COMMANDERS DIGEST
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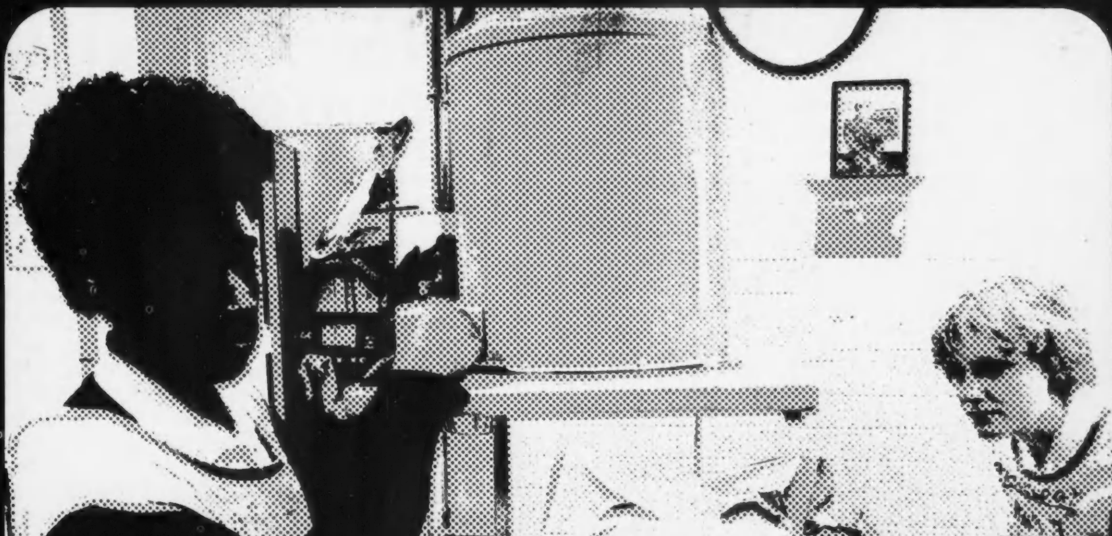
New Guidelines for Health Care Assistance



CHAMPUS

CHAMPUS

A poster distributed this summer proclaims, "CHAMPUS is a changing program—Keep yourself up-to-date."

Indeed, the Civilian Health and Medical Program of the Uniformed Services—commonly called CHAMPUS—has been a changing program during 1975. New guidelines to ensure better management of the program were announced. A Department of Defense directive placing the Office of the Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS) under the policy guidance and operational direction of the Assistant Secretary of Defense (Health and Environment) (ASD (H&E)) was being implemented throughout most of the year. And steps were taken to set up an overseas administration of CHAMPUS under ASD (H&E) management.

New Guidelines Insure More Effective Program Management

NEW GUIDELINES

DoD announced 28 new guidelines for CHAMPUS in February and March of 1975. This was part of an effort to bring CHAMPUS within the intent of the law as a comprehensive program of financial assistance for services that are essentially medical and necessary in the treatment and care of eligible beneficiaries.

The new guidelines were developed after CHAMPUS managers took a long, hard look at the laws and regulations pertaining to the program and compared them with the benefits that were being authorized. They determined that the laws and regulations were being interpreted too liberally and that an increasing number of authorized services and supplies went beyond the original intent of these laws and regulations. They also found areas of relatively uncontrolled coverage where a small number of beneficiaries obtained an inordinate amount of CHAMPUS resources. In many cases, services were being obtained from non-medical practitioners.

To improve management of CHAMPUS resources with respect to the above observations, a number of changes have been made in the past two years. Some of the new guidelines are regarded by CHAMPUS officials as clarifications of CHAMPUS laws and regulations—to ensure that the program's resources will be used to cost-share only those medical services and supplies considered necessary for the treatment of an illness, injury, or bodily malfunction, and that these supplies and services will be provided by or under the supervision of medical professionals.

Of course, the effort to implement these measures in a short period of time has brought harsh criticism from some users of the program and some providers of services. Some CHAMPUS users believe that their benefits have been eroded. Some providers of service feel that they are being discriminated against. Neither effect was intended, say CHAMPUS officials, who feel these complaints can find little justification when the facts are viewed objectively.

In developing the current CHAMPUS guidelines, care was taken to ensure that no essential medical benefit was cut from the program, according to DoD officials. These officials also emphasize that elimination of certain non-medical services from the list of CHAMPUS benefits in no way implies that these services are not necessary or appropriate for the person using them. But some of the services that have been affected, such as special education for children, are considered not to be part of medical coverage. In many cases, it was determined that providers of these services are not a part of the "medical team," although they may be highly qualified and perfectly competent in their own fields.

