



## DEPARTMENT OF DEFENSE

### Office of the Secretary

#### 32 CFR Part 199

[Docket ID: DOD-2017-HA-0058]

RIN 0720-AB71

### **TRICARE: Referring of Physical Therapy and Occupational Therapy by Doctors of Podiatric Medicine Acting Within the Scope of their License**

**AGENCY:** Office of the Secretary, Department of Defense (DoD).

**ACTION:** Final rule.

**SUMMARY:** The DoD is amending its TRICARE regulation. Specifically, this rule allows coverage of otherwise authorized physical therapy (PT) and occupational therapy (OT) for TRICARE beneficiaries when such services are referred by a TRICARE-authorized Doctor of Podiatric Medicine, also known as a Podiatrist, acting within the scope of his/her license.

**DATES:** This rule is effective [INSERT DATE 30 DAYS FROM DATE OF PUBLICATION IN THE FEDERAL REGISTER].

**FOR FURTHER INFORMATION CONTACT:** Amber Butterfield, Defense Health Agency, TRICARE Health Plan, Medical Benefits and Reimbursement Section, (303) 676-3565 or [amber.l.butterfield.civ@mail.mil](mailto:amber.l.butterfield.civ@mail.mil).

### **SUPPLEMENTARY INFORMATION:**

#### **I. Executive Summary**

##### **A. Purpose of the Rule**

This rule permits coverage of services referred by TRICARE-authorized Podiatrists for PT and OT. Prior to the issuance of this regulatory action, the language of Title 32 Code of Federal Regulations (CFR), § 199.4(c)(3)(x) stated that PT and OT may be cost-shared when services are referred and monitored by a physician, certified physician assistant, or certified

nurse practitioner. As a result, otherwise authorized PT and OT services for TRICARE beneficiaries were not covered benefits when Podiatrists (even when acting within their scope of license) referred the services. Podiatrists are included in the provider category of “Other allied health professional” listed in 32 CFR 199.6(c)(3)(iii) and are recognized by TRICARE statute, 10 U.S.C. 1079(a), as authorized to assess or diagnose illness, injury, or bodily malfunction as a prerequisite for TRICARE coverage of otherwise allowable treatment. According to the American Podiatric Medical Association, all United States jurisdictions recognize podiatrists as independent practitioners and do not limit Podiatrists’ authority to refer their patients to PT and OT services. This rule makes it possible for that care to be cost-shared by the TRICARE program.

State governments generally regulate the licensure and practice of health care professionals, and DoD limits TRICARE benefits coverage to services and supplies furnished by otherwise authorized TRICARE individual professional providers performing within the scope of their state license or certification; granted by the applicable state or jurisdiction. State scope of practice laws vary with regard to the range of services, and some include the authority to refer PT and OT. Title 32 CFR 199.6(c)(1) provides that licensing be interpreted as requiring a license to practice in the jurisdiction where services are being furnished; generally a state license in the United States, or for care and treatment provided outside the continental United States, whatever comparable jurisdictional requirements (including licensure or certification) may exist in the host nation. Title 32 CFR 199.1(b) states that the regulation applies in all foreign countries, unless specific exemptions are granted by the Director. After assessing the information available, DoD has determined that it is unnecessarily restrictive not to cover otherwise authorized PT and OT services for TRICARE beneficiaries merely because the services are referred by a Podiatrist. Therefore, the regulation is amended to allow TRICARE coverage of PT and OT services when referred by a Podiatrist who is a TRICARE-authorized provider and acting within the scope of their state licensure or certification.

## **B. Summary of Major Provisions**

This rule allows TRICARE coverage of otherwise authorized PT and OT services when referred by a TRICARE-authorized Podiatrist, acting within the scope of his/her state licensure or certification.

## **C. Legal Authority for this Program**

This rule is issued under 10 U.S.C. 1073 (a)(2) giving authority and responsibility to the Secretary of Defense to administer the TRICARE program. The text of 10 U.S.C. chapter 55 can be found at <https://manuals.health.mil/pages/DisplayManual.aspx?SeriesId=MD>.

## **II. Regulatory History**

The Department of Defense published a proposed rule in the Federal Register on April 8, 2019 (84 FR 13855). Comments were accepted for 60 days, and the comment period closed on June 7, 2019. A total of 22 comments were received. Those comments and the resulting changes to the rule text are described in the next section.

