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The Defense Health Agency has authorized the following addition(s)/revision(s).

**CHANGE TITLE: NATIONAL DEFENSE AUTHORIZATION ACT FISCAL YEAR 2016, SECTION 725,  
URGENT CARE PILOT**

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**PAGE CHANGE(S): See page 2.**

**SUMMARY OF CHANGE(S): The National Defense Authorization Act 2016 (section 725) mandates an Urgent Care Pilot effective May 23, 2016. The purpose of the pilot is to determine if the elimination of the requirement to obtain a referral influences beneficiaries to seek care at less intensive health care resources such as a TRICARE authorized Urgent Care Center, rather than the Emergency Room. The Secretary is required to carry out the pilot program for a period of three years.**

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## Referrals/Preauthorizations/Authorizations

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### 1.0 REFERRALS

**1.1** The contractor is responsible for reviewing all requests for referrals. The contractor shall not mandate an authorization, to include a medical necessity or utilization management determination, before referring a patient for an evaluation by a network Primary Care Manager (PCM) to obtain a referral prior to referring a beneficiary to a specialist. The contractor shall review the referral request, and if it is determined that the services being requested are not a TRICARE benefit, the beneficiary shall be informed that the services are excluded from coverage, and will not be paid by TRICARE, if obtained.

**1.2** The TRICARE beneficiary must be “held harmless” in cases where the network provider fails to request a referral and the contractor either denies payment or applies the Point Of Service (POS) option. If the referral involves services rendered by a non-network provider, “hold harmless” cannot apply, as “hold harmless” only applies to network providers. Once the patient is evaluated by the specialist, the contractor may require an authorization before the services are provided or the procedure performed. In those instances where a contractor requires authorization of services in addition to those listed in [Chapter 7, Section 2](#), such authorization must be available to and appealable by all beneficiaries, whether enrolled or not. Within Prime Service Areas (PSAs), the Military Treatment Facilities (MTFs) have the Right of First Refusal (ROFR) for all referrals, as determined by the Memorandum of Understanding (MOU) between the contractor and each MTF.

### 1.3 Urgent Care Referrals

Urgent care services are medically necessary services required for an illness or injury that would not result in further disability or death if not treated immediately, but does require professional attention within 24 hours. If urgent treatment is required by a TRICARE Prime enrollee after hours, while traveling away from their residence, or whose PCM is otherwise unavailable, the enrollee may contact their regional contractor (or designated provider) for assistance finding an appropriate facility/provider before receiving non-emergent care from a provider other than the PCM. If they do not coordinate urgent care with their PCM or regional contractor, the care may be covered under the POS option, resulting in higher out-of-pocket costs. If an enrollee is traveling overseas, he or she shall call the TRICARE Overseas Program (TOP) Regional Call Center for the region in which he or she is traveling to coordinate urgent care. **Exceptions allowed as described in [Chapter 18, Section 19](#).**

### 2.0 PREAUTHORIZATIONS/AUTHORIZATIONS

**2.1** The contractor is responsible for reviewing all requests for authorization. Issuance of authorizations shall not be used to restrict freedom of choice of the TRICARE Standard beneficiary who chooses to receive care from authorized non-network providers, except as required under [Chapter 7, Section 2](#).

**2.2** The contractor is required to advise beneficiaries, sponsors, providers, and other responsible persons of those benefits requiring authorization before payment may be made and inform them of the procedures for requesting the authorization. Although beneficiaries are required to obtain authorization prior to receiving payment for the care listed at [Chapter 7, Section 2](#), authorization may be requested following the care. Whether the authorization is requested before or after care, all qualified care shall be authorized for payment. The contractor shall emphasize the need for concerned persons to contact a Beneficiary Counseling Assistance Coordinator (BCAC)/Health Benefits Advisor (HBA) or the contractor for assistance.

**2.3** Because of the high risk that many services requiring special authorization may be denied, the contractor shall offer preauthorization for the care to all TRICARE beneficiaries who reside within its jurisdiction. The contractor shall process all requests for such authorization whether submitted by the beneficiary, sponsor or provider requesting authorization on behalf of the beneficiary.

**2.4** The contractor shall issue notification of preauthorization/authorization or waiver to the beneficiary or parent/guardian or a minor or incompetent adult, the provider, and to its claims processing staff. Notification may be made in writing by letter, or on a form developed by the contractor. These forms and letters are all referred to as TRICARE authorization forms. The contractor shall not issue an authorization for acute, inpatient mental health care for more than seven calendar days at a time.

**2.5** The contractor shall document authorizations. The contractor must also maintain an automated authorization file or an automated system of flagging to ensure claims are processed consistent with authorizations. The contractor shall verify that the beneficiary, sponsor, provider, and service or supply information submitted on the claim are consistent with that authorized and that the care was accomplished within the authorized time period.

**2.6** Prime enrollees receiving emergency care or authorized care from non-network, non-participating providers shall be responsible for only the Prime copayment. On such claims, contractors shall allow the amount the provider may collect under TRICARE rules; i.e., if the charges on a claim are subject to the balance billing limit (refer to the TRICARE Reimbursement Manual (TRM), [Chapter 3, Section 1](#) for information on balance billing limit), the contractor shall allow the lesser of the billed charges or the balance billing limit (115% of allowable charge). If the charges on a claim are exempt from the balance billing limit, the contractor shall allow the billed charges. Refer to the TRM, [Chapter 2, Section 1](#) for information on claims for certain ancillary services.

**2.7** The requirement that a TRICARE Prime enrollee obtain a referral/authorization from their PCM to receive the H1N1 immunization from a non-network, TRICARE-authorized provider has been temporarily waived from October 1, 2009 to May 1, 2010. During this period, Prime enrollees may obtain the H1N1 immunization from a non-network TRICARE-authorized provider without prior authorization or PCM referral. POS cost-shares normally associated with non-referred care obtained by Prime enrollees from non-network providers without appropriate authorization will not apply during this period.

### **3.0 FAILURE TO COMPLY WITH PREAUTHORIZATION - PAYMENT REDUCTION**

During claims processing, provider payments shall be reduced for failure to comply with the preauthorization requirements for certain types of care. See the TRM, [Chapter 1, Section 28](#), for

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## Chapter 18

## Section 1

### General

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#### 1.0 PURPOSE OF AND AUTHORITY FOR DEMONSTRATIONS

Section 1092, Chapter 55, Title 10 of the United States Code (USC) allows the Secretary of Defense to conduct studies and demonstration projects. This section also specifies that the Secretary may enter into contracts with public or private organizations to conduct these studies and demonstrations.

#### 2.0 ORGANIZATION

In the spring of 1985, the Director, Defense Health Agency (DHA) was charged with the responsibility for administering all medical care demonstrations for the Department of Defense (DoD). This chapter provides specific instructions regarding processing claims which are affected by demonstrations.

#### 3.0 RESTRICTIONS ON SCOPE OF BENEFITS FURNISHED UNDER DEMONSTRATION PROJECTS

3.1 Proposed new benefits provided under demonstration authority must receive DHA agency coordination in the same manner as any other proposed TRICARE benefit; and

3.2 Unless specific statutory demonstration authority provides otherwise, benefits may not be provided under a demonstration project that would otherwise be considered unproven under TRICARE Standard.

- END -



## EXPIRED - Department Of Defense (DoD) Cancer Prevention And Treatment Clinical Trials Demonstration

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### 1.0 PURPOSE

The purpose of this demonstration is to improve TRICARE-eligible family member access to promising new cancer therapies, assist in meeting the National Cancer Institute's (NCI) clinical trial goals, and to assist in the formulation of conclusions regarding the safety and efficacy of emerging therapies in the prevention and treatment of cancer. The Department of Defense's (DoD's) financing of these sponsored studies will include Phase II and Phase III protocols approved under the NCI for all types of cancer.

### 2.0 BACKGROUND

**2.1** On November 16, 1998 (Vol 63, No. 220) the **Federal Register** announced the one year extension of a demonstration project in which the DoD provides TRICARE reimbursement for eligible beneficiaries who receive cancer treatment under approved NCI clinical trials. A **Federal Register** Notice was published on January 5, 2000, extending the DoD Cancer Prevention and Treatment Clinical Trials Demonstration until such time the Interagency Agreement between DoD and the NCI is terminated. Extending the demonstration will allow for an evaluation of costs associated with this demonstration project.

**2.2** The NCI sponsors and actively coordinates an extensive clinical trials program for the evaluation of prevention, early detection, treatment, and supportive care for various types of cancer. The NCI's program includes sponsorship of studies in single institutions, as well as large, multi-center, randomized trials in cooperative networks. The trials encompass studies of cancers occurring in virtually all anatomical sites and in all stages of development. The NCI clinical trials program has been the means by which the oncology community has developed most of the formal clinical evidence for the efficacy of the various prevention, early detection, and management approaches in treating cancer.

**2.3** In support of NCI's efforts to further the science of cancer treatment, the DoD expanded its breast cancer demonstration to include all NCI-sponsored Phase II and Phase III clinical trials. This expanded demonstration will enhance current NCI efforts to determine safety and efficacy of promising cancer therapies by expanding the patient population available for entry into clinical trials and stabilizing the referral base for these clinical activities.

**2.4** On June 21, 1999, the Assistant Secretary of Defense (Health Affairs) (ASD(HA)) expanded the successful partnership with the NCI by allowing TRICARE eligible family members to participate in NCI sponsored clinical trials in cancer prevention in addition to cancer treatment. Cancer prevention clinical trials include screening and early detection clinical trials. This expansion of the current demonstration will enhance continued NCI efforts to determine safety and efficacy of

promising cancer prevention strategies by expanding the patient population available for entry into clinical trials and stabilizing the referral base for these clinical activities.

**2.5** While this demonstration provides an exception to current TRICARE benefit limitations, the DoD hypothesizes that this increased access to innovative cancer strategies will occur at a cost comparable to that which the DoD has experienced in paying for conventional care under the TRICARE Standard program. The results of the demonstration will provide a framework for determining the scope of DoD's continued participation in the NCI's clinical research efforts.

### **3.0 POLICY**

**Note:** Effective June 21, 1999, the DoD expanded the demonstration to include NCI sponsored cancer prevention, screening and early detection clinical trials.

**3.1** Effective January 1, 1996, the cancer demonstration was authorized for those TRICARE-eligible patients selected to participate in NCI sponsored Phase II and Phase III studies for treatment of cancer. NCI sponsorship of clinical trials occurs through the Cancer Therapy Evaluation Program (CTEP), Cooperative Group Studies, NCI Grants or Cancer Center Studies. Evidence of NCI sponsorship in one of these categories will be that it is identified in the NCI comprehensive database, Physicians's Data Query (PDQ), or NCI supplements to that database; formal notification of approval from The Clinical Protocol Review and Monitoring Committee; or verification from the NCI project officer; or through protocols co-sponsored by the NCI and other federal agencies.

**3.2** The DoD will cost-share all medical care and testing required to determine eligibility for an NCI-sponsored trial, including the evaluation for eligibility at the institution conducting the NCI-sponsored study. DoD will cost-share all medical care required as a result of participation in NCI sponsored studies. This includes purchasing and administering all approved chemotherapy agents (except for NCI-funded investigational drugs), all inpatient and outpatient care, including diagnostic and laboratory services not otherwise reimbursed under an NCI grant program if the following conditions are met:

- The provider seeking treatment for a TRICARE-eligible family member in an NCI approved protocol has obtained preauthorization for the proposed treatment before initial evaluation; and
- Such treatments are NCI sponsored Phase II or Phase III protocols; and
- The patient continues to meet entry criteria for said protocol; and
- The institutional and individual providers are TRICARE-authorized providers.

**3.3** The DoD will not provide reimbursement for care rendered in the National Institutes of Health Clinical Center or costs associated with non-treatment research activities associated with the clinical trials. Costs associated with non-treatment research activities may include administrative costs, such as, record keeping costs, publication costs, etc.

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**3.4** Cost-shares and deductibles applicable to TRICARE also apply under this Demonstration. For TRICARE Prime enrollees, including those enrolled in Uniformed Services Family Health Plan (USFHP), applicable copays apply.

**Note:** Those patients enrolled in the previous breast cancer demonstration prior to January 1, 1996 (the effective date of the expanded cancer demonstration), will continue to have cost-shares and deductibles waived through the completion of their protocol. Waiver of the cost-shares and deductibles apply regardless of whether they were randomized to the experimental or conventional arm of the protocol.

**3.5** Retroactive authorizations can be authorized in accordance with the provisions outlined in [32 CFR 199.4\(g\)\(19\)](#). A retroactive authorization for coverage of a cancer clinical trial can be issued to those beneficiaries who began participation in such trial before termination of the cancer demonstration. such retroactive authorization for coverage under the cancer demonstration rules can be issued even after termination of the Demonstration.

**3.6** The demonstration will expire on March 31, 2008. Requirements of this chapter as related to cancer demonstration cease at 12:00 midnight on March 31, 2008, except for claims for demonstration enrollees whose treatment is in progress when the Demonstration expires. The Demonstration retains responsibility for these claims until the beneficiary is discharged from the cancer clinical trial. For cancer clinical trials benefit, see TRICARE Policy Manual (TPM), [Chapter 7, Section 24.1](#).

**3.7** The records management requirements described in [Chapter 2](#) apply to cancer demonstration records.

#### **4.0 APPLICABILITY**

**4.1** The Demonstration applies to all TRICARE-eligible beneficiaries. Active duty members continue to be eligible for Direct Care (DC) system services. The demonstration does not apply to Continued Health Care Benefit Program (CHCBP) enrollees.

**4.2** Since demonstration benefits are not the same as TRICARE benefits, all inquiries and claims related to the Demonstration, including claims for conventional therapy under Phase III protocols shall be submitted to the appropriate contractor, referencing the DoD Cancer Prevention and Treatment Clinical Trials Demonstration.

**4.3** Since the DoD has no authority regarding the NCI protocol eligibility for the sponsored study, if a patient does not meet the criteria for enrollment, appeal rights do not apply.

#### **5.0 GENERAL DESCRIPTION OF ADMINISTRATIVE PROCESS**

**5.1** The attending oncologist or physician shall determine the eligible patient's needs and consult with the contractor/NCI to determine which, if any, Phase II or Phase III, NCI-sponsored studies are appropriate for the patient.

**5.2** Following the identification of an appropriate sponsored study within the terms of the Demonstration, the attending oncologist or physician shall apply for Demonstration benefits to the case manager's office specially designated at the contractor.

**5.3** Following a validation of the eligibilities of the patient and the sponsored study under the terms of the Demonstration, the contractor shall issue a written decision to both the patient and the applicant provider.

**5.4** All claims for approved care under the Demonstration shall be submitted to the contractor for adjudication.

## **6.0 DEFENSE HEALTH AGENCY (DHA) AND CONTRACTOR RESPONSIBILITIES**

**6.1** DHA will provide:

**6.1.1** Demonstrations will be non-financially underwritten transactions and follow vouchering rules set forth in the contract.