One CHAMPUS official, whose job includes responding to numerous inquiries from individuals who feel that the recent changes in CHAMPUS constitute an erosion of their medical care benefits, observes, "A true erosion of benefits would be a reduction of benefits below that mandated by law." He adds, "CHAMPUS coverage today is comparable to the most comprehensive coverage available to the Government employee and as beneficial or, more so, than many health programs in the private sector."

Following are explanations on specific areas of CHAMPUS coverage affected by the new guidelines:

Psychotherapy Coverage

The changes in psychotherapy coverage resulted from a DoD conclusion that excessive costs being experienced were due in part to an extremely liberal interpretation of the law which intended only medical coverage and to the failure to exercise necessary controls on the quality of care provided.

Reasons for this include the extremely broad and questionable interpretation of "treatment of mental conditions"—the term used to describe the coverage authorized by the law (Chapter 55 of Title 10, United States Code).

Additional factors pertaining to this interpretation include:

- The wide range of individual providers, other than psychiatrists, who were permitted to provide services which CHAMPUS cost-shared;

- The inclusion under coverage of a wide variety of institutions/facilities providing "therapeutic" services ranging from psychiatric hospitals with accreditation from the Joint Commission on the Accreditation of Hospitals to "therapy" centers with extremely little, if any, orientation to psychiatry;

- The long-term, continuous, intensive inpatient/residential care for minor psychiatric diagnoses, educational deficiencies, and for permanently, seriously neurologically impaired individuals for whom such services are professionally considered ineffective and inappropriate.

Any diagnosis listed by the American Psychiatric Association and many that were not, no matter how minimal, was used to justify coverage. Any physician could order services of clinical and nonclinical social workers, educators, remedial reading teachers, speech pathologists, audiologists, vocational therapists, recreational therapists, and others . . . and all these were covered by the physician's order. Once the order was written, it was not necessary that any further supervision or concern by the order-writer be evidenced, and frequently the order was the end of all medical supervision. All this was cost-shared as psychotherapy under a program designed by the Congress in 1966 to cover only medical care.

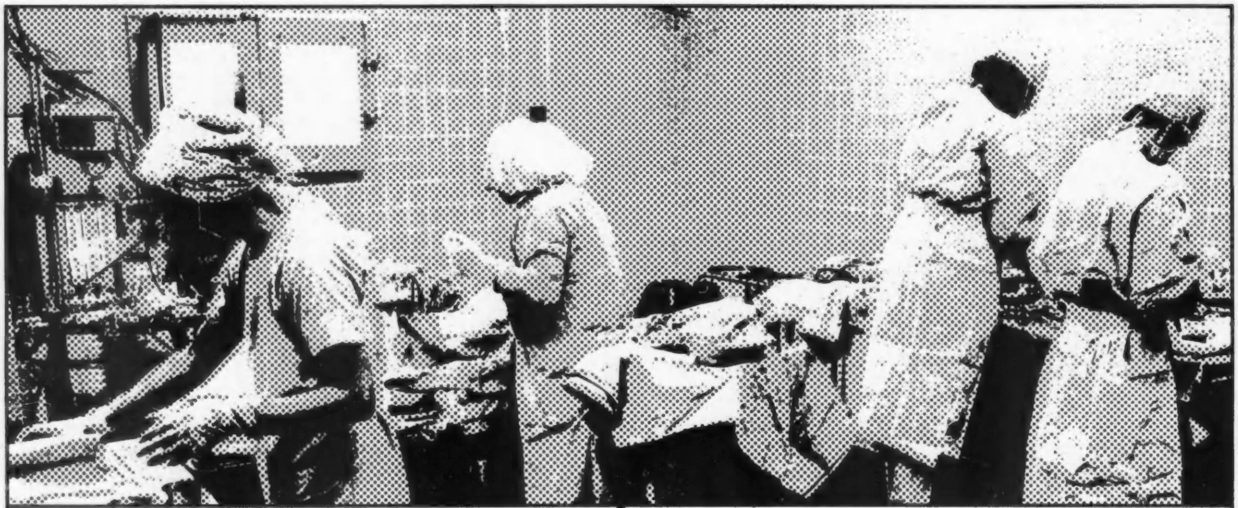
The foregoing observations indicated that two types of actions would be required. One would remove from coverage services not considered medical or medically necessary and providers of services, individual or institutional, not considered part of the medical team. The other action would institute quality control measures.

