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TRICARE  
MANAGEMENT ACTIVITY

MB&RS

CHANGE 6  
6010.47-M  
APRIL 17, 2003

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FOR  
TRICARE POLICY MANUAL

The TRICARE Management Activity has authorized the following addition(s)/  
revision(s) to the 6010.47-M, reissued March 2002.

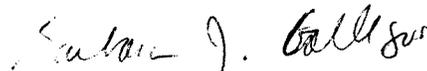
**CHANGE TITLE:** CONSOLIDATED PRIORITY MANUALS CHANGE

**PAGE CHANGE(S):** See pages 2 through 5.

**SUMMARY OF ADDITIONS/REVISIONS:** The attached package is a consolidation of six separate change orders previously coordinated with the Managed Care Support Contractor (MCSCs) as part of the bilateral contracting process. They include the: 1) High Priority 7 Change Package; 2) Consolidated Policy Manual Update; 3) Consolidated TRICARE Reimbursement Manual Update; 4) Cost Operations Manual Update; 5) No-Cost Operations Manual Update; and 6) ADP Manual Update. These consolidated manual changes will be issued as a single unilateral change order.

**IMPLEMENTATION DATE:** The Implementation Date is August 1, 2003.

This change is made in conjunction with May 1999 ADP Manual, Change No. 35; Mar 2001 MCSC Operations Manual, Change No. 24; and Mar 2002 Reimbursement Manual, Change No. 14.

  
Barbara J. Gallegos  
Director, Office of Medical Benefits  
and Reimbursement Systems

**ATTACHMENT(S):** 242 PAGE(S)

**DISTRIBUTION:** 6010.47-M

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## SUMMARY OF CHANGES

### INTRODUCTION

1. Changes the cross-reference for the definition of unproven from 32 CFR 199.2 to 32 CFR 199.4 (g)(15).

### CHAPTER 1

2. Section 9.1 (**Immunization Injections**) extends coverage for the age appropriate doses of vaccines recommended and adopted by CDC's Advisory Committee on Immunization Practices (ACIP).
3. Section 10.1 (**TRICARE Standard - Clinical Preventive Services**) provides coverage of meningococcal vaccines for college students. It also extends coverage for the age appropriate doses of vaccines recommended and adopted by CDC's Advisory Committee on Immunization Practices (ACIP). Expands coverage of screening mammography from one every 24 months to one every 12 months for asymptomatic women over the age of 39; provides more frequent screening for individuals at increased risk for colon cancer and allows coverage of additional procedures (biopsy and tumor/polyp removal) performed during a routine screening sigmoidoscopy or colonoscopy. Removes the increased risk factor for coverage of fecal occult blood testing.
4. Section 10.1A (**TRICARE Prime - Clinical Preventive Services**) provides coverage of meningococcal vaccines for college students. It also extends coverage for the age appropriate doses of vaccines recommended and adopted by CDC's Advisory Committee on Immunization Practices (ACIP). Expands coverage of screening mammography from one every 24 months to one every 12 months for asymptomatic women over the age of 39. Provides more frequent screening for individuals at increased risk for colon cancer and allows coverage of additional procedures (biopsy and tumor/polyp removal) performed during a routine screening sigmoidoscopy or colonoscopy. The expanded procedure codes will be covered under the preventive benefit (i.e., the preventive diagnosis will be acceptable for coverage of the expanded procedure codes and referral/authorization will not be required). Removes the increased risk factor for coverage of fecal occult blood testing. Extends vision screening benefit for beneficiaries above the age of 64 that continue to be eligible under TRICARE Prime.
5. Section 10.2 (**Papanicolaou (Pap) Tests**) consolidates procedure code range.
6. Section 10.3 (**Well-Child Care**) provides coverage for a second PKU test and clarifies that well-child services are subject to the same cost-sharing/co-payment and authorization/referral requirements as preventive services.
7. Section 12.3 (**Attention Deficit/Hyperactivity Disorder**) removes the exclusion for the T.O.V.A.