**6.1.2** Case management and claims adjudication functions via specific contractual arrangement(s) with one or more Demonstration claims processors.

**6.1.3** Periodic review and evaluation of the Demonstration claims adjudication process.

**6.1.4** Specific written guidance to the Demonstration claims processor(s) regarding case management services and claims adjudication services to be provided by the claims processor under the terms of the Demonstration.

**6.1.5** Public affairs functions to properly inform and periodically update the patient and provider communities regarding the terms of the Demonstration.

**6.2** The contractor shall:

**6.2.1** Provide a registered nurse to serve as case manager for inquiries and actions pertinent to the Demonstration.

**6.2.2** Ensure the provider has submitted a letter on the facility's letterhead certifying:

**6.2.2.1** The protocol is an NCI sponsored study; and

**6.2.2.2** The index patient meets all entry criteria for said protocol; and

**6.2.2.3** Notification will be provided to the contractor's Demonstration case manager of the patient's registration date when treatment actually begins; and

**6.2.2.4** Notification will be provided to the contractor's Demonstration case manager if the patient becomes ineligible for the study prior to treatment.

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**6.2.3** Verify the letter from the facility includes the patient's name, sponsor's Social Security Number (SSN), the title and phase of the protocol, and the NCI number of the protocol and/or other appropriate evidence of NCI sponsorship.

**6.2.4** Subscribe to the NCI's Comprehensive Cancer Database known as the PDQ, to assist in determining whether a particular study meets the requirements of the Demonstration and whether the patient is eligible for a particular protocol. For those studies that are not listed on the PDQ, the contractor will work with NCI staff to verify NCI sponsorship.

**6.2.4.1** Unlike the other NCI sponsorship categories listed in [paragraph 3.1](#), protocols for Cancer Center Studies are not individually reviewed by the NCI. Instead, the NCI designates specific institutions as meeting NCI criteria for clinical and comprehensive cancer centers. Cancer center protocols receive approval through an NCI approved institutional peer review and quality control system at the institution. Protocols which have been through this process receive formal notification of approval from The Clinical Protocol Review and Monitoring Committee and, therefore, are considered NCI sponsored, but may not appear in the PDQ. A provider who is seeking to enter a patient into a Cancer Center Study must provide evidence of NCI sponsorship by forwarding the formal notification of approval from this specific committee. Formal notification of approval by the Clinical Protocol Review and Monitoring Committee will be required for approval of treatment in Cancer Center Studies which are not otherwise sponsored through the CTEP program, NCI cooperative groups, or NCI grants.

**6.2.4.2** Certain protocols listed in the PDQ may not be clearly identified in terms of NCI sponsorship. Clinical trials conducted as part of an NCI grant, or those identified with a "V" number, must be verified for NCI sponsorship with the NCI project officer. Physicians who are holders of the grant at the institution must provide written clarification that the proposed treatment is a protocol under their NCI grant. The grant title and number must be specified.

**6.2.4.3** Requests for treatment in clinical trials overseas must be verified as to NCI sponsorship with the NCI project officer.

**6.2.4.4** Protocols that are co-sponsored by the NCI and other Federal Agencies must be verified by the NCI project officer.

**6.2.5** Verify the patient's eligibility on the Defense Enrollment Eligibility Reporting System (DEERS).

**6.2.5.1** If the patient is authorized to receive the care under the Demonstration, but DEERS reflects that the patient is not eligible, a statement shall be added to the authorization letter indicating before benefits can be paid, the patient must be listed as eligible on DEERS.

**6.2.5.2** The patient shall be referred to the pass/ID card section of the military installation nearest their home for an eligibility determination.

**6.2.5.3** If a patient is listed on DEERS as being eligible as of the date the cancer therapy begins, all services provided as a result of participation in an NCI sponsored study shall be covered. This also applies to patients whose treatment is in progress when the Demonstration expires.

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**6.2.6** Issue an authorization ([Figure 18.2-2](#)) or denial ([Figure 18.2-3](#)) letter to the applicant provider and patient once a determination is made regarding a particular protocol.

**6.2.7** Establish and maintain a database of patients participating in the Demonstration. The database shall include the patient's name, sponsor's SSN, name and number of protocol, type of cancer, hospital name, and address and total cost.

**6.2.8** Furnish a list of enrollees in the Demonstration to the contractor's Program Integrity Unit with instructions to run an annual post-payment report to determine if hospitals are receiving additional unlawful payments as a result of also receiving payment under TRICARE. If such payment exists, it shall be the responsibility of the contractor to initiate recoupment action for any Demonstration benefits paid in error. This function will be supervised by the **DHA** Program Integrity Office (PI).

**6.3** The contractor may at its discretion establish a dedicated toll-free telephone number to receive inquiries from both patients and providers regarding the Demonstration. If a dedicated toll-free telephone number is established for this demonstration, the phone shall be staffed seven hours a day during normal business hours. In the absence of a dedicated toll-free number for Demonstration inquiries, contractors shall use their primary toll-free telephone inquiry system (see [Chapter 11, Section 6](#) and [Chapter 20, Section 4](#)).

**6.4** The contractor may at its discretion establish a dedicated mailing address where Demonstration inquiries and claims shall be sent for expedited response and/or claims adjudication. In the absence of a dedicated mailing address for Demonstration inquiries and claims, contractors shall use their primary address(es) for written correspondence and claims (see [Chapter 11, Sections 4, 5](#), and [Chapter 20, Section 4](#)).

## **7.0 CLAIMS PROCESSING REQUIREMENTS**

**7.1** Verify TRICARE-eligibility on the DEERS prior to payment.

**7.2** Both institutional and professional charges shall be reimbursed based on billed charges.

**7.2.1** The cancer center shall submit all charges on the basis of fully itemized bills. Each service and supply shall be individually identified and submitted on the appropriate claim forms.

**7.2.2** All claims for medical care required as a result of participation in an NCI sponsored study for cancer prevention or treatment that is not a TRICARE benefit, shall be processed and paid under the demonstration.

**7.3** Cost-shares and deductibles applicable to TRICARE will also apply under the Demonstration. For TRICARE Prime enrollees, including those enrolled in USFHP, applicable copays will apply.

**7.3.1** The contractor shall query the DEERS Catastrophic Cap and Deductible Data (CCDD) to determine the status of deductible and catastrophic cap met amounts for TRICARE-eligible beneficiaries at the time the costs are listed on the voucher for processing and payment.

## EXPIRED - Department Of Defense (DoD) In-Utero Fetal Surgical Repair Of Myelomeningocele Clinical Trial Demonstration

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### 1.0 PURPOSE

This demonstration will improve access to patients with fetuses who have a prenatal diagnosis of myelomeningocele; and to assist in meeting clinical trial goals under the Management of Myelomeningocele Study (MOMS) Protocol, in the formulation of conclusions regarding the safety and efficacy of intrauterine repair of fetal myelomeningocele.

### 2.0 BACKGROUND

**2.1** The current state of the medical literature does not allow for a TRICARE benefit for in-utero surgical intervention for myelomeningocele as it is considered unproven. This determination is based on a Blue Cross Blue Shield (BCBS) technology assessment conducted in February 1999, which examined health outcomes resulting from prenatal correction to fetal malformations known to interfere with organ development (in a potentially fatal manner), and surgical techniques for which prenatal corrections have been developed and applied in humans. Because the evidence for in-utero repair of myelomeningocele was too scant, BCBS did not conduct a detailed analysis. Likewise, **Defense Health Agency's (DHA's)** December 1999 and October 2001 medical reviews of literature did not reveal any new evidence to justify TRICARE coverage for in-utero surgical repair of myelomeningocele.

**2.2** On February 13, 2003 (Vol 68, No 30), the **Federal Register** announced a demonstration project in which the DoD provide TRICARE reimbursement for active duty members, former members, and their dependents to receive prenatal and postnatal surgical intervention for the repair of myelomeningocele under approved National Institute of Child Health and Human Development (NICHD) clinical trial.

**2.3** The NICHD agreed to sponsor and actively coordinate an unblinded randomized controlled clinical trial program for the evaluation of the safety and efficacy of intrauterine repair of fetal myelomeningocele. Two hundred eligible patients whose fetuses have been diagnosed with myelomeningocele at 16 to 25 weeks' gestation who are at the age of 18 years or older would be screened for enrollment via telephone by the Biostatistics Center (BCC) at George Washington University in Rockville, Maryland, to undergo an initial evaluation. The NICHD program includes sponsorship in three participating MOMS Centers (Vanderbilt University Medical Center in Nashville, the University of California at San Francisco, and Children's Hospital of Philadelphia) where final evaluation and screening will be performed.

**2.4** Approximately 60,000 TRICARE births occur at the Military Treatment Facilities (MTF) each year. Approximately 40,000 TRICARE births occur in the civilian hospitals. According to the Center of Disease Control, in 2001 there were 20.09 cases of spina bifida per 100,000 births; approximately 19 cases would occur annually in TRICARE. This Demonstration Project is projected to have approximately 6 to 16 TRICARE patients that has a fetus with a prenatal diagnosis of spina bifida participating in the protocol each year. DoD financing of this procedure will assist in meeting clinical goals and arrival at conclusions regarding the safety and efficacy of intrauterine repair of fetal myelomeningocele.

### **3.0 POLICY AND ELIGIBILITY**

**3.1** Effective March 17, 2003, the myelomeningocele demonstration is authorized for all eligible DoD beneficiaries including Active Duty Service Members (ADSMs) selected to participate in the NICHD-sponsored clinical trial for the treatment of myelomeningocele as outlined in the Myelomeningocele Clinical Trial Demonstration Protocol (MCTDP) (Figure 18.3-1).

**3.2** The DoD will cost-share all medical care and testing required to determine eligibility for the NICHD-sponsored clinical trial, including the evaluation of eligibility at the institution conducting the NICHD-sponsored study, except to the extent that these services are covered by Other Health Insurance (OHI) of the beneficiary, or through grant support from the NICHD to participating institutions.

**3.3** DoD will cost-share all medical care required as a result of participation in NICHD sponsored clinical trials. This includes purchasing and administering all approved pharmaceutical agents, perioperative, preoperative and postoperative x-ray or magnetic resonance imaging procedures and ultrasound procedures, physical examination, laboratory investigations, surgical interventions, postoperative management, and peripartum medical or surgical interventions including management of complications not otherwise reimbursed under NICHD grant program or beneficiaries' OHI if the following conditions are met:

**3.4** The providers have obtained preauthorization for the proposed treatment before initial evaluation. If a preauthorization was not obtained before the initial evaluation, preauthorization can take place once the referral sheet from the MOMS Centers is received. A preauthorization for enrollment will suffice to cover each incidental expense or claim related to participation in the NICHD sponsored trial extending through the duration of the clinical trial. A preauthorization is required even when the beneficiary has OHI and must include verification with the NICHD that the patient has been enrolled in the NICHD-sponsored trial; and such treatments are those indicated in NICHD sponsored protocols; and the patient continues to meet entry criteria for said protocol.

**3.5** The DoD will not provide reimbursement for costs associated with any non-treatment research activities associated with the clinical trial. This includes, but is not limited to:

- Data collection activities;
- Management and analysis of the data;
- Salaries of the research nurses;
- Travel to and from participating fetal surgery centers, per diem and hotel accommodation cost.

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**Note:** These research costs will not be the responsibility of the patient participating in the trial but will be covered by NICHD grant program or the grantee Institution. If travel costs to and from the participating fetal surgery centers are not covered by NICHD grant program, DoD beneficiaries may receive any travel entitlements they are entitled to under the Joint Travel Regulations, the Joint Federal Travel Regulations, or the TRICARE Prime specialty care travel benefit as the case may be.

**3.6** Cost-shares and deductibles applicable to TRICARE will also apply under this Demonstration. For TRICARE Prime enrollees, including those enrolled in Uniformed Services Family Health Plan (USFHP), applicable copays will apply, if any.

**3.7** The Assistant Secretary of Defense (Health Affairs) (ASD(HA)) approved this DoD Demonstration commencing on the effective date of participation, which is the date 30 calendar days after publication of the Notice in the **Federal Register**, with those enrolled having periodic examinations during a three year follow-up period.

#### **4.0 APPLICABILITY**

**4.1** The provisions of this demonstration are limited to those TRICARE-eligible beneficiaries and ADSMs whose fetuses have been diagnosed with myelomeningocele at 16 to 25 weeks' gestation and who are at the age of 18 years or older (on the date of enrollment). The demonstration does not apply to those TRICARE-eligible beneficiaries enrolled in the Continued Health Care Benefit Program (CHCBP).

**4.2** Inquiries and claims related to the Demonstration's prenatal protocol, excluding claims for the post-natal protocol, shall be submitted to the South Region referencing the DoD In-Utero Fetal Surgical Repair of Myelomeningocele Clinical Trial Demonstration. All inquiries and claims related to the Demonstration's post-natal protocol shall be submitted to the appropriate regional Managed Care Support (MCS) contractor, as these services are covered under the Basic Program. The DoD has no authority regarding the NICHD protocol eligibility for the sponsored study. Therefore, if a patient does not meet the criteria for enrollment, appeal rights do not apply.

#### **5.0 GENERAL DESCRIPTION OF ADMINISTRATIVE PROCESS**

The regional MCS contract shall verify the TRICARE eligibility of the patient on the Defense Enrollment Eligibility System (DEERS). Patient selection will be made by the BCC at George Washington University in Rockville, Maryland in accordance with the protocol. Those patients remaining eligible and interested will be assigned by the BCC to one of the three participating MOMS Centers. The contractor will not be involved in medical necessity or clinical review of the Demonstration claims. Claims for approved care under the Demonstration shall be submitted to the South Region for adjudication.

#### **6.0 ASD(HA) RESPONSIBILITIES**

ASD(HA) is the designated Executive Agent for the Demonstration project. They shall designate a project officer in the Office of the DASD (Clinical Services) for the Demonstration. The project officer shall provide clinical oversight and resolve any clinical issue among DoD, NICHD, and MCTDP.

## 7.0 THE BCC

For the myelomeningocele clinical trial, the BCC will serve as a referral center for patients and coordinate the outcome evaluations, including both the review of the Magnetic Resonance Imaging (MRI), and ultrasounds, as well as the infant follow-up examinations. The BCC may be contacted at:

Dr. Catherine Shaer, Program Manager  
Management of Myelomeningocele Study (MOMS)  
The Biostatistics Center, The George Washington University  
6110 Executive Boulevard, Suite 750  
Rockville, MD 20852

Call toll-free: 1-866-ASK-MOMS (1-866-275-6667)

Fax toll-free: 1-866-458-4621

<http://www.spinabifidamoms.com>

## 8.0 PARTICIPATING MOMS CENTERS

**8.1** Participating MOMS Centers will be responsible for obtaining information regarding possible Third Party Liability (TPL) and OHI coverage of the TRICARE beneficiary. The MOMS Centers shall collect from third party or the OHI and bill any remaining balance of the total amount to the appropriate regional contractor within 30 calendar days of the receipt of the payment from the OHI. The MOMS Centers shall ensure proper entry regarding the OHI on the Centers for Medicaid and Medicare Services (CMS) 1450 UB-04 claim form before submitting the claim form to the contractor.

