

I. Elimination of Mental Health Pre-Authorization

Section 701 of the NDAA-03 eliminates the preauthorization requirement for inpatient mental health where Medicare is primary payer and has already authorized the care. Currently, in situations where a Medicare beneficiary, who is also TRICARE eligible, receives inpatient mental health care, TRICARE applies its rules for preauthorization even though TRICARE is not the primary payer. The language found in section 701 of the NDAA-03 changes the way we currently operate. Once this change is implemented, Medicare beneficiaries who are also TRICARE eligible, will follow Medicare's rules until their Medicare benefit is exhausted. Once the Medicare benefit is exhausted, TRICARE's rules regarding preauthorization will apply. We expect implementation of this change will reduce providers' administrative burden as they will no longer have to obtain a preauthorization from TRICARE until the beneficiary's Medicare benefit is exhausted. It will also reduce the burden on our contractors as they will be required to obtain preauthorization only after the patient's Medicare benefits are exhausted.

Additionally, Section 701 of the NDAA-03 continues our current policy that pre-authorization is not required in the case of an emergency.

II. Medicare Provider Certification Applicable to TRICARE Individual Professional Providers

Section 705 of the NDAA-03 provides that Medicare certification of individual professional providers shall be considered sufficient documentation to also certify authorized individual professional providers under TRICARE. When an individual professional provider has been certified by Medicare and meets one of the TRICARE individual professional provider categories, the Medicare certification shall be considered sufficient documentation to certify the provider under TRICARE.

Our contractors are currently in compliance with this provision. By accepting Medicare certification as sufficient documentation, TRICARE has reduced the administrative burden of separately applying for certification under two federal health care programs. While our contractors are currently in compliance with this provision this interim final rule is necessary to add the statutory language to our regulation.

Section 705 continues the current TRICARE policy of excluding providers

who are sanctioned or who have program integrity violations under Medicare, TRICARE, or other Federal health programs. Such providers are specifically excluded as TRICARE providers.

III. TRICARE Dental Program

Currently, eligibility in the TDP includes any such dependent of a member who died while on active duty for a period of more than 30 days or a member of the Ready Reserve if the dependent was enrolled on the date of the death of the member. The exception to this is that the term does not include the dependent after the end of the three-year period beginning on the date of the member's death. Section 703 of the NDAA FY03 TRICARE changes eligibility in the TDP by including any such dependent of a member who dies while on active duty for a period of more than 30 days or a member of the Ready reserve if, on the date of the death of the member, the dependent is enrolled in dental benefits plan or is not enrolled in such a plan by reason of a discontinuance of a former enrollment due to transfer to a duty station where dental care is provided to the member's eligible dependents under a program other than that plan. The exception remains that the term does not include the dependent after the end of the three-year period beginning on the date of the member's death.

IV. Regulatory Procedures

Section 801 of title 5, United States Code, and Executive Order 12866 requires certain regulatory assessments and procedures for any major rule or significant regulatory action, defined as one that would result in an annual effect of \$100 million or more on the national economy or which would have other substantial impacts.

The Regulatory Flexibility Act (RFA) requires that each Federal agency prepare, and make available for public comment, a regulatory flexibility analysis when the agency issues a regulation which would have a significant impact on a substantial number of small entities.

This is not a major rule under 5 U.S.C. 801. It is a significant regulatory action but not economically significant. In addition, we certify that this proposed rule will not significantly affect a substantial number of small entities. This rule has been designated as significant and has been reviewed by the Office of Management and Budget as required under the provisions of E.O. 12866.

Paperwork Reduction Act

This rule, as written, imposes no burden as defined by the Paperwork Reduction Act of 1995 (44 U.S.C. 3501-3511). If, however, any program implemented under this rule causes such a burden to be imposed, approval thereof will be sought from the Office of Management and Budget in accordance with the Act, prior to implementation.

List of Subjects in 32 CFR Part 199

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

■ Accordingly, 32 CFR Part 199 is amended as follows:

PART 199—[AMENDED]

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

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

■ 2. Section 199.4 is amended by revising paragraph (a)(12)(ii)(A) and the first sentence in paragraph (b)(6)(ii)(A) and adding a new paragraph (a)(12)(ii)(E) to read as follows:

§ 199.4 Basic program benefits.

(a) * * *

(12) * * *

(ii) *Preadmission authorization.* (A)

This section generally requires preadmission authorization for all non-emergency inpatient mental health services and prompt continued stay authorization after emergency admissions with the exception noted in paragraph (a)(12)(ii) of this section. It also requires preadmission authorization for all admissions to a partial hospitalization program, without exception, as the concept of an emergency admission does not pertain to a partial hospitalization level of care. Institutional services for which payment would otherwise be authorized, but which were provided without compliance with preadmission authorization requirements, do not qualify for the same payment that would be provided if the preadmission requirements had been met.

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(E) Preadmission authorization for inpatient mental health services is not required in the following cases:

(1) In the case of an emergency.

(2) In a case in which benefits are payable for such services under part A of title XVIII of the Social Security Act (42 U.S.C. 1395c *et seq.*) subject to paragraph (a)(12)(iii) of this section.

(3) In a case of inpatient mental health services in which paragraph (a)(12)(ii) of this section applies, the Secretary shall