## SUMMARY OF CHANGES (Continued)

### CHAPTER 1 (Continued)

8. Section 12.6 (**Psychotherapy**) adds D. to clarify that after 8 visits, PCM referral is not needed and that the health care can be authorized by First level reviewer.
9. Section 13.1 (**Biofeedback**) removes confusing statement “cost-sharing” or “cost-sharing provided for” to further clarify policy.
10. Section 16.1 (**Ophthalmological Services - Basic Program**) clarifies the level of services available to active duty family members for routine eye examinations under section 632 of P.L. 98-525 signed into effect on October 19, 1994.
11. Section 17.1 (**Speech Services**) adds exclusion regarding services for occupational and educational deficits.
12. Section 19.1 (**Non-Invasive Vascular Diagnostic Studies: Cerebrovascular Arterial Studies**) removes Peripheral from the title, expands the CPT code range to 93888 and removes the exclusion of carotid bruit analysis.
13. Section 20.1 (**Pulmonary Services**) allows other medically proven indications.
14. Section 21.1 (**Allergy Testing And Treatment**) updates the policy to reflect the circumstances in which serial skin test endpoint titration may not be cost-shared under TRICARE. Deletes #5 under B. Unproven allergy treatments.
15. Section 25.1 (**Physical Therapy**) clarifies that PT is reimbursed based on the appropriate CPT code and reinserts policy criterion to ensure that physical therapy services are only covered when a patient has been diagnosed and evaluated by a physician. Removes gait analysis as an exclusion and rewords #10 for clarity. Updates CPT code range adding 96000-96004 for gait analysis.
16. Section 25.3 (**Occupational Therapy**) adds sensory integration to exclusions and rewords #7 for clarity.
17. Section 26.1 (**Nutritional Therapy**) includes the requirement that nutritional products that are classified by the U.S. Food and Drug Administration (FDA) as “Exempt Infant Formula not generally available at the retail level” may be cost-shared. This revision was not a benefit change; rather, it provided greater specificity than the former policy with regard to what nutritional therapy products can be cost-shared. Since the FDA does not maintain a current list of products meeting the above criteria, nutritional therapy products listed on the Enteral Nutrition Product Classification List maintained by the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) may be considered for TRICARE cost-sharing.

## SUMMARY OF CHANGES (Continued)

### CHAPTER 1 (Continued)

18. Section 26.3 (**Hyperbaric Oxygen Therapy**) reference added for coverage. Peripheral vascular disease removed as an exclusion, however it is not covered under the Hyperbaric Oxygen Therapy Committee.
19. Section 28.1 (**Telemedicine/Telehealth**) new policy for coverage and reimbursement of telemedicine.

### CHAPTER 3

20. Section 1.6A (**Heart Transplantation**) adds coverage for transplants performed in TRICARE-approved pediatric consortium heart transplant centers.
21. Section 1.6B (**Heart-Lung And Lung Transplantation**) allows coverage for the use of FLOLAN in patients with pulmonary hypertension secondary to the scleroderma spectrum of diseases, whether or not they have been approved and are awaiting lung transplant, adds pediatric consortia to coverage and removes ICD codes 33.50, 33.51, 33.52, 33.6.
22. Section 1.6C (**Liver Transplantation**) changes the exclusions in regard to active alcohol or substance abuse--criterion 2(a)(1) to the patient has been abstinent (at least six months prior to transplantation is recommended), adds pediatric consortia to coverage, removes ICD codes 50.51, 50.59 and adds criteria for coverage: demonstrates plans for a long-term adherence to a disciplined medical regimen are feasible and realistic.
23. Section 1.6D (**Small Intestine - Combined Small Intestine-Liver And Multivisceral Transplantation**) adds pediatric consortia to coverage.
24. Section 1.6E (**Liver-Kidney Transplantation**) changes the exclusions in regard to active alcohol or substance abuse--criterion 2(a)(1) to the patient has been abstinent (at least six months prior to transplantation is recommended) and adds pediatric consortia to coverage.
25. Section 1.6F (**Kidney Transplantation**) adds that pediatric consortia is not available for kidney transplants and clarifies what services are covered related to a kidney transplant and removes ICD codes 55.61, 55.69.
26. Section 1.6G (**Simultaneous Pancreas-Kidney, Pancreas-After-Kidney, And Pancreas-Transplant-Alone**) adds pancreas-after-kidney and pancreas-transplant alone as a covered benefit, adds coverage under pediatric consortia and adds cross reference to organ center certification.
27. Section 1.6J (**Combined Heart-Kidney Transplantation**) adds coverage for pediatric consortia.