Changes made to date have been in line with the above. Policy memorandums have required the accreditation of facilities providing services, have limited the types of services covered by CHAMPUS, and have returned patient-CHAMPUS cost-sharing to the original system contemplated by the Congress.

Dental Care

Dental care under CHAMPUS is restricted to those instances in which clinical evidence establishes that an oral disease or infection is significantly complicating a medical or surgical condition other than one involving the teeth and their supporting structures. Dental services are limited to those necessary to eliminate the oral disease or infection.

All non-emergency dental care now requires approval in advance. This requirement is designed to create an understanding among CHAMPUS, the patient, and the dentist as to exactly what CHAMPUS will pay for before services are provided. In the past, much dental care was obtained by beneficiaries with mistaken ideas as to what would actually be payable under CHAMPUS rules.



Dental Care During Pregnancy

The rule used in authorizing dental care during pregnancy is the same one, stated above, that applies to all dental care under CHAMPUS. However, there are special guidelines and information that apply to maternity cases.

Service dependents who are receiving pregnancy care at Service medical facilities and need dental care as part of the management of their pregnancy must look first to their Service facility for that dental care.

Recently-issued guidelines concerning dental care for pregnant dependents had been interpreted at some Service medical facilities to contain a mandatory requirement for them to provide such dental care, which is not the case.

As clarification, CHAMPUS officials explain that a dependent receiving care for pregnancy in a Uniformed Services facility and needing authorized dental care will receive that care there if the dental officer determines that it can be provided by the facility. If it cannot, the dental officer will give her a nonavailability statement and she can then seek the needed dental care from a civilian source. The nonavailability statement is needed by any CHAMPUS eligible except a dependent of an active duty member of one of the Uniformed Services residing apart from her sponsor.

This is an exception to the normal CHAMPUS rule which requires a nonavailability statement only from the patient who is a dependent of an active duty member, residing with that member within 30 miles of a Service medical facility having inpatient medical care capability, and who is seeking inpatient care not qualifying as emergency care.

This exception was included in the guidelines, according to CHAMPUS officials, because authorized dental care during pregnancy is regarded as a complication of the pregnancy for which the dependent is already receiving care at the Service medical facility; it is part of the maternity care package and, therefore, should be provided, if it is available, at that facility along with the rest of the maternity care.

Dependents who are receiving care for pregnancy from a civilian source under CHAMPUS and for whom authorized dental care has been prescribed follow the normal rule regarding nonavailability statements.

Therapists' Services

Therapists' services now require a physician's certification which states that:

a. The patient requires the services for a stated diagnosis;

b. A plan for furnishing such services has been established and will be reviewed by the physician no less than once each 30-day period; and

c. The services are to be furnished only while the patient is under the care of the physician.

Formerly, therapists' services had been available under CHAMPUS for indefinite periods of time following a simple one-time order by a physician for their coverage. This change calls for additional information from the physician as to the need for services to preclude CHAMPUS cost-sharing of services not considered medically necessary.

Services of these therapists now require recertification by the attending physician at least once every 30 days. The recertification must state that there is a continuing need for such services and must include an estimate of how long such services will be required. This is a follow-up to the change above to assure that continuing services are still medically necessary and that physician supervision is being maintained for the well-being and proper care of the patient.

Psychologists' Services

Payment of psychologists' services billed on a fee-for-service basis is now limited to those psychologists who are licensed or certified, have a doctoral degree in clinical psychology, and have a minimum of two years of supervised experience in clinical psychology in a licensed hospital, a mental health center, or other appropriate clinical setting as determined by the Director, OCHAMPUS. This action was taken to ensure that CHAMPUS beneficiaries receive high quality care from professionally competent and clinically experienced psychologists.

Deductions and Coinsurance

In determining deductions and coinsurance, credits are now limited to authorized services and supplies, and reasonable charges as determined by CHAMPUS. In determining shares of reasonable charges for the patient and CHAMPUS, payments made by or on behalf of the patient are limited to services and supplies authorized by CHAMPUS. It continues to exclude coverage of comfort and convenience items, telephone service, etc. In certain instances, this results in greater patient cost-sharing than in the past.

Ambulatory Surgery

All surgery in ambulatory surgical centers is now cost-shared under outpatient cost-sharing rules. Although surgery in such centers is provided on an outpatient basis, a previous liberal interpretation of the law permitted cost-sharing as though the patient was an inpatient in a hospital. DoD officials consider the earlier cost-sharing rule to be contrary to congressional intent behind the legislation.