**8.2** In the event that the MOMS Centers are unable to collect from a third party or the OHI for health care services that would be covered under the TPL or by the OHI if provided by a private provider, no bill shall be presented by the MOMS Centers to the DoD contractor. The MOMS Centers shall determine patient acceptance for participation in the Demonstration in accordance with the protocol outlined in [Figure 18.3-1](#).

**8.3** Participating MOMS Centers shall request reimbursement for inpatient services provided under the Demonstration completing a CMS 1450 UB-04 and submitting the form to the appropriate regional contractor. Reimbursement will be based on billed charges, which will cover all professional and institutional services. The MOMS Centers shall be responsible for collecting the beneficiary cost-shares from TRICARE patients. The participating MOMS Centers shall submit all charges on the basis of fully itemized bills.

**8.4** The MOMS Centers shall establish a POC to respond to inquires related to participation in the Demonstration and for coordination with the regional contractors. Unless otherwise agreed to between NICHD and DoD/DHA, the coordination support by the MOMS Centers shall be provided for up to 12 months after termination of the demonstration.

## **9.0 DHA AND CONTRACTOR RESPONSIBILITIES**

### **9.1 DHA will provide:**

- A special fund for the purpose of the demonstration.
- Periodic review and evaluation of the Demonstration claims adjudication process.
- Beneficiary Education and Support Division (BE&SD) functions to properly inform and periodically update the patient and provider communities regarding the terms of the Demonstration.

### **9.2 The contractor shall:**

**9.2.1** Verify the patient's eligibility on DEERS. If the patient is authorized to receive the care under the Demonstration, but DEERS reflects that the patient is not eligible, a statement shall be added to the authorization letter indicating before benefits can be paid, the patient must be listed as eligible on DEERS. If a patient is listed on DEERS as being eligible as of the date enrollment begins, all services provided as a result of participation in an NICHD sponsored study shall be covered. This also applies to patients whose treatment is in process when the Demonstration expires.

**9.2.2** Issue an authorization to the applicant provider and patient once a determination is made regarding eligibility and/or a particular protocol.

**9.2.3** Refer eligible patients to BCC for initial screening and protocol information for participation in the study.

**9.2.4** Furnish a list of enrollees in the Demonstration to the contractor's Program Integrity Unit with instructions to run an annual post-payment report to determine if hospitals are receiving additional unlawful payments as a result of also receiving payment under TRICARE. If such payment exists, it shall be the responsibility of the contractor to initiate recoupment action for any Demonstration benefits paid in error. This function will be supervised by the DHA Program Integrity Office (PI).

**9.2.5** Establish and maintain a database of patients participating in the Demonstration. The database shall include the patient's name, sponsor's Social Security Number (SSN), name and number of protocol, treatment, hospital name and address and total cost. The database shall also include the date the TRICARE beneficiary was either accepted, or denied enrollment into the clinical trial and the patient shall be carried in the database until the Demonstration ends.

## **10.0 CLAIMS PROCESSING REQUIREMENTS**

**10.1** Claims under the NICHD clinical trial demonstration project shall be processed by the South Region. Jurisdiction edits shall not apply thereby ensuring that claims are paid and submitted to the DHA in accordance with current requirements for not at risk funds.

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**10.2** Verify TRICARE-eligibility on the DEERS prior to payment.

**10.3** Both institutional and professional charges shall be reimbursed based on billed charges.

**10.3.1** The NICHD participating MOMS Centers shall submit all charges on the basis of fully itemized bills. Each service and supply shall be individually identified and submitted on the appropriate claim forms.

**10.3.2** Claims for medical care required as a result of participation in an NICHD sponsored study for in-utero fetal repair of myelomeningocele or treatment that is not a TRICARE benefit (i.e., the Demonstration's pre-natal protocol portion), shall be processed and paid under the South Region.

**10.3.3** Cost-shares and deductibles applicable to TRICARE will also apply under the Demonstration. For TRICARE Prime enrollees, including those enrolled in USFHP, applicable copays will apply.

**10.3.4** The contractor shall query the DEERS Catastrophic Cap and Deductible Data base (CCDD) to determine the status of deductible and catastrophic cap met amounts for TRICARE-eligible beneficiaries at the time the costs are listed on the voucher for processing and payment. The contractor shall determine what expenses to apply to the deductible and catastrophic cap and report these to the CCDD. These expenses shall be reported at the same time the costs are listed on the voucher for processing, prior to payment of the claim.

**10.4** Double coverage provisions apply. Acceptable evidence of processing by the double coverage plan is outlined in the TRICARE Reimbursement Manual (TRM), [Chapter 4](#). In double coverage situations, the Demonstration will pay the balance after the OHI has paid.

**10.5** Claims shall be paid from the applicable non-underwritten bank accounts, see [Chapter 3](#), and submitted through normal TRICARE Encounter Data (TED) processing as required in the TSM with the applicable coding for clinical trials.

**10.6** Once in-utero fetal surgical repair of the myelomeningocele becomes a TRICARE benefit, claims for treatment shall be processed and paid based on the regional contractor's implementation date for the change. If a claim spans the implementation date, the contractor shall process and pay those charges on the claim that are prior to the implementation date and the regional contractor shall process the remaining charges under its at-risk contract. The contractor shall notify the provider the claim has been split for processing of charges as of the date of implementation for the TRICARE benefit. If the patient is an inpatient at the time in-utero fetal surgical repair of the myelomeningocele becomes a TRICARE benefit, and the claim is subject to the DRG-based payment, then the claim cannot be split. Under these circumstances, the entire claim shall be processed and paid under the Demonstration.

**10.7** A Non-Availability Statement (NAS) is not required under the Demonstration.

## EXPIRED - Department Of Defense (DoD) Weight Management Demonstration

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### 1.0 PURPOSE

This demonstration will allow the Department of Defense (DoD) to determine the efficacy and acceptability of pharmacotherapy and distance behavioral interventions in producing and maintaining clinically significant weight loss in an at-risk overweight or obese individual. The Weight Management Demonstration (hereby referred to as the Demonstration) will also provide information that will enable DoD to determine whether to seek a change in statute to authorize, as part of the TRICARE benefit, behavior modification either alone or with pharmacotherapy for the treatment of patients that are overweight or obese.

### 2.0 BACKGROUND

**2.1** Obesity is the seventh leading cause of preventable death in the United States contributing to more than 112,000 deaths annually. All segments of the DoD population demonstrate upward weight trends with approximately 13% of active duty, 34% of non-active duty, and 19% of dependent DoD adolescents classified as obese according the National Institutes of Health (NIH). Many high volume, high cost medical conditions, including diabetes, heart disease, back and joint pain, asthma, some cancers, and sleep apnea are related to obesity.

**2.2** According to the Centers of Disease Control and Prevention (CDC) in the four demonstration states, there are 315,000 eligibles in total. Out of the 315,000 eligibles, approximately 71,000 Prime enrollees are age 18 and older, and approximately 45,000 Prime enrollees meet the definition for overweight or obese.

**2.3** Under TRICARE, the treatment of obesity, as a sole medical condition, is excluded by law [10 USC 1079(a)(11)]. As a result, TRICARE policy is limited to proven surgical interventions for individuals with associated medical conditions (i.e., hypertension, cholecystitis, narcolepsy, diabetes mellitus, pickwickian syndrome (and other severe respiratory diseases), hypothalamic disorders, and severe arthritis of the weight-bearing joints). TRICARE does not cover non-surgical treatment of obesity or morbid obesity for dietary control or weight reduction (i.e., nutritional or behavioral counseling or weight loss medication).

**2.4** One of the priorities of the Assistant Secretary of Defense for Health Affairs (ASD(HA)) is to establish a uniform weight management program for TRICARE Prime enrollees in the Military Health System (MHS). Therefore, on July 6, 2005 (Vol 70, No 38888), the **Federal Register** announced a demonstration project in which the DoD will provide TRICARE reimbursement for Prime enrollees (excluding active duty members and those enrolled in special programs) residing in Indiana, Illinois, Michigan, and Ohio to receive weight management intervention for the treatment of obesity.

**2.5** The Demonstration project is planned for three years. The Demonstration will continue based on outcome measures related to utilization rates, weight loss rates, and success of pharmacotherapy.

### **3.0 POLICY AND ELIGIBILITY**

**3.1** Effective October 1, 2005, the Demonstration is authorized for overweight (Body Mass Index (BMI > 25)) non-active duty TRICARE Prime enrollees, who are age 18 to 64, residing in Ohio, Michigan, Indiana, or Illinois.

**3.2** The Demonstration does not apply to active duty members or those TRICARE-eligible beneficiaries enrolled in special programs (i.e., Extended Care Health Option (ECHO)) available through TRICARE.

### **4.0 MANAGED CARE SUPPORT CONTRACTOR (MCSC) RESPONSIBILITY**

**4.1** The MCSC shall enroll eligible beneficiaries into the Demonstration through the Defense Online Enrollment System (DOES) based on applications received from the Demonstration contractor. The MCSC is not required to verify or validate enrollment information. Rather, the MCSC is simply the data entry portal for reporting the enrollment to the Defense Enrollment Eligibility Reporting System (DEERS). The MCSC shall accomplish the required data entry within five calendar days of receiving an approved enrollment application from the Demonstration contractor. Enrollments that cannot be effected because of ineligibility on DEERS or because of invalid or incomplete information shall be returned to the Demonstration contractor with an explanation of the problem within five calendar days of receipt of the application.

**4.2** The MCSC shall disenroll beneficiaries and make changes as necessary. The MCSC shall notify the Demonstration contractor of any changes in status from DEERS.

**4.3** The MCSC shall provide Pharmacy Data Transaction Service (PDTs) with a weekly list of all enrollments completed during the week. The list will include: beneficiary's name, beneficiary's Social Security Number (SSN), sponsor's name, sponsor's SSN, beneficiary's address and date of enrollment into the Demonstration. The weekly list shall be e-mailed to **pdt.ameddcs@amedd.army.mil**.

**4.4** DoD will cost-share all medical care required as a result of participation in the Demonstration. This includes physician visits for medical management and prescription pharmacotherapy through the TRICARE Mail Order Pharmacy (TMOP).

**4.5** The MCSC shall process claims and allow TRICARE benefits for otherwise covered health care services (i.e., physician visit, medication management visit, etc.) related to the treatment of obesity. Normal TRICARE Prime cost-sharing applies.

### **5.0 APPLICABILITY**

The provisions of this demonstration are limited to those TRICARE-eligible beneficiaries as stated above in [paragraph 3.1](#).

## EXPIRED - Department Of Defense (DoD) Tobacco Cessation Demonstration

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### 1.0 PURPOSE

This demonstration will allow the Department of Defense (DoD) to determine the efficacy and acceptability of a telephone-based tobacco cessation quitline and pharmacotherapy in producing and maintaining tobacco cessation. The Tobacco Cessation Demonstration (hereby referred to as the Demonstration) will also provide information that will enable DoD to determine whether to authorize telephone-based tobacco cessation counseling alone or with pharmacotherapy as part of the TRICARE benefit.

### 2.0 BACKGROUND

**2.1** Tobacco use is the leading cause of preventable death in the United States. It is responsible for 440,000 deaths annually nationwide, including 14,000 in the DoD. The case for an expanded and comprehensive approach to DoD tobacco cessation is compelling. With estimated medical costs from tobacco use that exceed \$1.6 billion per year and the observation of an alarming increase in smoking prevalence among young active duty, the need for a global and effective DoD strategy has never been greater.

**2.2** Research indicates tobacco use has a negative impact on readiness during wartime (e.g., 20-50% reduction in night vision; rapid nicotine withdrawal affects cognitive functioning and visual acuity; significant decrement in tracking and longer reaction times). Tobacco use also:

- Puts individuals at greater risk for pneumonia, asthma, and lung disease;
- Results in more hospitalization and lost work in young active duty;
- Degrades performance on physical fitness tests; and
- Increases likelihood of sustaining musculoskeletal injuries.

**2.3** Substantial research confirms that pharmacotherapy, proactive telephone quitlines, and individual/group counseling are effective interventions. According to the Centers for Disease Control and Prevention (CDC), smokers are more likely to utilize telephone counseling than group and individual counseling. High intensity interventions are more effective than lower intensity ones. The Demonstration will provide the opportunity to test the effectiveness of potential benefit changes in the DoD population.

**2.4** One of the priorities of the Assistant Secretary of Defense for Health Affairs (ASD(HA)) is to establish a uniform tobacco cessation program for TRICARE Prime enrollees in the Military Health System (MHS). Therefore, on July 6, 2005 (Vol 70, No 38888), the **Federal Register** announced a demonstration project in which the DoD will provide TRICARE reimbursement for tobacco cessation services for TRICARE beneficiaries who meet the eligibility requirements outlined in

paragraph 3.1. The scope of services available through this demonstration will include:

- The availability of a proactive toll-free telephone quitline;
- The availability of a web-based tobacco cessation information resource;
- Prescription pharmacotherapy and physician visits, with normal copays; and
- Unlimited numbers of quit attempts.

This demonstration project is being conducted under the expanded Health Maintenance Organization (HMO) Uniform Benefit of the [32 CFR 199.18\(b\)\(2\)](#).

**2.5** The Demonstration project is planned for three years. The Demonstration will continue based on outcome measures related to utilization rates, quit rates, and success of pharmacotherapy.

### **3.0 POLICY AND ELIGIBILITY**

**3.1** Effective October 1, 2005, the Demonstration is authorized for TRICARE eligible beneficiaries enrolled in Prime, 18-64 years of age, and who are non-Medicare entitled and reside in the identified zip code areas of the demonstration. The demonstration area includes an area greater than 40 miles from inpatient Military Treatment Facilities (MTFs) in Colorado, Minnesota, Missouri, and Kansas.

**3.2** The Demonstration does not apply to those TRICARE-eligible beneficiaries enrolled in special programs (e.g., Extended Care Health Option (ECHO)) available through TRICARE.

### **4.0 MANAGED CARE SUPPORT CONTRACTOR (MCSC) RESPONSIBILITY**

**4.1** The MCSC shall enroll eligible beneficiaries into the Demonstration through Defense Online Enrollment System (DOES) based on applications received from the Demonstration contractor. The MCSC is not required to verify or validate enrollment information. Rather, the MCSC is simply the data entry portal for reporting the enrollment to Defense Enrollment Eligibility Reporting System (DEERS). The MCSC shall accomplish the required data entry within seven calendar days of receiving an approved enrollment application from the demonstration contractor. Enrollments that cannot be effected because of ineligibility on DEERS or because of invalid or incomplete information shall be returned to the demonstration contractor with an explanation of the problem within seven calendar days of receipt of the application.