## SUMMARY OF CHANGES (Continued)

### CHAPTER 3 (Continued)

28. Section 2.1 (**Integumentary System**) adds coverage for cultured skin grafts for diabetic foot ulcers.
29. Section 2.3 (**Prophylactic Mastectomy And Prophylactic Oophorectomy**) adds prophylactic oophorectomies as a covered benefit and adds criteria for coverage of a prophylactic mastectomy.
30. Section 2.6 (**Breast Reconstruction As A Result Of A Congenital Anomaly**) changes the title from "Breast Construction" to "Breast Reconstruction" and clarifies that all breast deformities when related to a verified congenital anomaly are covered.
31. Section 5.3 (**Photopheresis**) adds coverage for the prevention of rejection in cardiac transplantation, and a general coverage provision when indication is proven.
32. Section 5.5 (**GDC-Endovascular Coiling For Unruptured Intracranial Aneurysms**) new policy which adds coverage for GDC endovascular coiling, for unruptured intracranial aneurysms.
33. Section 6.1 (**High Dose Chemotherapy And Stem Cell Transplantation**) clarification has been provided under description B. and Policy C. and E. Adds allogeneic peripheral stem cell transplantation as a covered procedure. Adds coverage under HDC with ABMT/ PSCT for non-Hodgkin's follicular lymphoma and changes the qualifying criteria, adds coverage of Hodgkin's disease under certain conditions, adds tandem autologous stem transplantation for multiple myeloma, adds osteosarcoma (osteogenic sarcoma) and adds germ cell tumors in a second or subsequent relapse. For allogeneic stem cell transplantation with or without HDC the following covered conditions are added; multiple myeloma when HDC with ABMT or PSCT has failed, x-linked hyper-IgM syndrome and Chediak-Higashi Syndrome. X-linked hyper-IgM syndrome is added for allogeneic umbilical cord blood transplantation.
33. Section 6.1 (Continued) Under exclusions epithelial is added in front of ovarian cancer. Removal from the list of exclusions are: HDC with ABMT or PSCT for yolk sac tumor (endodermal sinus tumor), in vitro stem cell processing (purging), allogeneic BMT or PSCT with HDC for treatment of multiple myeloma, HDC with ABMT or PSCT for low-grade non-Hodgkin's lymphoma and allogeneic peripheral stem cell transplantation for non-Hodgkin's lymphoma. Corrections include the spelling of hypereosinophilic syndrome, cross-reference in paragraph III. Policy I.2. from paragraph III. A. to III.B., under allogeneic umbilical cord blood transplantation "for children and adolescents" is deleted as well as the duplicate reference to non-Hodgkin's lymphoma. The effective date for allogeneic umbilical cord blood transplants is changed from August 1, 1996 to January 1, 1995.