## **III. Discussion of Comments & Changes**

The majority of comments received supported the proposed rule as a time and cost-saving measure for TRICARE beneficiaries as well as the TRICARE program. Included were comments received from organizations representing various medical fields regarding specific aspects of the rule. These comments provided feedback that in part, resulted in several changes to the rule text. The changes include: refocusing to solely address referrals by Podiatrists instead of all “Other allied health professionals” to refer for PT and OT; revising the nomenclature for Podiatrists from Doctors of Podiatry or Surgical Chiropody to Doctors of Podiatric Medicine, or Podiatry; adding Podiatrists to the list of providers who can refer and provide ongoing oversight in order for the services of physical therapists and occupational therapists to be considered for benefits on a fee-for service basis; and removing the option in the proposed rule for Podiatrists to refer patients to speech therapy (ST) services based on the lack of direct relationship between

such a referral and podiatric practice. A discussion of the more significant comments concerning DoD's proposed rule, and our responses to these comments, are set forth below.

A commenter asked why TRICARE doesn't support the use of Physical Therapist Assistants (PTAs) and Certified Occupational Therapy Assistants (COTAs) in the care of its beneficiaries. The commenter also stated that TRICARE was the only payer source to have that restriction. The Department published a final rule on March 17, 2020, (85 FR 15061) which added certified or licensed PTAs and OTAs as TRICARE-authorized providers when supervised by a TRICARE-authorized physical therapist or occupational therapist in accordance with Medicare's rules for supervision and qualification.

Another commenter asserted that athletic trainers, if recognized by TRICARE as paramedical providers, would support the DoD in providing greater efficiencies through care coordination. The addition of athletic trainers as TRICARE-authorized providers is outside the scope of this rule.

Several commenters requested clarification regarding PTs, OTs, and STs' ability to self-refer where allowed by state law under the proposed rule. The commenters assert that as PTs, OTs and STs are recognized as "Other allied health professionals" under 32 CFR 199.6(c)(3)(iii), the proposed rule includes the ability for PTs, OTs, and STs to self-refer as well as refer beneficiaries to another therapy practitioner where allowed by state law. The commenters reason that when state law is silent, no referral from another health care professional is required, whereas when state law imposes a referral requirement, TRICARE coverage will hinge on the PTs, OTs, and STs securing a referral in accordance with state law. This rule is revised to only allow Podiatrists to refer for PT and OT services, therefore, the commenters' issue is moot. However, to respond to this comment generally, self-referral by TRICARE providers is prohibited under 32 CFR 199.6(a)(13)(xi), which directs providers to "refer CHAMPUS beneficiaries only to providers with which the referring provider does not have an economic interest, as defined in § 199.2." Title 32 CFR 199.2 defines economic interest as "(1) Any right,

title, or share in the income, remuneration, payment, or profit of a CHAMPUS-authorized provider, or of an individual or entity eligible to be a CHAMPUS-authorized provider, resulting, directly or indirectly, from a referral relationship; [...] (2) A referral relationship exists when a CHAMPUS beneficiary is sent, directed, assigned or influenced to use a specific CHAMPUS-authorized provider, or a specific individual or entity eligible to be a CHAMPUS-authorized provider.” Under these provisions, TRICARE-authorized providers are barred from self-referral, even if self-referral is acceptable under the state or jurisdiction’s licensure or certification requirements.

A commenter also requested clarification as to whether and how the “ongoing oversight and supervision” of the program of treatment would apply to “Other allied health professionals” who would refer TRICARE beneficiaries for therapy services. As an example, the commenter asked if a social worker [referring] occupational therapy for a TRICARE beneficiary, would have to sign the OT plan of care and would that same social worker have to monitor and sign off on any changes to the plan of care if there is a significant change in function for the TRICARE beneficiary 6 months after they initiated the plan of care. This rule is revised to only allow Podiatrists to refer PT and OT services; therefore the commenter’s issue is moot. However to address the commenter, consider a Podiatrist rather than a social worker referring OT for a TRICARE beneficiary. The Podiatrist will provide ongoing and continual supervision by signing the OT plan of care, monitoring treatment and signing off on any changes to the plan of care if there is a significant change in function for the TRICARE beneficiary six months after they initiated the plan of care. Requirements for referral and supervision are defined at § 199.6(c)(2)(iv).

#### **IV. Summary of Changes from NPRM**

We adopt the proposed rule with changes as described in the comment responses.

#### **V. Regulatory Analysis**

##### **A. Regulatory Planning and Review**

## **a. Executive Orders**

### **Executive Order 12866, “Regulatory Planning and Review” and Executive Order 13563, “Improving Regulation and Regulatory Review”**

Executive Orders (E.O.s) 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distribute impacts, and equity). E.O. 13563 emphasizes the importance of quantifying both costs and benefits, of reducing costs, of harmonizing rules, and of promoting flexibility. It has been determined that this rule is not a significant regulatory action. The rule does not: (1) Have an annual effect on the economy of \$100 million or more or adversely affect in a material way the economy; a section of the economy; productivity; competition; jobs; the environment; public health or safety; or State, local, or tribal governments or communities; (2) Create a serious inconsistency or otherwise interfere with an action taken or planned by another Agency; (3) Materially alter the budgetary impact of entitlements, grants, user fees, or loan programs, or the rights and obligations of recipients thereof; or (4) Raise novel legal or policy issues arising out of legal mandates, the President’s priorities, or the principles set forth in these Executive Orders.