Medicare Disability Coverage

With respect to beneficiaries who have coverage under the Social Security Amendments of 1972 for physical disability or kidney failure, coverage will be limited to those authorized services and supplies not paid under Medicare. CHAMPUS policy officials believe that Congress did not intend that two medical programs should simultaneously cover the same benefits. CHAMPUS will supplement what Medicare will not pay.

Public Official's Statement

A public official's statement that appropriate care is not available from public institutions is now required for all long-term care requiring prior approval. There are many free or relatively inexpensive state and local programs for long-term medical care. The public official's statement required must certify that such programs are not available to the beneficiary before CHAMPUS will provide payment.

Prior Approval

Under new guidelines affecting both the CHAMPUS Basic Program and the CHAMPUS Program for the Handicapped, claims for all services and supplies requiring prior approval which have not been approved in advance will be disallowed. There are several situations which require that services be approved by CHAMPUS in advance of their receipt. The General Accounting Office has objected to retroactive coverage by CHAMPUS in cases where prior approval was not obtained. This new policy corrects this situation.

ESTIMATE OF NUMBER OF PERSONS ENTITLED TO CHAMPUS BENEFITS

Dependents of Active Duty Members	**3,328,718**
Retired Members	**1,075,714**
Dependents of Retired Members	**2,474,142**
Survivors of Active Duty and Retired Members	**782,398**
TOTAL	**7,660,972**

CHAMPUS ADMINISTRATION

CHAMPUS, instituted in 1956, is a civilian medical care program for the dependents of active duty members of the Uniformed Services, retired members and their dependents, and the survivors of active duty and retired members. The program covers approximately 7.7 million people and includes beneficiaries from the Department of Defense, the Coast Guard, the Public Health Service, and the National Oceanic and Atmospheric Administration. The fiscal year 1975 presidential budget requested more than $520 million for CHAMPUS medical care and administrative support costs.

During the first 10 years of the program, the Army served as executive agent for CHAMPUS under policy guidance from the Office of the Secretary of Defense (OSD). During that period, CHAMPUS was relatively small and uncomplicated, as it only afforded alternative care to dependents of active duty members. With the enactment of Public Law 89-614 in 1966, however, health benefits under the program were liberalized and coverage was significantly expanded. The number of CHAMPUS beneficiaries almost doubled and CHAMPUS became a major cost-sharing health care program available to retirees and their dependents, as well as the dependents of active duty members.

(Continued on page 8)

PATIENTS	UNIFORMED SERVICES FACILITIES	CIVILIAN HEALTH A	
		Basic Prog	
	Hospitalization/Outpatient	Hospitalization	
Spouse or child of active duty member	On a space-available basis	Eligible, but may need non-availability statement	
Retired member	On a space-available basis	Eligible*	
Spouse or child of retired member	On a space-available basis	Eligible*	
Surviving spouse or child of deceased active duty or retired member	On a space-available basis	Eligible*	
Dependent parent or parent-in-law of active duty, retired, or deceased member	On a space-available basis	Not eligible	

COSTS	Hospitalization	Outpatient	Hospitalization	
Spouse or child of active duty member	$3.70** per day	No charge	$3.70** per day or $25, whichever is greater	20 ab $5 $1
Retired: Enlisted	No charge	No charge	25% of the allowable medical facility charges and professional fees	25 al $5 $
Officer	Subsistence	No charge		
Spouse or child of retired or deceased member	$3.70** per day	No charge		
Dependent parent or parent-in-law of active duty, retired, or deceased member	$3.70** per day	No charge	Not eligible	

*Unless eligible at age 65 for Medicare hospital insurance

**For calendar year 1975. The amount is subject to review and change each year.

AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES	
ram	
Outpatient	Program for the Handicapped
Eligible	Eligible
Eligible*	Not eligible
Eligible*	Not eligible
Eligible*	Not eligible
Not eligible	Not eligible
Outpatient	Program for the Handicapped
0% of allowable charges bove the deductible (first 50 each fiscal year - - 100 maximum per family)	Patient's share per month depends on paygrade of sponsor -- $25 for E-1 to $250 for 0-10. CHAMPUS pays remainder up to $350 per mo.
25% of allowable charges bove the deductible (first $50 each fiscal year -- $100 maximum per family)	Not eligible
Not eligible	Not eligible

Uniformed Services Health Benefits Program

Comprehensive medical care is provided dependents of active duty Uniformed Service members, retired members and their dependents, and surviving dependents through the Uniformed Services Health Benefits Program (USHBP). The program provides medical care through Uniformed Services medical facilities on a space-available basis or through participation in CHAMPUS. The Uniformed Services are the Army, Navy, Air Force, Marine Corps, Coast Guard, and the commissioned corps of the Public Health Service and of the National Oceanic and Atmospheric Administration.