## SUMMARY OF CHANGES (Continued)

### CHAPTER 3 (Continued)

34. Section 8.3 (**Transjugular Intrahepatic Portosystemic Shunt (TIPS)**) adds language “this list is not all inclusive” those indications for which reliable evidence supports that the procedure is safe, effective and comparable or superior to standard care (proven) are also covered.” TIPS for refractory ascites is added as a covered indication and the exclusion of TIPS for refractory ascites is removed.
35. Section 9.1 (**Urinary System**) adds coverage of enuretic device. Clarifies the policy by adding reference to the FDA policy and a NOTE section as an example of a device that has received FDA approval and the indication for use of the device is supported by reliable evidence. To avoid conflict with policy criteria in Chapter 7, Section 10.1, the bladder stimulator reference in the exclusion section was deleted.
36. Section 13.2 (**Maternity Care**) adds two exclusions; lymphocyte or paternal leukocyte immunotherapy in the treatment of recurrent spontaneous fetal loss and salivary estriol test for pre-term labor.
37. Section 13.5 (**Fetal Surgery**) provides new policy guidelines on fetal surgery.
38. Section 15.4 (**Stereotactic Radiosurgery/Radiotherapy**) adds coverage for additional conditions for proton beam radiosurgery/radiotherapy when medically necessary and appropriate and when conventional radiotherapy is contraindicated. Coverage is approved for glioblastoma multiforme, soft tissue sarcoma (liposarcoma), Hodgkin’s disease when conventional radiotherapy is contraindicated, acoustic neuromas, and the treatment of juvenile nasopharyngeal angiofibroma when provided as adjuvant therapy after failure of surgery or for extensive intracranial extension. Coverage is added for extracranial stereotactic radiosurgery/radiotherapy for primary and metastatic lung carcinoma. Coverage is added for frameless stereotaxy (neuronavigation) for given indications. Removes the exclusion of proton beam radiosurgery/radiotherapy for glioblastoma multiforme.
39. Section 17.2 (**Cochlear Implantation**) allows reimbursement of the replacement of the cochlear implant external speech processor device.

### CHAPTER 4

40. Section 1.3 (**SPECT**) additional covered codes added.
41. Section 2.1 (**Magnetic Resonance Imaging (MRI) And Magnetic Resonance Angiography (MRA)**) adds CPT codes 72198, 73725, 74185. Changes paragraph C to: MRA is covered when medically necessary, appropriate and the standard of care and deletes the exclusion of MRA for other than head and neck.

## SUMMARY OF CHANGES (Continued)

### CHAPTER 4 (Continued)

42. Section 5.1 (**Radionuclide Imaging Procedure**) reinstates old policy and adds Indium 111 Pentetreotide (Octreoscan) Scintigraphy for the localization and monitoring of treatment of primary and metastatic neuroendocrine tumors.

### CHAPTER 7

43. Section 2.1 (**Ambulance Service**) extends coverage of ambulance transfers ordered by military personnel, provides guidelines for reimbursement of ambulance services and supplies when the patient is not transported to a hospital and updates HCPC procedure codes.
44. Section 4.3 (**Orthotics**) modifies the exclusion for cranial orthosis and cranial molding helmets to state "when used alone as sole treatment of craniosynostosis." Additional terms for nonsynostotic positional plagiocephaly (deformational plagiocephaly, plagiocephaly without synostosis) are added.
45. Section 4.4 (**Prosthetic Devices**) expands coverage which was previously limited to limbs, eyes and voice prostheses to include prosthetic devices for ears, noses and fingers. Implements Section 702 of National Defense Authorization Act for Fiscal Year 1998, which authorizes purchase of prosthetic devices; as determined by the Secretary of Defense, to be necessary because of significant conditions resulting from trauma, congenital anomalies, or disease.
46. Section 7.1 (**Pharmacy**) adds back language regarding the exclusion of placebo drugs and injections and early fills, adds clarification regarding holds on new or refilled prescriptions and adds website locations to obtain additional information regarding the use of Viagra. Changes exclusion paragraph I.E. on treatment INDs to correspond with the language in 32 CFR 199.4(g)(15) regarding cost-sharing of medical care related to the use of treatment INDs.
47. Section 16.1 (**Unproven Devices, Medical Treatment And Procedures**) adds #45 the Heidelberg Retina Tomograph (HRT), a scanning image ophthalmoscope used in the diagnosis and treatment of patients with glaucoma, #65 lymphocyte or paternal leukocyte immunotherapy in the treatment of recurrent spontaneous fetal loss, and #84 salivary estriol test for preterm labor. Removes: #5 allogeneic peripheral stem cell transplantation for non-Hodgkin's lymphoma, #14 bladder stimulators, #38 extracorporeal immunoabsorption using Protein A column, #42 gait analysis, #50 b. and e. high dose chemotherapy with stem cell rescue for testicular cancer and yolk sac tumor, #60 in-utero fetal surgery, #65 keratomileusis, #70 MRA, #76 navelbine (unlabelled use for refractory platinum-resistant epithelial ovarian cancer), #80 OrthoLogic 1000, #83 pelvic floor stimulators, #85 photopheresis, #88 photorefractive keratectomy, #89 proton beam radiosurgery, #90 positron emission tomography (PET), #92 proton beam radiosurgery/ radiotherapy for ependymoma and high grade glioma, #93 pulmonary rehabilitation, #95