### **Executive Order 13771, “Reducing Regulation and Controlling Regulatory Costs”**

E.O. 13771 seeks to control costs associated with the government imposition of private expenditures required to comply with Federal regulations and to reduce regulations that impose such costs. Consistent with the analysis of transfer payments under OMB Circular A-4, this rule does not involve regulatory costs subject to E.O. 13771.

## **b. Summary**

This rule allows TRICARE coverage of otherwise authorized PT and OT services when referred by a TRICARE-authorized Podiatrist acting within the scope of his/her license.

## **c. Affected Population**

This rule impacts all TRICARE beneficiaries, TRICARE-authorized providers, the TRICARE program and its Managed Care Support Contractors (MCSC). Beneficiaries will spend less time and expense obtaining referrals from their TRICARE-authorized primary care provider for PT and OT services related to foot and ankle conditions. Beneficiaries' courses of treatment will not be unnecessarily delayed by the need to obtain a referral from their primary care provider. TRICARE-authorized primary care providers and specialists will not need to spend unnecessary time seeing patients requiring PT or OT referrals for foot and ankle conditions, resulting in savings to the TRICARE program. TRICARE-authorized Podiatrists will be able to prescribe and oversee their patients' PT and OT courses of treatment. MCSCs will also be minimally impacted as this rule will require them to update their systems to accommodate the change.

#### **d. Costs**

Once beneficiaries initiate an episode of care with a Podiatrist for a covered disease or condition, they need not return to their primary care provider or specialist for an office visit to obtain an examination and a referral for PT and OT services. Assuming two hours by appointment (appointment, travel, waiting room, exam room), beneficiaries will save approximately 20,000 hours each year by not having to visit their referring provider prior to seeking PT or OT services. Referring providers will also save time, approximately 2,200 hours (15 minutes for a podiatrist to consult with a referring provider regarding a PT prescription) each year, as a result of reduced coordination and paperwork.

The amendment covers PT and OT services, when referred by a TRICARE-authorized Podiatrist acting within the scope of their license, and is not expected to increase the amount of otherwise covered PT and OT services. This is because referrals for such services are currently being written by those providers authorized to do so under the TRICARE program or those providers are countersigning prescriptions or referrals from a Podiatrist. The DoD does anticipate, however, that there may be a marginal increase in administrative costs to

accommodate changes to our contractors' systems, although the overall result of this change will create an efficiency in the process.

This rule does not create new costs to the government, because it falls under the Transfer Payment clause in accordance with OMB Circular A-4. As this rule states, TRICARE payments for PT and OT services provided to military beneficiaries and prescribed by TRICARE-authorized Podiatrists, represents an "Insurance Payment" as described in OMB Circular A-4.

#### **e. Benefits**

The primary impact of this rule will result in less time and expense spent by beneficiaries and referring providers to obtain necessary medical services and supplies. Almost 10,000 beneficiaries visited a primary care provider after seeking care from a Podiatrist, but prior to PT services, in 2017. With an average copay/cost-share of \$24 across networks and TRICARE programs, this rule will conservatively save beneficiaries up to \$230,000 per year in cost-sharing and will conservatively save TRICARE \$1.1 million per year as a result of reduced visits to referring providers.

#### **f. Alternatives**

DoD considered several alternatives to this rulemaking. The first alternative involved taking no action. Although this alternative would be the most cost neutral for DoD, it was rejected as not benefitting TRICARE beneficiaries in need of PT and OT services during the regular course of foot and ankle treatment. For example, and according to "American Podiatric Medical Association," plantar fasciitis is treated with conservative efforts such as PT and OT services before turning to surgery. Additionally following foot or ankle surgery PT and OT services are necessary as a part of the post-operative treatment. This alternative also placed TRICARE at odds with common practice by other health care entities.