**4.2** The MCSC shall provide the Pharmacy Data Transaction Service (PDTs) with a weekly list of all enrollments completed during the week. The list will include: beneficiary's name, beneficiary's Social Security Number (SSN), sponsor's name, sponsor's SSN, beneficiary's address, and date of enrollment into the Demonstration. The weekly list shall be e-mailed to [pdt.ameddcs@amedd.army.mil](mailto:pdt.ameddcs@amedd.army.mil).

**4.3** DoD will cost-share all medical care required as a result of participation in the Demonstration. This includes physician visits for medical management and prescription pharmacotherapy through the TRICARE Mail Order Pharmacy (TMOP).

**4.4** The MCSC shall process claims and allow TRICARE benefits for otherwise covered health care services (i.e., physician visits, medication management visits, prescription pharmaceuticals, etc.) related to tobacco cessation. Normal TRICARE Prime copays for provider visits and prescription

## EXPIRED - Department Of Defense (DoD) Alcohol Abuse Prevention And Education Demonstration

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### 1.0 PURPOSE

The purpose of this demonstration is to test the efficacy of web-based training in the avoidance of abusive behaviors related to alcohol consumption. This section is for information only.

### 2.0 BACKGROUND

**2.1** Web-based alcohol prevention education courses are a new and innovative approach to education that active duty members can relate to and feel comfortable with. Such an approach combines proven science-based teaching with the latest web-based media technologies. Available courses offer potentially engaging and easy to follow audio-visual productions including streaming video, interactive assignments and case studies, self assessments, customized feedback about current drinking levels, as well as final examinations. These courses also offer the benefit of being available at any time for the user. Additionally, due to the very nature of the internet, such programs also have the potential to provide researchers with a wealth of data that can help determine the outcomes of the program.

**2.2** This project will enhance Service-level Alcohol Prevention Education Program by providing another option for alcohol prevention education. The case of an expanded and innovative Department of Defense (DoD) approach to alcohol prevention education is compelling. According to the 2002 DoD "Survey of Health Related Behaviors Among Military Personnel," trends in alcohol consumption between 1982 and 1998 were showing great promise. Over this period, heavy alcohol consumption had declined by 36%, members facing serious consequences from alcohol consumption declined by 54%, and productivity losses from alcohol consumption declined by 60%. However, between 1998 and 2002, alarming trends have begun to emerge erasing many of the gains made in the late 1980s and 1990s. Heavy alcohol consumption increased by 27%. Additionally, for the first time, binge drinking was measured in the 2002 survey, and DoD rates of 18-25 year old active duty binge drinkers (53%) exceed civilian binge drinkers in the same age group (44%).

**2.3** Research of the literature and studies conducted within the Military Health System (MHS) indicate the impact of heavy alcohol use. According to the DoD Task Force Report on Care for Victims of Sexual Assault, alcohol use contributes to 50% of alleged sexual assaults by service members. Based on a review of active duty suicide data, alcohol was a factor in approximately 29% of all DoD suicides. In review of active duty private motor vehicle fatalities, alcohol contributed to 20-25% of those fatalities (civilian rate 40%). The DoD administratively separates more than 700 members per year for alcohol-related reasons. Research indicates alcohol reduces productivity by at least 1,764 Full Time Equivalent (FTEs)/year (treatments, illness, hospitalization, and duty losses). All these issues directly impact force readiness.

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**EXPIRED** - Department Of Defense (DoD) Alcohol Abuse Prevention And Education Demonstration

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**2.4** One of the priorities of the Assistant Secretary of Defense for Health Affairs (ASD(HA)) is to establish a uniform inexpensive web-based alcohol prevention education program for active duty in the MHS.

**2.5** The Alcohol Prevention Education Program is planned for two years. The Demonstration will continue based on outcome measures related to utilization rates, alcohol abuse rates, and who will need a continuum of services.

**3.0 ELIGIBILITY**

Effective October 1, 2005, the Demonstration is authorized for all active duty members.

**4.0 OPERATION**

The Alcohol Abuse Prevention and Education Demonstration will be operated by a Demonstration contractor. No Managed Care Support Contractor (MCSC) involvement is required.

- END -

## EXPIRED - TRICARE Demonstration Project For The State Of Alaska - Critical Access Hospital (CAH) Payment Rates

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### 1.0 PURPOSE

Under this demonstration project, TRICARE will reimburse Critical Access Hospitals (CAHs) in the state of Alaska in a similar manner as they are reimbursed under Medicare. This demonstration project will test adopting a Medicare-like CAH reimbursement methodology prior to nationwide implementation, in those states that have established State Flex Programs. It will also test CAH provider participation in TRICARE, beneficiary access to care, cost of health care services, military medical readiness, morale and welfare. This demonstration will be conducted under statutory authority provided in 10 United States Code (USC) 1092.

### 2.0 BACKGROUND

**2.1** Hospitals are authorized TRICARE institutional providers under 10 USC 1079(j)(2) and (4). Under 10 USC 1079(j)(2), the amount to be paid to hospitals, Skilled Nursing Facilities (SNFs), and other institutional providers under TRICARE, "shall be determined under joint regulations... which provide that the amount of such payments shall be determined to the extent practicable in accordance with the same reimbursement rules as apply to payments to providers of services of the same type under [Medicare]:". Under [32 CFR 199.14\(a\)\(1\)\(ii\)\(D\)\(1\)](#) through [\(9\)](#) it specifically lists those hospitals that are exempt from the Diagnosis Related Groups (DRG)-based payment system. CAHs are not listed as excluded, thereby making them subject to the DRG-based payment system. CAHs are not listed as exempt, because at the time this regulatory provision was written, CAHs were not a recognized entity.

**2.2** Legislation enacted as part of the Balanced Budget Act (BBA) of 1997 authorized states to establish State Medicare Rural Hospital Flexibility Programs, under which certain facilities participating in Medicare could become CAHs. CAHs represent a separate provider type with their own Medicare conditions of participation as well as a separate payment method. Since that time, a number of hospitals, acute care and general, as well as Sole Community Hospitals (SCHs), have taken the necessary steps to be designated as CAHs. Since the statutory authority requires TRICARE to apply the same reimbursement rules as apply to payments to providers of services of the same type under Medicare to the extent practicable, TRICARE must proceed with publication of a proposed and final rule to exempt CAHs from the DRG-based payment system and adopt a method similar to Medicare principles for these hospitals when it becomes practicable to implement. The purpose of the demonstration is to test implementation immediately for CAHs in the state of Alaska.

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EXPIRED - TRICARE Demonstration Project For The State Of Alaska - Critical Access Hospital (CAH)  
Payment Rates

**3.0 POLICY**

**3.1** Otherwise covered services and supplies provided by CAHs in the state of Alaska shall be reimbursed for inpatient and outpatient facility services at the lesser of the billed charge or on the basis of 101% of their allowable and reasonable costs. That is, an overall inpatient Cost-To-Charge Ratio (CCR) and overall outpatient CCR, obtained from data on the hospital's most recent Medicare cost report will be multiplied by the billed charge; the resulting amount will be increased by 1%. This amount shall be compared to the billed charge and the lesser of the two shall be paid to the provider.

**3.2** The following inpatient CCRs shall be effective for inpatient admission on or after July 1, 2007. The outpatient CCRs shall be effective for outpatient facility services with dates of service on or after July 1, 2007.

**FIGURE 18.7-1 CRITICAL ACCESS HOSPITALS (CAHs) IN ALASKA AND THEIR CCRS ON OR AFTER JULY 1, 2007**

<b>NAME</b>	<b>INPATIENT CCR</b>	<b>OUTPATIENT CCR</b>
Valdez Regional Health Authority (VRHA)	2.1029	1.3978
Providence Seward Medical & Care Center (PSMCC)	0.6799	0.7674
Sitka Community Hospital (SCH)	1.0100	0.8098
Petersburg Medical Center (PMC)	0.9762	0.8901
Wrangell Medical Center (WMC)	0.9445	0.7574
Providence Kodiak Island Medical Center (PKIMC)	0.6992	0.6079
Cordova Community Medical Center (CCMC)	1.0544	1.3456
Norton Sound Health Corporation (NSHC)	1.0438	1.1183
Ketchikan General Hospital (KGH)	0.5770	1.1669

**3.3** The following inpatient CCRs shall be effective for inpatient admission on or after July 1, 2008. The outpatient CCRs shall be effective for outpatient facility services with dates of service on or after July 1, 2008.

**FIGURE 18.7-2 CRITICAL ACCESS HOSPITALS (CAHs) IN ALASKA AND THEIR CCRS ON OR AFTER JULY 1, 2008**

<b>NAME</b>	<b>INPATIENT CCR</b>	<b>OUTPATIENT CCR</b>
Valdez Regional Health Authority (VRHA)	1.5739	1.2364
Providence Seward Medical & Care Center (PSMCC)	0.9906	0.6405
Sitka Community Hospital (SCH)	1.0852	0.8717
Petersburg Medical Center (PMC)	0.8958	0.8895
Wrangell Medical Center (WMC)	0.8391	0.7346
Providence Kodiak Island Medical Center (PKIMC)	0.6340	0.5586
Cordova Community Medical Center (CCMC)	0.6026	0.8697

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**FIGURE 18.7-2 CRITICAL ACCESS HOSPITALS (CAHs) IN ALASKA AND THEIR CCRS ON OR AFTER JULY 1, 2008 (CONTINUED)**

<b>NAME</b>	<b>INPATIENT CCR</b>	<b>OUTPATIENT CCR</b>
Norton Sound Health Corporation (NSHC)	1.0967	0.8851
Ketchikan General Hospital (KGH)	0.6827	0.6711

**3.4** The **Defense Health Agency (DHA)** shall provide a list of CAHs in the state of Alaska to the MCSC and the inpatient and outpatient CCRs to be used for this demonstration. The CCRs shall be updated on an annual basis using the most recent CCRs for each hospital. **DHA** shall provide the updated inpatient and outpatient CCRs to the contractor and the updated inpatient and outpatient CCRs shall be effective as of July 1 of each respective year, with the first update occurring effective July 1, 2008.

**3.5** Payment for TRICARE covered outpatient services provided by physicians and other non-institutional individual professional providers in the state of Alaska shall be reimbursed in accordance with the Federal Register (FR) notice published on November 20, 2006 (71 FR 67112-67113). That is, TRICARE will adopt a rate that is 1.35 times the current TRICARE allowable rate. These rates are included in the CHAMPUS Maximum Allowable Charge (CMAC) file that is provided to each of the Managed Care Support Contractors (MCSCs).

**3.6** The TRICARE cost-shares, copayments, and deductibles applicable to hospitals shall also apply to the services provided by CAHs under this demonstration.

**3.7** The CAH portion of the state of Alaska demonstration excludes those Indian Health Service (IHS) facilities that are also CAHs. IHS facilities will continue to be reimbursed the DRG or the negotiated rate for inpatient care, the lower of the billed charge or negotiated rate for outpatient facility care, and the CMAC rates for Alaska for care rendered by individual professional providers.

**4.0 MCSC RESPONSIBILITY**

**4.1** The MCSC for the state of Alaska shall price and process inpatient and outpatient facility claims under this demonstration using the reimbursement methods described in [paragraph 3.0](#).

**4.2 Out-Of-Jurisdiction Claims**

**4.2.1** In the event the MCSC for the state of Alaska receives an out-of-jurisdiction claim, the MCSC shall price the claim using the methods described in [paragraph 3.0](#). Once the claim has been priced, the claim shall be forwarded to the appropriate contractor based on the jurisdiction provisions found in [Chapter 8, Section 2](#).

**4.2.2** In the event that a north or south MCSC or other TRICARE contractor receives a claim from one of the CAHs under this demonstration, the claim shall be sent to the MCSC for the state of Alaska to be priced using the provision of this demonstration. Once the claim has been priced by the state of Alaska MCSC, the claim shall be forwarded to the appropriate contractor based on the jurisdiction provisions found in [Chapter 8, Section 2](#). The claim shall be sent to the fax number: 1-715-843-8435, Attn: CAH Processing.

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**5.0 EFFECTIVE DATES**

**5.1** The portion of the state of Alaska demonstration that provides for 1.35 times the current TRICARE allowable rate took effect on February 1, 2007.

**5.2** The enhanced portion of the state of Alaska demonstration that provides for 101% of reasonable costs for inpatient and outpatient facility reimbursement to CAHs shall be effective for inpatient admissions on and after July 1, 2007, and for outpatient facility services with dates of service on or after July 1, 2007.

**5.3** The CAH portion of the demonstration will expire on November 30, 2009. Requirements of this section as related to the CAH portion of the demonstration cease at 12:00 midnight on November 30, 2009, except for claims for patients admitted prior to 12:00 midnight on November 30, 2009. The demonstration retains responsibility for these claims until the beneficiary is discharged from the CAH. For information on CAH reimbursement, see the TRICARE Reimbursement Manual (TRM), [Chapter 15, Section 1](#).

- END -

## Department Of Defense (DoD) Enhanced Access To Autism Services Demonstration

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### 1.0 PURPOSE

The Enhanced Access to Autism Services Demonstration (“Autism Demonstration”) provides TRICARE reimbursement for Applied Behavior Analysis (ABA) for Active Duty Family Members (ADFM) with Autism Spectrum Disorders (ASDs). This Autism Demonstration will enable the DoD to determine whether:

- There is increased access to these services;
- The services are reaching those most likely to benefit from them;
- The quality of those services is meeting a standard of care currently accepted by the professional community of providers, including the Behavior Analyst Certification Board (BACB); and
- Requirements are met for State licensure and certification where such exists.

### 2.0 BACKGROUND

**2.1** The Military Health System (MHS) includes 59 military hospitals, over 350 military health clinics, and an extensive network of private sector health care partners, that provides medical care for more than nine million beneficiaries, including Active Duty Service Members (ADSMs) and ADFMs.

**2.2** Autistic Spectrum Disorders affect essential human behaviors such as social interaction, the ability to communicate ideas and feelings, imagination, and the establishment of relationships with others.

**2.3** ABA is the only service accepted within the MHS as having been shown to possibly reduce or eliminate specific problem behaviors and teach new skills to individuals with ASD. ABA reinforcement is rendered by TRICARE-authorized providers as an Other Service benefit under the Extended Care Health Option (ECHO). Only those individuals who are licensed or certified by a State or certified by the BACB (<http://www.bacb.com>) as a Board Certified Behavior Analyst (BCBA) or a Board Certified Assistant Behavior Analyst (BCaBA) are eligible to be TRICARE-authorized providers of ABA.

**2.4** The Autism Demonstration allows TRICARE reimbursement for ABA services, referred to as Intensive Behavioral Interventions in the Federal Register Demonstration Notice (72 FR 68130,

December 4, 2007), delivered by paraprofessional providers under a modified Corporate Services Provider (CSP) model.