## SUMMARY OF CHANGES (Continued)

### CHAPTER 7 (Continued)

47. Section 16.1 (Continued) radial keratotomy, #102 single photon emission computed tomography (SPECT), and #111 test of variable of attention (T.O.V.A.). The removal of paragraphs #65 keratomileusis, #88 photorefractive keratectomy, and #95 radial keratotomy is not whether these procedures are proven or unproven, but the fact that they are comparable to eyeglasses to correct a refractive error and are excluded from 32 CFR. The date of the unproven status of Home Uterine Activity Monitoring is updated to April 2000. Paragraph #48: high dose chemotherapy with stem cell rescue: epithelial is added in front of ovarian cancer.
48. Section 20.2 (**Exclusions**) adds the remainder of language to exclusion #39. Revises the exclusion on prostheses to: other than those determined to be necessary because of significant conditions resulting from trauma, congenital anomalies, or disease and corrects the cross-reference in paragraph 50 for the policy on eyeglasses to Chapter 7, Section 5.2, and deletes the following from #58: "Enuretic devices".
49. Section 23.1 (**Family Planning**) clarifies that emergency contraceptives are a covered benefit. This includes the Preven Emergency Contraceptive Kit approved by the FDA on September 2, 1998.
50. Section 26.1 (**Adjunctive Dental Care**) adds clarification on preauthorization, coverage of professional services and when benefits may be cost-shared. Provides clarification of coverage of adjunctive dental and orthodontia for severe congenital anomalies.
51. Section 28.1 (**Diabetes Outpatient Self-management Training Services**) adds new policy on coverage of Diabetes Outpatient Self-Management Training Services.

### CHAPTER 8

52. Section 1.1 (**Program For Persons With Disabilities (PFPWD): General**) adds language that indicates TRICARE is 1st payer for allowable IDEA Part C services.
53. Section 1.3 (**Program For Persons With Disabilities (PFPWD): Benefit Authorization**) changes the valid authorization period from a maximum of 6 months to a maximum of 12 months.
54. Section 1.4 (**Program For Persons With Disabilities (PFPWD): Public Facility Use Certification**) adds language that indicates no certification is required when TRICARE is 1st payer for allowable IDEA Part C services.
55. Section 1.5 (**Program For Persons With Disabilities (PFPWD): Eligibility General**) corrects typo "or" to "of" in I.A.2.

## SUMMARY OF CHANGES (Continued)

### CHAPTER 8 (Continued)

56. Section 1.7 (**Program For Persons With Disabilities (PFPWD): Eligibility Qualifying Condition - Serious Physical Disability**) clarifies the type of hearing testing to be used in determining hearing loss.
57. Section 1.15 (**Durable Equipment And Durable Medical Equipment**) provides policy when a beneficiary transfers from the jurisdiction of the MCSC who issued an authorization for purchase of equipment and proration of its allowable cost into another MCSC jurisdiction.

### CHAPTER 9

58. Section 4.1 (**Continued Health Care Benefit Program**) removes the National Mail Order Pharmacy Program (NMOP) as a CHCBP exclusion. CHCBP eligibles may use the TMOP (TRICARE Mail Order Pharmacy).