The CHAMPUS portion of USHBP makes it possible for Service families to obtain authorized medical care from civilian sources on a cost-sharing basis. This is of particular value to military personnel serving away from their dependents who may not be near Service medical facilities. Also, active duty and retired families and surviving dependents may be located in remote sections, again, without access to Service facilities. And in areas of large military population, the Service medical facilities may be overtaxed and unable at times to meet the total medical needs of all eligibles.

DEFINITIONS

Active Duty Member—A person who is serving on active duty (including active duty for training) under a call or order that does not specify a period of 30 days or less.

Retired Member—A member and/or former member who is entitled to retired, retainer, or equivalent pay.

Child-Legitimate child, illegitimate child,* adopted child, or stepchild who is unmarried, and who:

Has not passed his 21st birthday;

Has passed his 21st birthday but is incapable of self-support because of a mental or physical incapacity that existed before that birthday and is dependent upon the member (or was at the time of the member's death) for more than one-half of his support.

Has not passed his 23rd birthday, is enrolled in a full-time course of study in an institution of higher learning, and is dependent upon the member (or was at the time of the member's death) for more than one half of his support.

*An illegitimate child of (a) a member, if the child's paternity has been judicially determined; or (b) a member or his spouse, if the child is residing with or in a home provided by the member or the parent who is the spouse and the member is providing more than one-half of the child's support.

Non-Availability Statement—A spouse or child residing with the active duty member usually must use a Uniformed Service medical facility for inpatient care if there is one available that can provide the required inpatient care. A facility is considered available if it is within 30 miles of the member's residence and provides inpatient care for dependents. If an available facility cannot provide the inpatient care needed, it should provide the dependent with a non-availability statement indicating this fact. With few exceptions, claims for inpatient care in civilian facilities cannot be paid without such a statement. For example, statements are not required of such dependents who receive care in a medical emergency or while away from the home area on a trip.

For further information about CHAMPUS contact your local CHAMPUS Advisor or Health Benefits Counselor.

Participating and Non-participating Providers of Care

In a recent appearance before a Senate appropriations subcommittee, Mr. Vernon McKenzie, Principal Deputy Assistant Secretary of Defense for Health and Environment, was asked why it is that while the law contains specific cost-sharing provisions, many CHAMPUS beneficiaries find themselves paying more than the share specified by CHAMPUS.

Mr. McKenzie responded by saying that when beneficiaries do pay more than the share specified by CHAMPUS, it is because they used a non-participating provider. "Beneficiaries do not pay more than the share set forth in the law if they use participating providers of services," he explained, pointing out the need for CHAMPUS beneficiaries to be aware of what is meant by "participating providers" and what might happen when beneficiaries use non-participating providers of services.

Participation in CHAMPUS means the physician or other health care professional providing the care agrees to accept, as full payment of his claim, the patient's and the Government's shares of the reasonable fee as determined by the CHAMPUS paying office. This agreement is made by the provider of care when he signs the statement to that effect on the claim form and in effect becomes the claimant.

For a provider of care, such as a physician, participation is entirely voluntary. If he declines to participate and the beneficiary still wishes to obtain medical services from him, then the beneficiary is responsible for any additional amount charged by the provider of care above the amount allowed by CHAMPUS. The beneficiary fills out and submits his or her own claim and CHAMPUS pays the Government's share of the reasonable fee for authorized services to the beneficiary.

The "reasonable fee" for a non-institutional provider of medical care is the lowest of the following:

a. The provider's usual and customary charge.

b. The prevailing fee charged by the majority of providers for the same service in the same geographical area.

c. The amount paid by the paying office to providers of care under similar circumstances in its non-CHAMPUS medical insurance business.

The beneficiary must realize that if he or she chooses a non-participating provider he does so at some financial risk.