### 3.0 DEFINITIONS

#### 3.1 Applied Behavior Analysis (ABA)

A well-developed discipline with a mature body of scientific knowledge, established standards for evidence-based practice, distinct methods of service, recognized experience and educational requirements for practice, and identified sources of requisite education. Information regarding the content of ABA is contained in the BACB Behavior Analysis Task List, available at <http://www.bacb.com/Downloadfiles/AutismTaskList/708AutismTaskListF.pdf>.

#### 3.2 Autism Spectrum Disorders (ASD)

**3.2.1** The covered ASD diagnoses are described under the Neurodevelopmental Disorders category of the most current edition of the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V). The DSM-V was released in May 2013. The DSM-V diagnostic code for ASD (299.00) is equivalent to the corresponding codes for Autistic Disorder (299.0) in the currently used edition of the International Classification of Diseases, Clinical Modification manual (currently **International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)**) used for claims processing under TRICARE for services provided before **the mandated date, as directed by Health and Human Services (HHS), for International Classification of Diseases, 10th Revision (ICD-10) implementation.**

- The Military Health System (MHS) and mental health community has transitioned to the DSM-5 (released May 2013). This transition resulted in the five covered diagnoses for an ASD (ASD, Rett's Disorder, Childhood Disintegrative Disorder (CDD), Asperger's Disorder, and Pervasive Developmental Disorder (PDDNOS)) under the DSM, Fourth Edition, Text Revision (DSM-IV-TR) falling under the one diagnosis of ASD (299.00) in the DSM-V. The corresponding ICD-9-CM code is Autistic Disorder (299.0) and the corresponding ICD-10-CM code is Autistic Disorder (F84.0).

**Note:** The DSM-IV-TR and the ICD-9-CM use the same numeric diagnosis codes for three of the five ASD Diagnoses found in the DSM-IV-TR (Autistic Disorder (299.00 & 299.0), CDD (299.10 & 299.1), and Asperger's (299.80 & 299.8)). The DSM-IV-TR uses one code 299.80 to refer to Rett's Disorder, PDD, and Asperger's Disorder whereas the ICD-9-CM designates a unique code for each diagnosis.

**3.2.2** Significant symptoms associated with ASD include communication and social behavior deficits, and behaviors concerning objects and routine.

**3.2.2.1** Communication deficits include a lack of speech, especially when associated with the lack of desire to communicate and lack of nonverbal compensatory efforts such as gestures.

**3.2.2.2** Social Skills Deficits. Children with ASD demonstrate a decreased drive to interact with others and share complementary feeling states. Children with ASD often appear to be content being alone, ignore their parents' and others' bids for attention with gestures or vocalizations and seldom make eye contact.

## 4.5 Specialized ASD Provider

A TRICARE authorized provider who is a:

- Physician board-certified or board-eligible in behavioral developmental pediatrics, neurodevelopmental pediatrics, pediatric neurology or child psychiatry; or
- Ph.D. clinical psychologist working primarily with children.

## 5.0 ABA PROVIDER REQUIREMENTS

### 5.1 ACSPs shall:

**5.1.1** Submit evidence to the appropriate Managed Care Support Contractor (MCSC) that professional liability insurance in the amounts of one million dollars per claim and three million dollars in aggregate, unless State requirements specify greater amounts, is maintained in the ACSP's name.

**5.1.2** Submit claims to the appropriate MCSC using the assigned Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes specified in [paragraph 9.0](#).

**5.1.3** Submit to the MCSC all documents necessary to support an application for designation as a TRICARE ACSP;

**5.1.4** Enter into a Participation Agreement ([Addendum A](#)) approved by the Director, [Defense Health Agency \(DHA\)](#) or designee;

**5.1.5** Employ directly or contract with ABA Supervisors and/or ABA Tutors;

**5.1.6** Certify that all ABA Supervisors and ABA Tutors employed by or contracted with the ACSP meet the education, training, experience, competency, supervision and Autism Demonstration requirements specified herein;

**5.1.7** Comply with all applicable organizational and individual licensing or certification requirements that are extant in the State, county, municipality, or other political jurisdiction in which ABA services are provided under the Autism Demonstration;

**5.1.8** Maintain employment or contractual documentation in accordance with applicable Federal, State, and local requirements and corporate policies regarding ABA Supervisors and ABA Tutors;

**5.1.9** Comply with all applicable requirements of the Government designated utilization and clinical quality management organization for the geographic area in which the ACSP provides ABA services; and

**5.1.10** Comply with all other requirements applicable to TRICARE-authorized providers.

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**5.2** ABA Supervisor shall:

**5.2.1** Have a current, unrestricted State-issued license to provide ABA services; or

**5.2.2** Have a current, unrestricted State-issued certificate as a provider of ABA services; or

**5.2.3** Have a current certification from BACB (<http://www.bacb.com>) as either a BCBA or a BCaBA where such state-issued license or certification is not available; and

**5.2.4** Enter into a Participation Agreement ([Addendum A](#)) approved by the Director, **DHA** or designee; and

**5.2.5** Employ directly or contract with ABA Tutors; and

**5.2.6** Report to the MCSC within 30 days of notification of a BACB sanction issued to the ABA Supervisor for violation of BACB disciplinary standards (<http://www.bacb.com/index.php?page=85>) or notification of loss of BACB certification. Loss of BACB certification shall result in termination of the Participation Agreement with the ABA Supervisor with an effective date of such notification. Termination of the Participation Agreement by the MCSC may be appealed to the **DHA** in accordance with the requirements of [Chapter 13](#); and

**5.2.7** Ensure that the quality of the ABA services provided by ABA Tutors meet the minimum evidence-based standards as indicated by the current BACB Task List, the BACB Professional Disciplinary Standards, the BACB Guidelines for Responsible Conduct for Behavior Analysts, the BACB Guidelines: Health Plan Coverage of Applied Behavior Analysis Treatment for ASD, and current BACB rules and regulations; and

**5.2.8** Maintain all applicable business licenses and employment or contractual documentation in accordance with Federal, State, and local requirements and the ABA Supervisor's business policies regarding ABA Tutors; and

**5.2.9** Meet all applicable requirements of the states in which they provide ABA services, including those of states in which they provide remote supervision of ABA Tutors and oversee ABA services provided where the beneficiary resides; and

**5.2.10** Cooperate fully with a designated utilization and clinical quality management organization which has a contract with the DoD for the geographic area in which the provider does business; and

**5.2.11** Comply with all other applicable TRICARE-authorized provider requirements.

**5.3** ABA Tutor:

**5.3.1** Prior to providing ABA services under the Autism Demonstration, shall have completed 40 hours of documented classroom training in ABA techniques in accordance with the BACB Guidelines for Responsible Conduct for Behavior Analysts (<http://www.bacb.com>), undergone a criminal background check as specified in [paragraph 5.4.3](#); and

- Completed a minimum of 12 semester hours of college coursework in psychology,

**7.1.3.1** A detailed description of the targeted skills and behaviors that will be addressed through the ABA sessions and the objectives that will be measured, which may include:

- Communication skills
- Mental health issues
- Vocational skills
- Adaptive skills
- Motor skills
- Academic skills
- Cognitive skills
- Developmental skills
- Behavior skills
- Social skills
- Medical and quasi-medical issues

**7.1.3.2** Administration of any diagnostic tests that will assess skill acquisition or behavior modification; and

**7.1.3.3** The frequency and method of assessing the beneficiary's progress towards achieving the goals and objectives.

**7.1.4** Parental training shall be included in the BP. Parental training shall be provided while billable ABA services are being provided to the beneficiary. The BP shall include a detailed plan that specifies how parents will be trained to:

**7.1.4.1** Implement and reinforce skills and behaviors; and

**7.1.4.2** Receive support to implement strategies within a specified setting.

**7.1.5** Summary and recommendations of the BP shall include the extent of parent/caregiver involvement that will be expected to support the plan.

**7.1.6** The initial BP shall be reviewed and updated by the ACSP at six-month intervals and submitted to the MCSC for review and authorization of ABA services.

**7.2** The PR shall include:

**7.2.1** Beneficiary's name, date of birth, inclusive dates of the evaluation period, sponsor's SSN, or DoD benefits number, name of the referring provider;

**7.2.2** A summary of the child's progress;

**7.2.3** A summary of the child's challenges to meet the goals and objectives; and

**7.2.4** A summary of parent/caregiver participation in implementing the BP during the evaluation period.

**7.2.5** Recommendations for continued ABA services.

**7.3** The updated BP shall include:

**7.3.1** The data elements specified in [paragraph 7.1](#);

**7.3.2** The dates of the plan being updated; and

**7.3.3** The number of ABA hours of services to be provided each month by the ABA Supervisor and the ABA Tutor.

**7.4** The ACSP shall provide an information copy of the BP, the PR, and the updated BP to the beneficiary's PCP or ASD Specialized provider, within 10 calendar days of completion.

## **8.0 POLICY**

**8.1** Under the Autism Demonstration, TRICARE will reimburse ACSP's only for ABA services that meet the minimum standards established by the current BACB Task List, the BACB Professional Disciplinary Standards, the BACB Guidelines for Responsible Conduct for Behavior Analysts, and current BACB rules and regulations when rendered by providers who meet all applicable requirements specified herein.

**8.2** All ABA services under this Autism Demonstration require prior written authorization by the Director, **DHA** or designee.

**8.3** The following are eligible for reimbursement under the Autism Demonstration:

**8.3.1** Evaluation of a beneficiary using the Functional Behavioral Assessment and Analysis.

**8.3.2** Development of the initial BP, the PR, and the updated BP.

**8.3.3** ABA rendered directly to a TRICARE beneficiary on a one-on-one basis. Group ABA sessions are not a TRICARE benefit.

**8.3.4** ABA services rendered jointly, in-person, or during directly supervised fieldwork of the ABA Tutor by the ABA Supervisor. Only the services provided by the Supervisor will be reimbursed as specified in [paragraph 9.1](#).

**8.3.5** Quarterly, in-person meetings between the ABA Supervisor and the beneficiary's primary caregivers.

**8.4** The allowed cost of services provided by this Autism Demonstration on or after October 14, 2008, accrue to the Government's maximum fiscal year share of providing benefits in accordance with the TRICARE Policy Manual (TPM), [Chapter 9](#), (except ECHO Home Health Care (EHHC)), of \$36,000.

## EXPIRED - Operation Noble Eagle/Operation Enduring Freedom Reservist And National Guard (NG) Benefits Demonstration

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### 1.0 PURPOSE

The purpose of this demonstration is to test if the Military Health System (MHS), with certain flexibility in operation, can ensure timely access to health care during a national crisis, maintain clinically appropriate continuity of health care to family members of activated reservists and guardsmen, appropriately limit the extraordinary out-of-pocket expenses for those family members, and remove potential barriers to health care access by families.

### 2.0 BACKGROUND

**2.1** A number of reservists and members of the NG are being ordered to active duty in support of operations that result from the terrorist attacks on the World Trade Center (WTC) and the Pentagon on September 11, 2001. These individuals are being ordered to active duty under Executive Order 13223, 10 U.S.C. 12302, 10 U.S.C. 12301(d), or 32 U.S.C. 502(f). Such operations include for example, Operation Noble Eagle and Operation Enduring Freedom.

**2.2** In many cases, reservist families live far from Military Treatment Facilities (MTFs), and are not supported by TRICARE provider networks. Some doctors do not participate in TRICARE, and by law may bill beneficiaries for up to 15% above TRICARE allowable amounts. Family members of reservists could face undue financial hardships if they use such providers.

**2.3** In some cases family members of activated reservists and members of the NG are in the middle of a course of medical care (e.g., obstetrical care) which would be disrupted if the family member were suddenly required to continue their care at a military treatment facility.

**2.4** Most reservists and members of the NG are enrolled in a commercial health plan when they are called to active duty. Since in nearly every case they will have paid a deductible under their commercial health plan, they would be unfairly penalized if they had to meet a second deductible under TRICARE for care provided to their family members.

### 3.0 POLICY

**3.1** Effective September 14, 2001, this demonstration is authorized for family members of reservists or members of the NG as described in [paragraph 2.1](#). These beneficiaries will be identified by Special Indicator (SI) Code "02" on the Defense Enrollment Eligibility Reporting System (DEERS).

**EXPIRED** - Operation Noble Eagle/Operation Enduring Freedom Reservist And National Guard (NG)  
Benefits Demonstration

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**3.2** The TRICARE Encounter Data (TED) record for each Noble Eagle/Enduring Freedom claim must reflect the Special Processing Code "NE".

**3.3** Claims are to be paid from financially underwritten funds. On claims for care from non-participating professional providers, contractors shall allow the lesser of the billed charges or the balance billing limit (115% of the allowable charge). If the charges on a claim from a non-participating professional provider are exempt from the balance billing limit, the contractor shall allow the billed charges. This applies to all claims from non-participating professional providers for services rendered to Standard beneficiaries. In double coverage situations, normal double coverage requirements shall apply.

**Note:** This special demonstration payment provision does not apply to Prime beneficiaries. Family members of reservists or members of the NG who are called to active duty in support of Operation Noble Eagle/Operation Enduring Freedom and who are enrolled in Prime will be protected when they receive services outside the network under the provisions of [Chapter 8, Section 5](#).

**3.4** In order to protect beneficiaries from incurring greater out-of-pocket costs under these special procedures, the beneficiary cost-share for these claims will be limited to what it would have been in the absence of the higher allowable amount under this demonstration. That is, the cost-share is 20% of the lesser of the CHAMPUS Maximum Allowable Charge (CMAC) or the billed charge. Any amounts that are allowed over the CMAC will be paid entirely by TRICARE.

**3.5** TED records submitted for these non-participating professional claims that are reimbursed at the lesser of the balance billing limit or the billed charge are to be identified with Pricing Rate Code "W" but only if the allowed amount is greater than the CMAC. If the billed charge equals or is less than the CMAC, Pricing Rate Code "W" is not to be used. On the other hand, when the claim is reimbursed as billed because the billed charge is greater than the CMAC but less than the balance billing limit or the charges are exempt from the balance billing limit, Pricing Rate Code "W" is to be used.

**3.6** All Non-Availability Statement (NAS) requirements are waived for beneficiaries identified by DEERS Special Indicator Code "02". TED records submitted for these beneficiaries are to use Care Authorization (CA)/NAS Exception Reason 9, "TRICARE Demonstration Project".

**3.7** The TRICARE Standard and Extra deductible is waived for all beneficiaries identified by DEERS Special Indicator Code "02".

#### **4.0 EVALUATION**

**4.1** The evaluation will assess the impact that the higher payment rates have on beneficiary access to care.

**4.2** The evaluation will assess the financial impact of the higher payment rates.

**4.3** The evaluation will assess the impact on the continuity of care for beneficiaries whose claims were paid at the higher rates and for whom the NAS requirements were waived.