### CHAPTER 10

59. Section 7.1 (**Certification Of Organ Transplant Centers**) adds criteria for certification of pancreas-after-kidney and pancreas-transplantation-alone centers, and adds pediatric consortium transplant center certification. The effective date paragraph is changed to add a provision for retroactive certification by changing the sentence to read; For those centers meeting the certification requirements, approval is effective on the date the application is signed by the applicant or the date the contractor determines that the facility met TRICARE certification requirements.
60. Section 13.1 (**Corporate Services Provider Class**) establishes a new corporate services provider class which will provide beneficiaries and the government access to a source of competitive ambulatory and in-home health care rendered by professional service corporations. The specific types of providers who fall within this category include: 1) radiation therapy programs; 2) cardiac catheterization clinics; 3) free-standing sleep disorder diagnostic centers; 4) independent physiological laboratories; 5) free-standing kidney dialysis centers; 6) free-standing magnetic resonance imaging centers; 7) Comprehensive Outpatient Rehabilitation Facilities (CORFs); and 8) Home Health Agencies (HHAs). The contractors will no longer be responsible for verification of the qualifications of employed and/or contracted individual providers. Authorization requirements under the new corporate provider class place the burden of ensuring that all individuals meet TRICARE requirements on the corporate service entity. This assurance is further strengthened by requiring Medicare certification as a condition of authorization under the program, since Medicare also relies on the delegation of certification of individual professional and allied health providers to the corporate entity. Although the actual provider of care still has to be identified on the claim form, verification of the qualifications of employed or contracted individuals will be left up to the corporate entity.

## SUMMARY OF CHANGES (Continued)

### CHAPTER 10 (Continued)

61. Addendum E (**Application Form For Corporate Services Providers**) is the information collection form that will be used by the contractor in determining whether the provider meets the criteria for authorization as a corporate services provider under the TRICARE program.

### CHAPTER 11

62. Section 1.1 (**Medical Records**) adds that medical record requirements are the same for computerized or electronic medical records as they are for paper.
63. Section 7.1 (**Primary Care Managers**) clarifies the PCM by name requirement. Deletes the requirement to annotate referrals in the contractor's system.
64. Section 9.1 (**Special Authorization Requirements**) eliminates the preauthorization requirements for those beneficiaries having "other insurance" that provides primary coverage.
65. Section 10.1 (**Transitional Assistance Management Program (TAMP)**) clarifies that cost-shares under TAMP are the same as those for family members of active duty members and removes expiration date of program.
66. Section 16.1 (**Qualified Accreditation Organization**) provides the criteria that must be met in order to be recognized as a qualified accreditation organization under TRICARE.
67. Section 17.1 (**Participation Agreement Requirements**) provides the minimum participation requirements that must be met by a provider in order to obtain authorization status under TRICARE.
68. Section 17.1, Enclosure 1 (**Participation Agreement**) provides an example of the qualifying participation agreement.

## SUMMARY OF CHANGES (Continued)

### CHAPTER 12

69. Section 8.1 (**TRICARE Overseas Program (Top) Prime - Clinical Preventive Services**) extends coverage for the age appropriate doses of vaccines recommended and adopted by CDC's Advisory Committee on Immunization Practices (ACIP) to overseas Prime beneficiaries. Expands coverage of screening mammography from one every 24 months to one every 12 months for asymptomatic women over the age of 39. Provides more frequent screening for individuals at increased risk for colon cancer and allows coverage of additional procedures (biopsy and tumor/polyp removal) performed during a routine screening sigmoidoscopy or colonoscopy. The expanded procedure codes will be covered under the preventive benefit (i.e., the preventive diagnosis will be acceptable for coverage of the expanded procedure codes and referral/authorization will not be required). Removes the increased risk factor for coverage of fecal occult blood testing. Extends vision-screening benefit for beneficiaries above the age of 64 that continue to be eligible under TRICARE Prime.