Congress became concerned about the escalating costs incident to the program's benefit payments, and several studies sponsored by the House Armed Services and House Appropriations Committees recommended changes in the management of the CHAMPUS program. In 1972, in order to bring management control of CHAMPUS closer to the immediate direction of the Secretary of Defense, OCHAMPUS, located at Fitzsimmons Army Medical Center in Denver, Colorado, was directed to operate the program under the policy guidance of the ASD (H&E). The Army continued to provide facilities, budgetary and administrative support, and necessary overhead resources to OCHAMPUS. Health care costs, including fiscal agent fees, continue to be prorated among the Uniformed Services. In Europe, CHAMPUS activities remained consolidated under Army management. Elsewhere, CHAMPUS overseas elements were administrated by the separate Military Departments.

Following these changes, costs continued to increase dramatically—from $390 million in FY 72 to the $520 million requested for FY 75. The House Appropriations Committee Report on the FY 75 Defense Budget recommended transferring CHAMPUS funds from the cognizance of the Military Departments to the level of OSD as a further necessary step in improving management of the Program's finances. Although this recommendation was recognized as a step in the right direction, it was felt that CHAMPUS problems went deeper than fiscal considerations and that action should also be taken to strengthen the program's organizational structure and management arrangements.

Two feasible alternatives for accomplishing this objective were proposed:

- Elevate OCHAMPUS to Defense Agency status. This would centralize management of CHAMPUS resources and streamline the administration of CHAMPUS activities. However, the size of the organization and the impact of its activities would fall short of the scope and magnitude of existing Defense Agencies. Moreover, if established as a self-sustaining Defense Agency, OCHAMPUS would have to expand considerably its headquarters and support staff, unnecessarily increasing DoD overhead support costs.

- Establish OCHAMPUS as an OSD field activity under the guidance of the ASD (H&E). Under this arrangement, military and civilian personnel would be assigned to OSD field spaces under the ASD (H&E) who would provide policy guidance and operational direction to OCHAMPUS. Administrative support and facilities for CHAMPUS activities located at Denver and in Europe would continue to be provided by the Department of the Army on a cross-servicing basis.

The latter alternative was favored because it would strengthen management controls and pinpoint program responsibility without requiring the development of a headquarters support organization.

In consonance with congressional recommendations, on December 4, 1974, a DoD directive established OCHAMPUS as an OSD field activity under the guidance of ASD (H&E). The following relationships and responsibilities were directed:

- ASD (H&E) continued to maintain responsibility for recommending policies for the administration of the CHAMPUS program to the Secretary of Defense and provided policy guidance and operational direction to the Director, OCHAMPUS.
- The Military Departments were to provide administrative support (e.g., field accounting and disbursement, personnel administration, facilities, office supplies) to OCHAMPUS on a reimbursable basis. The Department of the Army was to continue to provide such support to OCHAMPUS, Denver, and OCHAMPUS, Europe. The source of support for other subordinate offices will be determined as they are established.
- The Uniformed Services Health Benefits Committee, made up of representatives from all the Uniformed Services, was formally established to provide advice and recommend policy to ASD (H&E) on OCHAMPUS operations.
- The Office of Information for the Armed Forces, Office of the Assistant Secretary of Defense (Manpower and Reserve Affairs), would provide informational support regarding OCHAMPUS programs and services to CHAMPUS eligibles.

Chronological List of Changes In the CHAMPUS Program Implemented July 1, 1974–March 9, 1975

1. Required residential facilities providing services for children to have either accreditation by the Joint Commission on the Accreditation of Hospitals (JCAH) or approval under CHAMPUS standards and a pending application with JCAH for JCAH accreditation. (Basic Medical Program)

Reason for change: To effect better control of the nature and qualifications of institutions providing psychiatric care to CHAMPUS beneficiaries.

Date announced: April 5, 1974
Effective Date: July 1, 1974

2. Limited coverage of nonresidential outpatient and partial day care psychiatric programs to facilities which either have JCAH accreditation or have an application pending with the JCAH for JCAH accreditation. (Basic Medical Program).

Reason for change: To assure such programs were properly based in a medical institution.

Date announced: April 17, 1974
Effective date: July 1, 1974

3. Excluded "learning disabilities" as a sole basis for entitlement for benefits under the Program for the Handicapped.

Reason for the change: To limit Program for the Handicapped coverage to individuals suffering from conditions specified by public law (Chapter 55 of title 10, United States Code).

Date announced: April 30, 1974
Effective date: July 1, 1974

4. Required JCAH accreditation for all psychiatric hospitals. (Basic Medical Program)

Reason for change: To insure CHAMPUS payments were being made to quality institutions only.

Date announced: May 3, 1974
Effective date: July 1, 1974

5. Terminated the practice of cost-sharing psychiatric outpatient nonresidential care under inpatient cost-sharing rules as being unjustified under the law. (Basic Medical Program)

Reason for change: To terminate an administrative cost-sharing procedure that was not in accord with public law.