## EXPIRED - Web-Based TRICARE Assistance Program (TRIAP) Demonstration

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### 1.0 PURPOSE

The purpose of this Demonstration is to test the use of web-based technologies to get information and Employee-Assistance Program (EAP)-like Behavioral Health (BH) services to our beneficiaries to determine if it increases the effectiveness and efficiency of identifying those who need medically necessary mental health care and in identifying their medical mental health needs earlier and in getting them referred or getting them access to the appropriate level of mental health care more effectively. We are also interested in learning if providing this level of care reduces a later need for mental health care. In addition, this will enable the Department of Defense (DoD) to determine whether:

- The availability to provide web-based EAP-like counseling is a valid mechanism to improve access in rural or underserved areas.
- There is acceptance and use of this delivery system by eligible beneficiaries.
- It is feasible to offer this service on a permanent basis.

### 2.0 AUTHORITY

**2.1** Section 1092, Chapter 55, Title 10 of the United States Code (USC) allows the Secretary of Defense to conduct studies and demonstration projects. This section also specifies that the Secretary may enter into contracts with public or private organizations to conduct these studies and demonstrations.

**2.2** In the House Report 2638 DoD Appropriations Act for Fiscal Year (FY) 2009 Joint Explanatory Statement (p.405), Congress stated: "An area of particular interest is the provision of appropriate and accessible counseling of service members and their families who live in locations that are not close to Military Treatment Facilities (MTFs), other Military Health System (MHS) facilities or TRICARE providers. Web-based delivery of counseling has significant potential to offer counseling to personnel who otherwise might not be able to access it. Therefore, the Department is directed to establish and use a web-based Clinical Mental Health Services Program as a way to deliver critical clinical mental health services to service members and their families in rural areas." The ability to provide web-based TRICARE Assistance Program (TRIAP) services is a valid mechanism to augment the basic TRICARE mental health benefit to provide short-term counseling options.

### **3.0 BACKGROUND**

**3.1** The DoD currently provides a robust program of mental health care for our Active Duty Service Members (ADSMs) and their families. In addition, the Department offers Military One Source which provides multiple, currently 12, face-to-face BH non-medical counseling sessions for each issue faced by a beneficiary. For those needing medical treatment, BH care is provided in MTFs or through the TRICARE program.

**3.2** The Managed Care Support Contractors (MCSCs) currently provide an array of text and multi-media based educational materials targeting pre-deployment, deployment, and post-deployment adjustment concerns. They also have BH Provider Locator and Appointment Assistant Centers staffed with licensed counselors, or beneficiary service representatives and customer service representatives to provide first and second level support, triage, and make appropriate BH referrals and locate providers for beneficiaries. This demonstration project will expand access to on-line contact options including web-based e-mail and video-conferencing to those eligible as indicated in this section to provide TRIAP services which are not otherwise covered as TRICARE authorized medically necessary mental health services.

### **4.0 DEFINITIONS**

#### **4.1 Interactive Telecommunications System**

Interactive telecommunications systems are defined as multimedia communications equipment that includes, at a minimum, audio-video equipment permitting two-way, real time service or consultation involving the beneficiary and counselor as appropriate to the BH needs of the patient. Telephone services excluded by [32 CFR 199.4\(g\)\(52\)](#) do not meet the definition of interactive telecommunications services.

#### **4.2 TRIAP Counseling**

The DoD goal for professional, web-based assistance services is to provide ADSMs and their families, TRICARE Reserve Select (TRS) enrollees, and Transitional Assistance Management Program (TAMP) beneficiaries with an avenue for private, non-reportable discussion of personal life issues such as family difficulties and pressures, crisis intervention, anxiety, and self-esteem on a one-on-one basis in the context of a confidential relationship with a licensed professional.

#### **4.3 TRIAP Services**

Private, non-reportable discussions of personal life issues such as dealing with relationships, crisis intervention, stress management, family issues, parent-child communications, family separations, anxiety, and self-esteem on a one-on-one basis in the context of a confidential relationship with a licensed professional.

### **5.0 POLICY**

**5.1** TRIAP services will be provided to ADSMs and their spouses of any age, and their family members 18 years of age or older, and those beneficiaries enrolled in TRS and TAMP 18 years of age or older. A full range of private, confidential, counseling services via the web, including on-line video chat to address current and emerging needs are available.

counseling that have the ability for more immediate follow-up or intervention if necessary. This includes MTFs, combat stress control units, and supervisors/commanders. Military One Source services are available in both CONUS and OCONUS and are a viable referral option. If the TRIAP counselor believes that the ADSM is at-risk of any of the circumstances in which a DoD issuance requires health care providers to notify an ADSM's commander, the counselor shall obtain as much information as possible regarding the individual; i.e., Branch of Service, unit, a contact/call-back number, their location (as precisely as possible), closest MTF (if known) and command information. The TRIAP counselor shall then contact the ADSM's commander (or the commander's designee for receiving protected health information) and inform the commander or designee about the at-risk individual, in order to ensure he or she receives appropriate counseling/care. The circumstances triggering this requirement include, but are not limited to, serious risk of causing harm to oneself or others. The currently applicable DoD issuances are DoD 6025.18-R, C7.11.1 and Directive-Type Memorandum (DTM) 09-006, "Revising Command Notification Requirements to Dispel Stigma in Providing Mental Health Care to Military Personnel," July 2, 2009. The requirements of this DTM will be incorporated in DoD 6025.18-R or its successor issuance. In the event the counselor cannot obtain enough information to contact the ADSM's commander, the counselor shall then contact the appropriate Service Operations Center (Army Operations Center, Air Force Watch, Navy Watch Center, Coast Guard Operations Center, or Marine Corps Operations Center) for assistance. The Service Operations Center contact numbers are unclassified but sensitive and will be provided by the Contracting Officer's Representative (COR).

**10.3** In the event reservists who lose TRICARE eligibility or are not enrolled in TRS access TRIAP services, TRIAP personnel should encourage the reservist to utilize other outlets for counseling such as community resources or the Department of Veterans Affairs (DVA) if eligible.

## **11.0 MCSC RESPONSIBILITY**

**11.1** An assessment made by a licensed professional at the BH Care Provider Locator and Appointment Assistance or Customer Service Staff to determine if web-based professional TRIAP services are appropriate for the beneficiary. If it is, the BH contact center will determine if the beneficiary has the necessary software and hardware (the most currently available technology that meets the requirements of this Demonstration) to support web-based care. If that is the case, the BH Care Provider Locator and Appointment Assistance or Customer Service Staff will instruct the beneficiary on accessing web-based counseling.

**11.2** Referral to an appropriate level of care if the beneficiary does not have the necessary hardware or software, or requires care beyond the scope of this Demonstration. This level of care may include a MTF, or a TRICARE network or authorized provider.

**11.3** Provide a virtual resource library of electronic documents related to BH/mental health concerns, to include, but not limited to, suicide prevention, post-traumatic stress disorder, and depression.

**11.4** Provide a secure, web-based e-mail, online video chat and IM capability.

**11.5** When a call is received from an ADSM, the TRIAP counselor shall ask if the caller is on the Personnel Reliability Program (PRP). The purpose of the PRP is to ensure that each person who performs duties involving nuclear weapons meets the reliability standards of the PRP. Each person assigned to PRP duties is responsible for their reliability and is required to report any behavior or

circumstance about themselves or others in the PRP that may be expected to result in degradation in job performance or personal reliability or an unsafe or insecure condition involving nuclear weapons and/or Nuclear Command and Control (NC2) material. If the member responds that he/she is on the PRP, the TRIAP counselor shall read the following statement reminding the member of his or her obligation to self-report any information that could be Potentially Disqualifying Information (PDI) before providing any counseling services.

“As a Personnel Reliability Program (PRP) certified or administrative qualified individual, you are personally responsible for advising your Certifying Official or supervisor of any factors that could have an adverse impact on your performance, reliability, or safety while you are performing PRP duties. This includes factors that impact your physical and mental wellness, your dependability, your personal financial circumstances, or other legal concerns. When you receive any type of medical/dental treatment or evaluation, to include mental health or family related counseling, you are personally responsible for reporting the treatment or evaluation to your Certifying Official and for providing appropriate documentation concerning the treatment or evaluation to the competent medical authority (CMA) at your military treatment facility responsible for consulting with the certifying official on this matter. Failure to make these notifications or to provide the appropriate documentation may cast doubt on your reliability and may violate the provisions of DoD Regulation 5210.42. If you have any questions regarding these requirements you should consult with your Certifying Official for more information.”

**11.6** The TRIAP counselor shall document that the statement was read or that it could not be read for any reason including the person hanging up.

**11.7** By the 10th of each month, the contractor shall capture and report all service member, family member, TRS enrollee contracts by military service and installation, to include Guard and Reserve member affiliation as described in the Contract Data Requirements List (CDRL) DD Form 1423.

## **12.0 DEFENSE HEALTH AGENCY (DHA) RESPONSIBILITY**

An independent evaluation of the demonstration will be conducted. It will be performed retrospectively and use a combination of administrative and survey measures of BH care access to provide analyses and comment on the effectiveness of the demonstration in meeting this goal of improving beneficiary access to BH call centers by incorporating web-based technology.

## **13.0 EFFECTIVE DATES**

This demonstration project will be effective for services on or after August 1, 2009. The demonstration project will continue until March 31, 2012.

## **14.0 EXCLUSIONS**

Medical treatment including medication management and psychoanalysis.

- END -

## EXPIRED As Of May 4, 2015 - TRICARE South Region United States Coast Guard (USCG) Access To Care (ATC) Demonstration For TRICARE Prime/TRICARE Prime Remote (TPR) Beneficiaries

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### 1.0 PURPOSE

The purpose of the demonstration project is to determine if the elimination of the requirement to obtain a referral influences beneficiaries to seek care at less intensive health care resources such as a TRICARE authorized Urgent Care Center (UCC), rather than the Emergency Room (ER).

### 2.0 BACKGROUND

**2.1** Access to primary health care for acute episodic primary care continues to be in high demand by TRICARE Prime beneficiaries. The TRICARE manual guidance and process by which Prime beneficiaries currently access primary health care is defined under the [32 CFR 199.17](#) and the TRICARE Policy Manual (TPM), [Chapter 1, Section 8.1](#). The current law and regulations require that Prime beneficiaries obtain a referral for primary or urgent care if they seek that care from someone other than their Primary Care Manager (PCM). As a result, when an enrollee needs urgent care after hours or when the PCM in the Military Treatment Facility (MTF) does not have available appointments they have been seeking care from civilian sources such as the ER or with a UCC, including Convenience Clinics (CCs).

**2.2** In an effort to avoid over use of ER care and meet the demand for acute primary care, many facilities have expanded acute care hours within the MTFs or worked with the Managed Care Support Contractors (MCSCs) to utilize provider groups or UCCs in their network. However, these visits require an authorization. Seeking emergency care in an ER does not require authorization. Additionally, the cost of care in a civilian ER for non-emergent reasons is much higher than any other source of care.

### 3.0 POLICY AND ELIGIBILITY

**3.1** Under the demonstration, the USCG Active Duty Service Members (ADSMs) and their family members enrolled in TRICARE Prime or TPR in the TRICARE South Region may access a TRICARE network or TRICARE authorized UCC without prior authorization for up to four urgent care visits per fiscal year, per individual, including services provided when the enrollee is out of the area, without incurring the usual Point of Service (POS) deductibles and cost-shares. Referral requirements for specialty care and inpatient authorizations shall remain as currently required by [Chapter 8, Section 5](#).

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**3.2** The contractor shall educate the ADSM USCG members and their family members to notify their PCM of any urgent/acute care visits outside the PCM within 24 hours of the visit or the first business day following the visit and schedule follow-up treatment, if indicated, with their PCM.

**3.3** If more than four visits allowed under the demonstration are used or if the active duty USCG member or their enrolled family members seek care from a non-network provider (other than a TRICARE authorized UCC), the usual POS deductible and cost-shares shall apply with the usual POS exceptions, which include:

- ADSMs;
- Newborns and adopted children during the first 60 days (120 days if overseas) after birth or adoption, emergency care, clinical preventive services from a network provider;
- The first eight outpatient Behavioral Health Care (BHC) visits to a network provider per fiscal year (October 1st - September 30th); and
- Beneficiaries with Other Health Insurance (OHI).

#### **4.0 GENERAL DESCRIPTION OF ADMINISTRATIVE PROCESS**

**4.1** Referral (authorization) requirements for up to four urgent care visits per fiscal year, per individual, shall be waived for all TRICARE South Region USCG Prime enrolled ADSMs and Active Duty Family Members (ADFM) when services are rendered by a TRICARE network or TRICARE authorized UCC with the following primary specialty designations:

- Family Practice;
- Internal Medicine;
- General Practice;
- Pediatrician; and
- UCC or CC.

**Note:** In accordance with TPM, [Chapter 1, Section 8.1](#), Obstetricians/Gynecologists (OB/GYNs), Physician Assistants (PAs), Nurse Practitioners (NPs), and Certified Nurse Midwives (CNMs) can be considered Primary Care Providers (PCPs) and may be designated PCMs too.

**4.2** All claims shall be vouchered and paid as prescribed by policy for underwritten and non-underwritten care.

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#### **5.0 ASSISTANT SECRETARY OF DEFENSE (HEALTH AFFAIRS) (ASD(HA)) AND DEFENSE HEALTH AGENCY (DHA) RESPONSIBILITIES**

ASD(HA) is the designated Executive Agent for the demonstration project. The Medical Director of the TRICARE Regional Office-South (TRO-S) will be designated as the project officer for the demonstration.

#### **6.0 MANAGED CARE SUPPORT CONTRACTOR (MCSC) RESPONSIBILITIES**

**6.1** The contractor shall verify the TRICARE eligibility of the patient on the Defense Enrollment Eligibility Reporting System (DEERS).

**6.2** The contractor shall maintain sufficient staffing and management support services necessary to achieve and maintain compliance with all quantitative and qualitative standards for claims processing timeliness, claims inventory levels, claims control, and claims accuracy as required within the TRICARE manuals.

**6.3** By the 15th of the month, the contractor shall provide a monthly report as described in the Contract Data Requirements List (CDRL) DD Form 1423 and submit the information to the RD, TRO-S.

#### **7.0 APPLICABILITY**

This demonstration is limited to USCG ADSMs and their family members enrolled in TRICARE Prime and TPR in the 10 states that comprise TRICARE South Region.

#### **8.0 EXCLUSIONS**

This demonstration does not apply to referral requirements for specialty care and inpatient authorizations shall remain as currently required by [Chapter 8, Section 5](#).

#### **9.0 EFFECTIVE DATE**

This demonstration was originally effective for claims for services provided in accordance with this section for a 24 month period from the implementation date. This demonstration has been extended and will continue until May 4, 2015.

