:

(A) Determine whether a beneficiary is enrolled.

(B) Verify beneficiary eligibility. Establishment of eligibility is under the cognizance of personnel support activities and detachments.

(C) Identify any errors on the data base.

(iv) *Minimum checking requirements.* Process patients presenting at USMTFs and DTFs in the 50 States for DEERS eligibility verification per the following minimum checking requirements.

(A) Twenty five percent of all outpatient visits.

(B) One hundred percent of all admissions.

(C) One hundred percent of all dental visits at all DTFs for other than active duty members, retired members, and dependent.

(1) Active duty members are exempt from DEERS eligibility verification checking at DTFs.

(2) Retired members will receive a DEERS verification check at the initial visit to any DTF and annually thereafter at time of treatment at the same facility. To qualify for care as a result of the annually performed verification check, the individual performing the eligibility check will make a notation to this effect on an SF 603, Health Record—Dental. Include in the notation the date and result of the check.

(3) Dependents will have a DEERS eligibility verification check upon initial presentation for evaluation or treatment. This check will be valid for up to 30 days if, when the check is conducted, the period of eligibility requested is 30 days. A 30-day eligibility check may be accomplished online or via telephone by filling in or requesting the operator to fill in a 30 day period in the requested treatment dates on the DEERS eligibility inquiry screen. Each service or clinic is expected to establish auditable procedures to trace the date of the last eligibility verification on a particular dependent.

(D) One hundred percent of pharmacy outpatients presenting new prescriptions written by a civilian provider. Prospective DEERS checks are required for all patients presenting prescriptions of civilian providers. A DEERS check is not required upon presentation of a request for refill of a prescription of a civilian provider if the original prescription was filled by a USMTF within the past 120 days.

(E) One hundred percent of all individuals requesting treatment without a valid ID card if they represent themselves as individuals who are eligible to be included in the DEERS data base.

(v) *Ineligibility determinations.* When a DEERS verification check is performed and eligibility cannot be verified for

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any of the following reasons, deny routine nonemergency care unless the beneficiary meets the criteria for a DEERS eligibility override as noted in § 728.4(cc)(4)(viii).

(A) Sponsor not enrolled in DEERS.

(B) Dependent not enrolled in DEERS.

(C) "End eligibility date" has passed. Each individual in the DEERS data base has a date assigned on which eligibility is scheduled to end.

(D) Sponsor has separated from active duty and is no longer entitled to benefits.

(E) Spouse has a final divorce decree from sponsor and is not entitled to continued eligibility as a former spouse.

(F) Dependent child is married.

(G) Dependent becomes an active duty member of a uniformed service. (Applies only to CHAMPUS benefits since the former dependent becomes entitled to direct care benefits in his or her own right as an active duty member and must enroll in DEERS.)

(vi) *Emergency situations.* When a physician determines that emergency care is necessary, initiate treatment. If admitted after emergency treatment has been provided, a retrospective DEERS check is required. If an emergency admission or emergency outpatient treatment is accomplished for an individual whose proof of eligibility is in question, the patient administration department must determine the individual's beneficiary status within 30 calendar days of treatment and forward such determination to the fiscal department. Eligibility verifications will normally consist of presentation of a valid ID card along with either a positive DEERS check or a DEERS override as noted in § 728.4(cc)(4)(viii). If indicated, billing action for treatment will then proceed per NAVMED P-5020.

(vii) *Eligibility verification for non-emergency care.* When a prospective patient presents without a valid ID card and:

(A) DEERS does not verify eligibility, deny nonemergency care. Care denial will only be accomplished by supervisory personnel designated by the commanding officer.

(B) The individual is on the DEERS data base, do not provide non-emergency care until a NAVMED 6320/

9, Dependent's Eligibility for Medical Care, is signed by the member, patient, patient's parent, or patient's legal or acting guardian. This form attests the fact that eligibility has been established per appropriate directives and includes the reason a valid ID card is not in the prospective patient's possession. Apprise the aforementioned responsible individual of the provisions on the form NAVMED 6320/9 now requiring presentation of a valid ID card within 30 calendar days. Deny treatment or admission in physician determined nonemergency situations of persons refusing to sign the certification on the NAVMED 6320/9. For persons rendered treatment, patient administration department personnel must determine their eligibility status within 30 calendar days and forward such determination to the fiscal department. If indicated, billing action for treatment will then proceed following NAVMED P-5020.