Date announced: May 7, 1974
Effective date: July 1, 1974

6. Limited coverage of psychotherapeutic inpatient/residential care to 120 days and outpatient/nonresidential care limited to 40 visits (days) per fiscal year. (Basic Medical Program)

Reason for change: To establish some outer limits on the amount of psychiatric care CHAMPUS would cost-share. (Later modified, see item 10.)

Date announced: June 7, 1974
Effective date: July 1, 1974

7. Required claims for reimbursement for outpatient care authorized by sections 1079(a) and 1086(a) of title 10, United States Code, to be cost-shared under the outpatient cost-sharing rules of the Code. (Maternity care was an exclusion from this rule.) (Basic Medical Program)

Reason for change: To eliminate certain administrative procedures that permitted some outpatient care to be cost-shared under the inpatient cost-share formula.

Date announced: June 7, 1974
Effective date: August 1, 1974

8. Excluded camping sessions and absences of more than 72 hours from therapeutic psychiatric residential programs from coverage. (Basic Medical Program)

Reason for change: To restrict CHAMPUS coverage to psychiatric treatment programs of a medical orientation so that CHAMPUS will only be paying for active medical treatment.

CHAMPUS Overseas

The Office of CHAMPUS, Europe, (OCHAMPUSEUR) along with its functions and responsibilities, was transferred to the newly established field activity July 1, 1975. Two additional overseas offices are planned and will be set up in the future by OCHAMPUS. They are:

1. CHAMPUSSO, serving Bermuda, West Indies, Central and South America, and Mexico

2. CHAMPUSPAC, serving the Pacific area (exclusive of Hawaii).

In the interim period, two civilian contractors are handling claims from these areas.

All OCHAMPUSEUR personnel, funds, files, equipment, and other resources were included in this action. A support agreement is being finalized under which the Army will continue to provide administrative and logistic support.

The responsibilities of OCHAMPUSEUR are unchanged except that it now also processes claims under the Civilian Health and Medical Program of the Veterans Administration (CHAMPVA). Eligible under CHAMPVA are spouses and dependent children of totally disabled veterans or of veterans who have died as the result of a service-connected disability.

Uniformed Services families using CHAMPUS while in countries within the U.S. European Command, Africa, and the Middle East should continue to forward claims to OCHAMPUSEUR, APO New York 09403.

In other overseas areas, Service families had previously forwarded claims according to instructions obtained at their nearest U.S. military installation or the Defense Attache at the nearest U.S. embassy. All claims for care rendered on or after July 1, 1975 should now be submitted to one of the following addresses:

For CHAMPUSSO—
Mutual of Omaha Insurance Company
3301 Dodge Street,
Omaha, Nebraska 68131
For CHAMPUSPAC—
Hawaii Medical Service Association
P.O. Box 860
Honolulu, Hawaii 96808

Claims for care provided prior to July 1, 1975 should be forwarded in accordance with the old procedures.

Requests for prior approval of care, required by CHAMPUS for care under the Program for the Handicapped, extended care under the Basic Program, and authorized non-emergency dental care, should be forwarded as follows:

For the OCHAMPUSEUR area—OCHAMPUSEUR, APO New York 09403.

For other overseas areas—OCHAMPUS, Denver, Colo. 80240 (except for dental preauthorizations). All claims and preauthorizations related to dental care should be sent to the Colorado Dental Service, 1600 Downing Street, Denver, Colorado, 80218.

Date announced: June 13, 1974
Effective date: July 1, 1974

9. Terminated the policy of cost-sharing expense of orthodontia provided dependents of active duty members under the provisions of the Program for the Handicapped.

Reason for change: To stop payment for services related to a physical condition (irregular dental structure) which did not, in the majority of cases, meet the test of the law–a serious physical handicap. Serious congenital defects of the oral structure are coverable under the adjunctive rule of the Basic Program.

Date announced: July 2, 1974
Effective date: September 1, 1974

10. Removed the 120 inpatient days/40 visits limitations instituted July 1, 1974 and replaced by a system of professional review.

Reason for change: Limitations imposed earlier were removed because DoD received assurances from the professional community that appropriate standards could be developed to limit care to that care essential and appropriate in a given case.