- END -



## Department Of Defense (DoD) TRICARE Demonstration Project for the Philippines

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### 1.0 PURPOSE

This demonstration will allow the DoD to determine the efficacy and acceptability of an alternative approach to the delivery of health care in the Philippines. The DoD TRICARE Demonstration Project for the Philippines (hereinafter referred to as the demonstration) will enable DoD to determine whether it is possible to control costs, reduce aberrant billing activity, and eliminate balance billing issues while providing high quality, safe health care to TRICARE Standard beneficiaries residing in the Philippines and receiving care in designated demonstration area(s). This will be accomplished by the establishment of a dedicated list of providers who agree to comply with certain requirements and business processes as outlined below.

### 2.0 BACKGROUND

Although the number of TRICARE beneficiaries residing in the Philippines has remained relatively constant over time, there has been a significant increase in the amount billed for health care services. Administrative controls and the implementation of a government-directed foreign fee schedule have been only partially successful in containing costs. Additionally, certain billing practices in the Philippines have resulted in beneficiary dissatisfaction and excessive out-of-pocket expenses due to balance billing. Beneficiaries in the Philippines are frequently required to pay the provider or facility at the time services are rendered, and file their own claims for reimbursement. Since TRICARE reimburses these claims based on the fee schedule, a beneficiary may incur excessive out-of-pocket expenses (in addition to their normal cost shares and deductibles) if the billed charges exceed the fee schedule amount.

### 3.0 DEFINITIONS

#### 3.1 Approved (Demonstration) Provider

A provider who agrees to accept TRICARE reimbursement at the lesser of billed charges, a negotiated reimbursement rate, or the government-directed foreign fee schedule as payment in full; agrees to submit claims to the TRICARE Overseas Program (TOP) contractor on behalf of TRICARE beneficiaries; and agrees to collect only applicable cost-shares and deductibles from beneficiaries for all TRICARE-covered services. In addition, all approved demonstration providers must comply with the on-site verification and provider certification process described in [Chapter 24, Section 14](#) and the certification and credentialing requirements outlined in [Chapter 24, Section 4; 32 CFR 199.6](#); and the TRICARE Policy Manual (TPM), [Chapter 11](#).

### 3.2 Approved Provider List

A list of all approved demonstration providers maintained by the TOP contractor (see [paragraph 3.1](#) for specific requirements for approved providers). If a specialty waiver has been granted in accordance with the process outlined in [paragraph 4.9](#), the approved provider list must be annotated with this information so that beneficiaries understand their options when seeking care in demonstration area(s).

### 3.3 Certified (Philippines) Provider

A provider who meets the on-site verification and provider certification requirements outlined in [Chapter 24, Section 14](#), but who has not agreed to the additional conditions required for approved demonstration providers. For example, a certified provider in the Philippines may require a TRICARE beneficiary to pay up-front for services and file their own claim for reimbursement.

### 3.4 Non-Approved (Demonstration) Provider

Any provider in the Philippines who is not recognized as an approved demonstration provider and is not listed on the TOP contractor's approved provider list. This includes any certified Philippine providers (as defined in [Chapter 24, Section 14](#)) in demonstration locations who are not listed on the approved provider list.

## 4.0 POLICY

**4.1** This demonstration is applicable to all TRICARE Standard beneficiaries who reside in the Philippines and receive care in designated demonstration area(s). The demonstration is also applicable to beneficiaries who are receiving the TRICARE Standard benefit under TOP TRICARE For Life (TFL), TRICARE Retired Reserve (TRR), TRICARE Reserve Select (TRS), or TRICARE Young Adult (TYA) (Standard option) programs, who reside in the Philippines.

**4.2** For demonstration purposes, beneficiary residence will be determined by the address listed on the claim. This rule applies regardless of the residence address listed in Defense Enrollment Eligibility Reporting System (DEERS).

**4.3** Demonstration area(s) will be determined by [Defense Health Agency \(DHA\)](#) and will be publicized at least 60 calendar days in advance of the effective date for each location. [DHA](#) anticipates using a phased approach to implement the demonstration in multiple locations.

**4.4** TRICARE Standard beneficiaries who reside in the Philippines, in accordance with [paragraph 4.2](#), and receive care in designated demonstration area(s) must receive all care from approved demonstration providers, unless a specific waiver has been granted (see [paragraphs 4.8](#) and [4.9](#)). If these beneficiaries receive care from a non-approved demonstration provider without a waiver, TRICARE will not cost-share the claim and the beneficiary will be responsible for 100% of the charges. Normal TRICARE cost-shares and deductibles apply to care rendered to eligible beneficiaries by approved providers under the terms of the demonstration. Additionally, when a beneficiary receives care from an approved provider in a designated demonstration area, the provider will file the claim on the beneficiary's behalf, and the provider will collect only applicable cost shares and deductibles after receipt of the TOP EOB. The beneficiary will be held harmless for

denied charges rendered by an approved demonstration provider unless the beneficiary was notified in writing that the care provided was not a covered benefit prior to receiving the care. Beneficiary-submitted claims for services provided by an approved demonstration provider in an approved demonstration area shall be denied unless it is submitted with proof of payment showing that the beneficiary has paid for the service(s).

**4.5** Active Duty Service Members (ADSMs) are not eligible for TRICARE Standard and therefore are not included in this demonstration, regardless of their residence address or enrollment status. ADSMs not enrolled in TOP who are on Temporary Additional Duty/Temporary Duty (TAD/TDY), deployed, deployed on liberty, or in an authorized leave status in the Philippines shall follow referral/authorization guidelines for TOP Prime Remote enrollees (see [Chapter 24, Section 26](#)).

**4.6** This demonstration is not applicable to beneficiaries enrolled in TOP Prime, TOP Prime Remote, TRICARE Prime, TRICARE Prime Remote (TPR), TRICARE Prime Remote for Active Duty Family Members (TPRADFMs), or TYA (Prime option). Additionally, this demonstration is not applicable to TRICARE Standard beneficiaries whose home address (as determined by the claim) indicates a residence other than the Philippines. The demonstration is also not applicable to TRICARE Standard beneficiaries who reside in the Philippines (as determined by the claim) when they receive care from a provider who renders care in a location that is not included in the demonstration.

**4.7** All TOP requirements regarding utilization management, case management, quality management, and preauthorizations are applicable to demonstration participants. The TOP contractor is not required to enroll participants into the demonstration or to provide referral/authorization services to demonstration participants unless the requested service requires preauthorization (per [Chapter 7, Section 2](#) and TPM, [Chapter 1, Section 7.1](#)). The TOP contractor shall conduct a covered benefit review upon beneficiary or provider request; however, an authorization letter will not be generated except for those services which require preauthorization.

**4.8** TRICARE Standard beneficiaries who reside in the Philippines may request a waiver if they elect to receive care from non-approved providers or facilities in a demonstration area. Beneficiary waiver requests should be submitted in writing to the TOP contractor and will be considered on a case-by-case basis. Except for emergency care (which never requires prior approval), beneficiaries are encouraged to submit waiver requests prior to receiving care. However, the TOP contractor will also consider waiver requests that are submitted after care has been rendered. The Director, TRICARE Area Office (TAO)-Pacific will make the final determination if the beneficiary disagrees with the TOP contractor's decision. In such cases, the TOP contractor shall forward all supporting documentation and rationale regarding the waiver denial determination to the Director, TAO-Pacific to assist in the final determination. Some examples of potential beneficiary waiver situations include (this list is not all-inclusive):

- Beneficiaries who were engaged in an ongoing episode of care with a non-approved provider when the demonstration began, and who wish to continue care with their established provider.
- Beneficiaries who are unable to obtain an appointment with an approved provider within the appropriate time frame (based on TRICARE access standards for urgent, routine, and specialty care).

**Note:** Waivers for emergency care rendered by non-approved providers or facilities shall be approved on a retrospective basis based on TRICARE policy. Emergency care never requires preauthorization.

**4.9** Since provider participation in this demonstration is voluntary, there may be situations where the TOP contractor is unable to recruit a sufficient number and mix of approved providers in all specialties in designated demonstration areas. In these situations, the TOP contractor may request a specialty waiver so that beneficiaries can receive care from non-approved (certified) providers in accordance with normal TRICARE Standard reimbursement policy. The TOP contractor is responsible for identifying any anticipated or actual gaps in coverage by approved providers in demonstration area(s), and submitting a specialty waiver request in writing to the Director, TAO-Pacific. The waiver request shall include a description of the contractor's efforts to recruit approved providers in that particular specialty, as well as any perceived or known barriers to participation in the demonstration. If the Government approves the specialty waiver, the contractor shall implement processes to ensure that claims for that specialty (in the designated demonstration area) are processed under normal TRICARE Standard rules. This specialty waiver process will ensure that TRICARE Standard beneficiaries will not be liable for 100% of the charges (as described in [paragraph 4.4](#)) if the TOP contractor is unable to recruit approved providers in a particular specialty.

**4.10** A provider may be removed from the list for administrative reasons or may be removed for cause by the TOP contractor. The Government may also direct the TOP contractor to remove providers from the list for cause. A provider removed from the approved list may submit a written request to the TOP contractor for reconsideration. If the TOP contractor upholds the removal, the provider shall be given the right to appeal to the Director, TAO-Pacific. If the appeal decision is upheld by the Director, TAO-Pacific, there is no right to further appeal.

**Note:** The appeal process does not apply to certified providers who are not selected by the TOP contractor to participate in the demonstration as approved providers. Recruiting and retaining a sufficient number and mix of approved providers in demonstration area(s) is the responsibility of the TOP contractor. The TOP contractor is not required to offer approved provider status to every current certified provider in demonstration area(s).

**4.11** Claims for a provider removed from the list will be processed in accordance with [Chapter 13, Section 6, paragraph 4.4](#). The list will be updated on the contractor's web site on the first of the month following the provider being removed from the list.

## **5.0 DHA AND TOP CONTRACTOR RESPONSIBILITIES**

**5.1** The **DHA** Deputy Director (or his or her designee) shall:

**5.1.1** Determine the geographical area(s) for the demonstration and the phased implementation approach and timeline (if applicable) and communicate this information in writing to the TOP contractor no later than 240 calendar days prior to the start of health care delivery under the demonstration.

**5.1.2** Establish a process to allow a provider to appeal his/her removal from the approved list (see [paragraph 4.10](#)).

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**5.1.3** Issue final determinations regarding waiver requests from beneficiaries who elect to receive care from non-approved demonstration providers (see [paragraph 4.8](#)).

**5.1.4** Conduct periodic review and evaluation of the demonstration.

**5.2** The TOP contractor shall:

**5.2.1** Submit an implementation plan 180 days before the start of health care delivery under the demonstration in accordance with the requirements identified in the Contract Data Requirements List (CDRL), DD Form 1423-1, SP050 (Philippines Demonstration Implementation Plan). The contractor shall revise the plan if additional demonstration area(s) are identified by the Government after the contractor submits the implementation plan.

**5.2.2** Submit monthly data reports in accordance with the requirements identified on the CDRL, DD Form 1423-1, M360, Philippines Demonstration Data Report.

**5.2.3** Recruit and retain a sufficient number and mix of approved providers in demonstration area(s) to ensure access to the full range of covered TRICARE benefits, unless a specialty waiver has been requested. Approved providers must agree to comply with the demonstration participation requirements in [paragraph 3.1](#).

**5.2.4** Establish and maintain a list of all approved demonstration providers, including each provider's specialty, subspecialty, gender, work address, work fax number, and work telephone number for each demonstration location, and whether or not they are accepting new TRICARE patients. The approved list of providers must be submitted to **DHA** no later than 120 calendar days prior to the start of health care delivery under the demonstration. The TOP contractor shall provide beneficiaries with easy access to both the approved provider listing and the certified provider listing via a user-friendly searchable World Wide Web (WWW) site and any other means established at the contractor's discretion no later than 60 calendar days prior to the start of health care delivery in each demonstration area. Information on the WWW site and any other electronic lists shall be current within the last 30 calendar days. At a minimum, the data base shall be searchable by provider location, provider name, and provider specialty (if available).

**5.2.5** Provide certification oversight and monitor quality of care for providers and institutional facilities as prescribed in [Chapter 24, Section 4](#); [32 CFR 199.6](#); and TPM, [Chapter 12](#).

**5.2.6** Establish a waiver process for beneficiaries who reside in the Philippines and who request or receive care from non-approved providers or facilities in a demonstration area (see [paragraph 4.8](#)).

**5.2.7** Develop and publish materials to educate beneficiaries and providers on all aspects of the Philippines Demonstration Project. In addition to providing specific information regarding the demonstration, the TOP contractor shall educate approved providers on aspects of the TRICARE program, including (but not limited to) TRICARE eligibility requirements, TRICARE benefits, claims submission requirements, and the requirements in [32 CFR 199.9](#) and [Chapters 13](#) and [24](#) as they relate to anti-fraud activities.

**5.3 DHA** and the TOP contractor shall:

**5.3.1** Develop and implement a communication plan to ensure that beneficiaries and providers are informed regarding the area(s) that are participating and not participating in this demonstration. The communication plan shall also include the process(es) for educating beneficiaries and providers regarding the demonstration rules and business processes, to include the processes for requesting waivers.

**5.3.2** Establish timelines and processes to facilitate prompt processing of waiver requests and provider appeals in accordance with demonstration policy (see [paragraphs 4.8, 4.9, and 4.10](#)).

**6.0 CLAIMS PROCESSING AND REIMBURSEMENTS**

**6.1** All TRICARE Encounter Data (TED) records for this Demonstration must include Special Processing Code **PH** (Philippines Demonstration Project).

**6.2** TRICARE Standard beneficiaries residing in the Philippines who receive care from approved providers in demonstration area(s) will only be liable for normal cost-shares and deductibles applicable under the TRICARE Standard option. TRICARE Standard beneficiaries residing in the Philippines who receive care from non-approved providers in demonstration area(s) will be liable for 100% of the cost unless a beneficiary waiver or a specialty waiver has been granted (see [paragraphs 4.8 and 4.9](#)).

**7.0 EVALUATIONS**

**DHA** will evaluate the demonstration using a combination of administrative and survey measures to determine whether access to care is adequate under the terms of the demonstration. In addition, a cost analysis will be conducted to determine the cost impact to beneficiaries and the Government. Finally, the demonstration will be evaluated to determine the impact (if any) on the occurrence of aberrant claims activity.

**8.0 EFFECTIVE DATE**

The Philippines Demonstration Project is anticipated to last for three years. The effective date is January 1, 2013.

- END -

## TRICARE Evaluation Of Centers For Medicare And Medicaid Services (CMS) Approved Laboratory Developed Tests (LDTs) Demonstration Project

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### 1.0 PURPOSE

The purpose of the demonstration project is to improve the quality of health services for TRICARE beneficiaries. The demonstration is intended to determine whether it is feasible for the Department of Defense (DoD) to review CMS approved LDTs, which have not received U.S. Food and Drug Administration (FDA) medical device 510(k) clearance or premarket approval (therefore considered non-FDA approved), to determine if they meet TRICARE requirements for safety and effectiveness according to the hierarchy of reliable evidence ([32 CFR 199.2\(b\)](#)) and allow those that do to be covered as a benefit under the TRICARE Program. The demonstration project will operate throughout the continental United States, and in the TRICARE overseas regions.