The second alternative DoD considered, and the regulatory change offered in the proposed rule, was allowing all TRICARE-authorized "Other allied health professionals" to refer PT, OT and ST services. After the proposed rule was published, the Department received input



from internal and external stakeholders and ultimately determined that this alternative was problematic because more the half of the 18 types of TRICARE-authorized “Other allied health professionals” do not have the authority to diagnose and treat a mental or physical illness, injury or bodily malfunction in accordance with 10 U.S.C. 1079(a)(12). Commenters also raised concerns over self-referrals, causing the Department to re-evaluate this alternative. Moreover, in accordance with 32 CFR 199.6(c)(3)(iii), the majority of TRICARE-authorized “Other allied health professionals” require the ongoing monitoring and supervision of a physician for a program or episode of treatment. Those TRICARE-authorized “Other allied health professionals” who may not provide covered care independent of a physician include: Certified Physician Assistant, Anesthesiologist Assistant, Licensed Registered Nurse, Audiologist, Licensed Registered Physical and Occupational Therapists, Licensed Registered Speech Therapist, Nutritionist, Registered Dietician, and TRICARE Certified Mental Health Counselor. While certified physician assistants require supervision of a physician, they were given authority to refer for therapy services under a rule published on August 10, 2018 (75 FR 50882) due to changes in the way billing occurred under the national provider identification system, and to align with Medicare's allowance for nonphysician providers to provider referrals for therapy services. DoD finds it is appropriate to continue to allow certified physician assistants to refer and oversee therapy services due to the direct relationship physician assistants have with physicians, and because they often serve as a patient’s primary care provider, while not extending this privilege to other providers that may not provide independent care. Therefore DoD reconsidered this alternative and found it to be in conflict with current Program law. DoD considers the approach described in this final rule to be the most beneficial to both TRICARE beneficiaries and the TRICARE program. It offers time and cost savings and optimum continuity of care to beneficiaries, at no additional costs to the TRICARE program and affords the program the opportunity to expand health care delivery options.

**B. Public Law 96-354, “Regulatory Flexibility Act” (5 U.S.C. 601)**

The Department of Defense certifies that this final rule is not subject to the Regulatory Flexibility Act (5 U.S.C. 601) because it would not, if promulgated, have a significant economic impact on a substantial number of small entities. Therefore, the Regulatory Flexibility Act, as amended, does not require us to prepare a regulatory flexibility analysis.

#### **D. Congressional Review Act**

Pursuant to the Congressional Review Act (5 U.S.C. 801 et seq.), the Office of Information and Regulatory Affairs designated this rule as not a major rule, as defined by 5 U.S.C. 804(2).

#### **E. Sec. 202, Public Law 104-4, “Unfunded Mandates Reform Act”**

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) (2 U.S.C. 1532) requires agencies to assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of \$100 million in 1995 dollars, updated annually for inflation. This final rule will not mandate any requirements for State, local, or tribal governments, nor will affect private sector costs.

#### **F. Public Law 96-511, “Paperwork Reduction Act” (44 U.S.C. Chapter 35)**

This rulemaking does not contain a “collection of information” requirement, and will not impose additional information collection requirements on the public under Public Law 96-511, “Paperwork Reduction Act” (44 U.S.C. chapter 35).

#### **G. Executive Order 13132, “Federalism”**

E.O. 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. This final rule will not have a substantial effect on State and local governments.

## 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 (c)(3)(x)(A) to read as follows:

#### **§ 199.4 Basic program benefits.**

\* \* \* \* \*

(c) \* \* \*

(3) \* \* \*

(x) \* \* \*

(A) The services are prescribed and monitored by a physician, certified physician assistant, certified nurse practitioner or Doctor of Podiatric Medicine (Podiatrist) acting within the scope of their license.

\* \* \* \* \*

3. Section 199.6 is amended by:

- a. Revising paragraph (c)(3)(iii)(C);
- b. Revising paragraph (c)(3)(iii)(K)(2) introductory text;
- c. Removing paragraph (c)(3)(iii)(K)(2)(iii); and
- d. Adding paragraph (c)(3)(iii)(K)(3).

The revisions and addition read as follows:

#### **§ 199.6 TRICARE-authorized providers.**

\* \* \* \* \*

(c) \* \* \*

(3) \* \* \*

(iii) \* \* \*

(C) *Doctors of Podiatric Medicine or Podiatrists.*

\* \* \* \* \*

(K) \* \* \*

(2) The services of the following individual paramedical providers of care to be considered for benefits on a fee-for-service basis may be provided only if: the beneficiary is referred by a physician, certified physician assistant, certified nurse practitioner, or podiatrist; and a physician, certified physician assistant, certified nurse practitioner, or podiatrist must also provide continuing and ongoing oversight and supervision of the program or episode of treatment provided by these individual paramedical providers.

\* \* \* \* \*

(3) Licensed registered speech therapists (speech pathologists). In order to be considered for benefits on a fee-for-service basis, the services of a licensed registered speech therapist as an individual paramedical provider of care may be provided only if: (1) the beneficiary is referred by a physician, a certified physician assistant, or a certified nurse practitioner; and (2) a physician, a certified physician assistant, or a certified nurse practitioner must also provide continuing and ongoing oversight and supervision of the program or episode of treatment provided by these individual paramedical providers.

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Dated: November 12, 2020.

Aaron T. Siegel,

Alternate OSD Federal Register Liaison Officer, Department of Defense.

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