Date announced: September 6, 1974
Effective date: Retroactive to July 1, 1974

11. Change 11 is actually a group of 12 specific changes:

a. Changes in the Basic Program

(1) Limited coverage of operant psychological conditioning devices for enuresis to a supply purchase at a reasonable cost and restricted the payment for professional guidance on their use to attending physicians. Purchase shall be covered only upon certification by the attending physician that organic causes have been excluded by examination.

(2) Deleted coverage of devices, such as arch supports, which convert ordinary shoes to orthopedic shoes.

(3) Deleted coverage of megavitamin and orthomolecular therapy in psychiatry.

(4) Deleted services of pastoral counselors, family and child counselors, and marital counselors. (This action currently suspended in compliance with a temporary court injunction.)

(5) Deleted coverage of "stop-smoking" clinics or professional services for the same purpose.

(6) Required inpatient cost-sharing on each inpatient care admission except for pregnancy and complications of pregnancy which will be covered under a separate rule to be issued.

(7) Deleted coverage of all services and supplies determined to be not medically necessary for the diagnosis or treatment of an illness, injury, or bodily malfunction. Exceptions will be made for family planning and for Christian Science benefits.

(8) Deleted all coverage for which the patient, his estate, or responsible family member has no legal obligation to pay or for which no charge would be made if the patient was not eligible for CHAMPUS.

(9) Deleted coverage of all services and supplies for "treatment" of obesity when obesity is the sole or major condition being treated.

(10) Deleted coverage of all reconstructive surgical procedures which are justified solely on a psychiatric need.

b. Changes in the Program for the Handicapped

(11) Deleted the diagnosis of enuresis as a qualifying diagnosis for coverage.

c. Changes Affecting Both Programs

(12) Deleted coverage of all alterations to living spaces and permanent fixtures attached thereto.

Reason for changes: Changes instituted in order to effect better management and control over program expenditures and to generally bring the program in line with the law.

Date announced: February 21, 1975
Effective date: February 28, 1975

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12. This change also consisted of a group of 16 changes as follows:

a. Changes in the Basic Program

(1) Restricted adjunctive dental care to those instances in which clinical evidence establishes that an oral disease or infection is significantly complicating a medical or surgical condition other than one involving the teeth and their supporting structures. Dental services shall be limited to those necessary to eliminate the oral disease or infection. This does not include dental care necessitated by trauma which does not meet the above guideline.

(2) Required that all dental care adjunctive to pregnancy when provided on an outpatient basis be cost-shared under outpatient cost-sharing rules.

(3) Required a nonavailability statement for all adjunctive dental care to be provided by a civilian source to a dependent receiving care for pregnancy in a military medical facility. Dependents of active duty members not residing with the member were exempted.

(4) Required that all non-emergency dental care be approved in advance.

(5) Limited inpatient cost-sharing of complications of pregnancy to diseases, medical conditions, or surgical conditions directly influenced by or directly influencing the condition of pregnancy.

(6) Required that a therapist's services be supported by a physician's certification–

(a) that the patient requires the services for a stated diagnosis;

(b) that a plan for furnishing such services has been established and will, no less than once each 30-day period, be reviewed by the physician; and

(c) that the services are to be furnished only while the patient is under the care of the physician.

(7) Required that the services of all therapists be recertified at least once every 30 days by the attending physician. Such recertifications must state that there is a continuing need for such services, and include an estimate of how long such services will be required.

(8) Limited payment of psychologists' services billed on a fee-for-service basis to those psychologists who are licensed or certified, who have a doctoral degree in clinical psychology and a minimum of two years of supervised experience in clinical psychology in a licensed hospital, a mental health center, or other appropriate clinical setting as determined by the Director, OCHAMPUS.

(9) Deleted coverage of perceptual and visual training.

(10) In determining deductions and coinsurance, limited credits to authorized services and supplies and CHAMPUS-determined reasonable charges.

(11) Required that all surgery in ambulatory surgical centers be cost-shared under outpatient cost-sharing rules.

(12) Deleted coverage of air ambulance service unless a physician certifies that such service was necessary to preserve life or limb.

(13) With respect to beneficiaries who have coverage under the Social Security Amendments of 1972 for physical disability or kidney failure, limited coverage to those services and supplies not available under Medicare.

(14) Required public official's statement that appropriate care is not available from public institutions for all long-term care under the Basic Program.

b. Changes Affecting Both Programs

(15) Deleted coverage for service-connected conditions for which the Veterans Administration will provide necessary care.

(16) Required that claims for all services and supplies requiring prior approval which have not been approved in advance be disapproved.

Reason for changes: Changes instituted for better management and control over program expenditures and to bring the program in line with the law.

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