(viii) *DEERS overrides.* Possession of an ID card alone does not constitute sufficient proof of eligibility when the DEERS check does not verify eligibility. What constitutes sufficient proof will be determined by the reason the patient failed the DEERS check. For example, groups most expected to fail DEERS eligibility checks are recent accession members and their dependents, Guard or Reserve members recently activated for training periods of greater than 30 days and their dependents, and parents and parents-in-law with expired ID cards. Upon presentation of a valid ID card, the following are reasons to "override" a DEERS check either showing the individual as ineligible or when an individual does not appear in the DEERS data base.

(A) *DD 1172.* Patient presents an original of a copy of a DD 1172, Application for Uniformed Services Identification and Privilege Card, which is also used to enroll beneficiaries in DEERS. If the original is used, the personnel support detachment (PSD) furnishing the original will list the telephone number of the verifying officer to aid in verification. Any copy presented

must have an original signature in section III; printed name of verifying officer, his or her grade, title, and telephone number; and the date the copy was issued. For treatment purposes, this override expires 120 days from the date issued.

(B) *Recently issued identification cards—(1) DD 1173.* Patient presents a recently issued DD 1173, Uniformed Services Identification and Privilege Card. Examples are spouses recently married to sponsor, newly eligible stepchildren, family members of sponsors recently entering on active duty for a period greater than 30 days, parents or parents-in-law, and unremarried spouses recently determined eligible. For treatment purposes, this override expires 120 days from the date issued.

(2) *Other ID cards.* Patient presents any of the following ID cards with a date of issue within the previous 120 days: DD 2, DD 2 (Ret), Form PHS 1866-1, or Form PHs 1866-3 (Ret). When these ID cards are used for the purpose of verifying eligibility for a child, collateral documentation is necessary to ensure the child is actually the alleged sponsor's dependent and in determining whether the child is within the age limiting criteria outlined in § 728.31(b)(4).

(C) *Active duty orders.* Patient or sponsor presents recently issued orders to active duty for a period greater than 30 days. Copies of such orders may be accepted up to 120 days of their issue date.

(D) *Newborn infants.* Newborn infants for a period of 1 year after birth provided the sponsor presents a valid ID card.

(E) *Recently expired ID cards.* If the DEERS data base shows an individual as ineligible due to an ID card that has expired within the previous 120 days (shown on the screen as "Elig with valid ID card"), care may be rendered when the patient has a new ID card issued within the previous 120 days.

(F) *Sponsor's duty station has an FPO or APO number or sponsor is stationed outside the 50 United States.* Do not deny care to bona fide dependents of spon-

sors assigned to a duty station outside the 50 United States or assigned to a duty station with an FPO or APO address as long as the sponsor appears on the DEERS data base. Before initiating nonemergency care, request collateral documentation showing relationship to sponsor when the relationship is or may be in doubt.

(G) *Survivors.* Dependents of deceased sponsors when the deceased sponsor failed to enroll in or have his or her dependents enrolled in DEERS. This situation will be evidenced when an eligibility check on the surviving widow or widower (or other dependent) finds that the sponsor does not appear (screen shows "Sponsor SSN Not Found") or the survivor's name appears as the sponsor but the survivor is not listed separately as a dependent. In any of these situations, if the survivor has a valid ID card, treat the individual on the first visit and refer him or her to the local personnel support detachment for correction of the DEERS data base. For second and subsequent visits prior to appearance on the DEERS data base, require survivors to present a DD 1172 issued per § 728.4(cc)(4)(viii)(A).

(H) *Patients not eligible for DEERS enrollment.* (1) Secretarial designees are not eligible for enrollment in DEERS. Their eligibility determination is verified by the letter, on one of the service Secretaries' letterhead, of authorization issued.

(2) When it becomes necessary to make a determination of eligibility on other individuals not eligible for entry on the DEERS data base, patient administration department personnel will obtain a determination from the purported sponsoring agency, if appropriate. When necessary to treat or admit a person who cannot otherwise present proof of eligibility for care at the expense of the Government, do not deny care based only on the fact that the individual is not on the DEERS data base. In such instances, follow the procedures in NAVMED P-5020 to minimize, to the fullest extent possible, the write-off of uncollectible accounts.