### 2.0 BACKGROUND

**2.1** On December 27, 2011 a notice was published in the **Federal Register** (76 FR 80905-80907) announcing the start of a demonstration project in which the DoD will determine whether it is feasible for the DoD to evaluate the potential improvement of the quality of health care services for TRICARE beneficiaries who could access Centers for Medicare and Medicaid Services (CMS) approved LDTs not yet examined by the FDA. An evaluation will be conducted during the third year of the demonstration period to determine how many TRICARE approved LDTs were provided to beneficiaries across all TRICARE regions. The evaluation will also include a review of the LDT review and recommendation process. These results of the evaluation will provide an evaluation of the potential improvement of the quality of healthcare services for beneficiaries who would not otherwise have access to these safe and effective tests. Based on the utilization results, a decision will be made to modify [32 CFR 199.4\(g\)\(15\)\(i\)\(A\)](#) to remove the restriction for non-FDA approved devices and allow TRICARE cost-sharing of CMS approved LDTs determined to meet the TRICARE criteria for safety and effectiveness.

**2.2** According to [32 CFR 199.4\(g\)\(15\)\(i\)\(A\)](#) the **Defense Health Agency (DHA)** may not cost-share medical devices including LDTs if the tests are non-FDA approved, that is, they have not received FDA marketing 510(k) clearance or premarket approval. Non-FDA approved LDTs are not covered, except under the LDT demonstration project.

**2.3** An LDT is a test developed by a single clinical laboratory that provides testing to the public but does not sell the lab kit to other labs. In the past, these were relatively simple tests used to diagnose or monitor diseases and other conditions within a single laboratory usually at a local large hospital or academic medical center. Today, these tests are highly complex.

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**2.4** Laboratories are assessed and accredited under quality standards set by CMS under the Clinical Laboratory Improvement Amendments (CLIA) of 1988. CMS regulates laboratories that use LDTs as well as FDA approved tests. Laboratories performing moderate or high complexity tests are subject to specific regulatory standards governing certification, personnel, proficiency testing, patient test management, quality assurance, quality control, and inspections. CLIA certification and periodic inspections ensure the analytical validity of laboratory tests, including LDTs. Analytical validity refers to how well a test performs in the laboratory; that is, how well the test measures the properties or characteristics it is intended to measure.

**2.5** CMS regulations do not have a specific requirement that devices be FDA approved. As a result CMS policy provides a mechanism for the review and payment of non-FDA approved LDTs (Section 522 of the Benefits Improvement and Protection Act). Non-FDA approved LDTs which meet CMS's standards are approved through its National Coverage Determination (NCD) or Local Coverage Determination (LCD) process. Once a LDT receives a LCD, it is effectively considered a nationwide Medicare covered benefit.

### **3.0 POLICY**

**3.1** A demonstration project was initiated by the **DHA** to test whether CMS approved LDTs which have not received FDA medical device 510(k) clearance or premarket approval (therefore considered non-FDA approved) are safe and effective for cost-sharing for TRICARE beneficiaries. The demonstration project will establish a process for TRICARE to evaluate the subset of non-FDA approved LDTs currently covered by a CMS NCD or LCD for TRICARE-eligible patients prescribed LDTs for the diagnosis and treatment of cancer. Any LDT approved for cost-sharing under the demonstration project will be covered as of the date of approval by the Director/**DHA** as defined in [Figure 18.13-1](#).

**3.2** LDTs approved by the Director, **DHA** shall be limited to only those that significantly inform clinical decision making for cancer surveillance, surgery for cancer, chemotherapy, or radiation therapy for cancer. The demonstration project shall provide an evaluation of the potential improvement of the quality of health care services for TRICARE beneficiaries with diagnoses of specific oncological diseases, procedures, and treatments, who would not otherwise have access to these tests.

**3.3** LDTs approved by the Director, **DHA** for cost-sharing shall follow existing **DHA** processes for inclusion as a TRICARE benefit during the demonstration period. Those LDTs included in the demonstration project will have met the TRICARE requirements for safety and efficacy.

**3.4** Notification to the contractors of LDT eligibility for cost-sharing shall be published, periodically, to this chapter of the TOM, as detailed in [Figure 18.13-1](#). The codes listed in [Figure 18.13-1](#) which are payable under this demonstration project may also remain on the No Government Pay List (NGPL) since the tests are not covered under the TRICARE Basic Program. LDTs listed in [Figure 18.13-1](#) are covered only as part of the demonstration project as denoted with the special processing code which shall be associated with each claim.

**3.5** **DHA** shall cost-share all medical care and treatment associated with the LDT in the same manner it would any other care or treatment associated with the provision of medically needed

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care. DHA will reimburse, as directed in policy, and as covered under the TRICARE Basic Program and TRICARE policy, the costs associated with the purchase and administration of all approved chemotherapy agents, all inpatient and outpatient care, including diagnostic and laboratory services for eligible TRICARE beneficiaries if the following conditions are met:

**3.5.1** The specific LDT has been approved by the Director, DHA for cost-sharing to eligible TRICARE beneficiaries; and

**3.5.2** The contractor has preauthorized the LDT, and verified that the TRICARE authorized provider has determined the eligible patient's medical need for the LDT in accordance with all indications detailed in [Figure 18.13-1](#); and

**3.5.3** The contractor has verified that the patient's clinical diagnoses support the medical need and are fully documented according to and consistent with all indications detailed in [Figure 18.13-1](#); and

**3.5.4** The contractor has, as noted in TRICARE Policy Manual (TPM), [Chapter 1, Section 7.1, paragraph 2.0](#), for dual eligible beneficiaries, applied all requirements when TRICARE is primary payer. As secondary payer, TRICARE will rely on and not replicate Medicare's determination of medical necessity and appropriateness in all circumstances where Medicare is primary payer. In the event that TRICARE is primary payer for these services and preauthorization was not obtained, the contractor shall obtain the necessary information and perform a retrospective review.

**3.6** Cost-shares and deductibles applicable to TRICARE also apply under this demonstration. For TRICARE Prime enrollees, including those enrolled in Uniformed Services Family Health Plan (USFHP), applicable copays apply.

**3.7** The demonstration will expire on January 26, 2015. Requirements of this chapter as related to the laboratory tests demonstration cease at midnight on January 26, 2015. Only TRICARE beneficiaries with current eligibility, as defined in [paragraph 7.0](#), may participate in the LDT demonstration project. Claims shall not be processed for individuals not eligible for TRICARE benefits. All medical care, treatments, or testing, with the exception of the LDT which has approval during the demonstration period only, must be TRICARE eligible care provided to TRICARE eligible beneficiaries. This applies to all care rendered during or after the end date of the LDT demonstration project.

**3.8** The records management requirements described in [Chapter 2](#) apply to the LDT demonstration project.

#### **4.0 APPLICABILITY**

**4.1** The demonstration applies to all TRICARE-eligible beneficiaries. Active duty members continue to be eligible for Direct Care (DC) system services. All eligible TRICARE beneficiaries will be included in the demonstration project.

**4.2** The benefit for non-FDA approved LDTs covered by the LDT demonstration project differs from the Basic TRICARE benefit. Coverage inquiries shall be submitted to, and resolved by the

appropriate contractor (referencing the TRICARE Evaluation of CMS Approved LDTs Demonstration Project). Regarding a beneficiary with other insurance that provides primary coverage, any medically necessary reviews the contractor believes are necessary, to act as a secondary payer, shall be performed on a retrospective basis. As noted in TPM, [Chapter 1, Section 7.1, paragraph 2.0](#), for dual eligible beneficiaries, these requirements apply when TRICARE is primary payer. As secondary payer, TRICARE will rely on and not replicate Medicare's determination of medical necessity and appropriateness in all circumstances where Medicare is primary payer. In the event that TRICARE is primary payer for these services and preauthorization was not obtained, the contractor shall perform a retrospective claims review, and apply the special processing code after obtaining all necessary supporting information identified in this chapter and specified in [Figure 18.13-1](#).

**4.3** Since the DoD has no authority to cost-share non-FDA approved medical devices such as LDTs special appeals rights do not apply. Therefore, denials are not appealable.

## **5.0 GENERAL DESCRIPTION OF ADMINISTRATIVE PROCESS**

**5.1** The TRICARE authorized provider shall determine the eligible patient's needs and consult with the contractor to request preauthorization of the LDT.

**5.2** The contractor shall preauthorize LDTs to verify that the TRICARE authorized provider has determined the eligible patient's medical need based on the patient's clinical diagnoses which support the medical need and, the contractor shall document these facts according to and consistent with the American Medical Association (AMA) Current Procedural Terminology (CPT), International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) codes, and according to all indications detailed in [Figure 18.13-1](#). Following the contractor's identification of an appropriate request for an approved LDT, as identified within the terms of the demonstration, the TRICARE authorized provider requesting/ordering the LDT shall be notified that they are authorized to utilize the LDT for the purpose of informed clinical decision making for cancer related surveillance, surgical interventions, chemotherapy, and radiation therapy. The contractor shall issue the notification of decision to authorize use of the LDT in writing to both the applicant provider and the beneficiary receiving the LDT. In the event that TRICARE is primary payer for approved LDTs, and preauthorization was not obtained, the contractor shall obtain the necessary information and perform a retrospective review to assure that all [Figure 18.13-1](#) criteria for coverage have been met. If met, the LDT is eligible for TRICARE cost-sharing. The contractor shall identify each claim with the special processing code.

**5.3** LDTs with current FDA 510(k) clearance or premarket approval shall not be considered for this demonstration project; but shall continue to be considered for coverage under the current routine coverage determination process of the TRICARE program.

**5.4** All claims for approved care under the demonstration shall be submitted to the contractor for adjudication. In the event of contractor transition to another contractor, the outgoing contractor shall provide a list of all patients under approved LDT care.

## 6.0 DHA RESPONSIBILITIES

**6.1** The LDT Demonstration Project will be paid by DHA as non-financially underwritten transactions in accordance with each respective contractor's agreement and shall follow vouchering rules in [Chapter 3](#) or Section G of the contract.

**6.2** LDTs approved by the Director, DHA for cost-sharing under the demonstration will include the assignment of the special processing code to identify each TRICARE Encounter Data (TED) record to allow LDT identification.

**6.3** The special processing code shall be assigned to identify all claims paid under the demonstration. The intent of this policy is to process claims for the DHA identified LDTs with the special processing code and the associated technical and professional components associated with the LDT-related CPTs. All other medical care, treatments, and associated testing based on medical necessity as a result of the LDTs results are to be processed under the basic TRICARE benefit.

**6.4** Perform periodic review and evaluation of the demonstration claims adjudication process.

**6.5** Provide specific written guidance to the Managed Care Support Contractor or other contractor with jurisdiction for the claim regarding laboratory services and claims adjudication services to be provided by the claims processor under the terms of the demonstration.

**6.6** The Assistant Secretary of Defense (Health Affairs) (ASD(HA)) is the designated executive agent for the demonstration project. They shall designate a project officer in the Office of the Chief Medical Officer (OCMO) for the demonstration. The project officer shall provide clinical oversight and ongoing program management of the demonstration.

## 7.0 CONTRACTOR RESPONSIBILITIES

The contractor shall:

**7.1** Verify the patient's eligibility on the Defense Enrollment Eligibility Reporting System (DEERS).

**7.2** The patient shall be referred to the pass/ID card section of the military installation nearest their home for an eligibility determination. The patient shall be notified that participation in the LDT Demonstration is dependent on current eligibility.

**7.3** If a patient is listed on DEERS as being eligible as of the date the LDT is performed, all services provided shall be covered. This also applies to patients whose treatment is in progress when the demonstration expires.

**7.4** Issue an authorization or denial letter to the applicant provider and patient once a determination is made. It is the contractors' responsibility to correctly voucher the TED records for payment.

**7.5** The contractor shall preauthorize LDTs and verify medical need based according to all indications detailed in [Figure 18.13-1](#). The contractor shall issue the notification of decision to

authorize use of the LDT in writing to both the applicant provider and the beneficiary receiving the LDT. In the event that TRICARE is primary payer for approved LDTs, and preauthorization was not obtained, the contractor shall obtain the necessary information and perform a retrospective review to assure that all [Figure 18.13-1](#) criteria for coverage have been met. In addition, for all retrospective claims, the contractor shall include the special processing code.

**7.6** The contractor shall manage and resolve all inquiries related to the demonstration project, including claims inquiries related to LDTs approved for cost-sharing during the LDT demonstration project.

## **8.0 CLAIMS PROCESSING REQUIREMENTS**

**8.1** Verify TRICARE-eligibility in the DEERS prior to payment. It is the contractors' responsibility to correctly voucher the TED records for payment.

**8.2** Both laboratory and professional charges shall be reimbursed based on existing TRICARE reimbursement rules. The contractor shall develop a prevailing charge following the procedures in TRICARE Reimbursement Manual (TRM), [Chapter 5, Section 1](#).

**8.2.1** For purposes of the LDT demonstration project, Molecular Pathology Procedure test codes, when applicable, will be assigned to the list of approved LDTs in [Figure 18.13-1](#). Beginning January 1, 2012, 101 additional Molecular Pathology Procedure test codes were released by the AMA's CPT Editorial Panel and published in the CMS publication, MLN Matters at web site: <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7654.pdf>. These new molecular pathology procedure test codes are in the following CPT Code range: 81200 through 81299, 81300 through 81383 and 81400 through 81408. Each of these new molecular pathology procedure test codes represents a test that is currently being used. DHA understands that, for LDT identification and billing purposes, existing, valid, genetic laboratory CPT test codes are "stacked" or "bundled" to represent a given test. For example, Laboratory A has a genetic test that is generally billed in the following manner - 83891 (one time) + 83898 (multiple times) + 83904 (multiple times) + 83909 (multiple times) - in order to represent the performance of the entire test. All TED records for this demonstration shall be coded with the special processing code and should follow all TED requirements stated in the TRICARE Systems Manual (TSM), [Chapter 2](#).

**8.2.2** The contractor shall assure that the LDT manufacturers/laboratories submit all charges on the basis of fully itemized bills. Each service and supply shall be individually identified and submitted on the appropriate claim form. If a claim associated with the demonstration project has missing information, [Chapter 8, Section 6](#) guidelines shall be followed to either return or develop the claim requesting the missing information.

**8.2.3** All claims for the approved LDT shall meet the requirements outlined in [Figure 18.13-1](#). All other covered care associated with treatment will be provided in accordance with the respective provisions of the TPM or TRM. Care associated with the LDT must be medically needed and appropriate medical care and not otherwise excluded as a TRICARE benefit.

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### Chapter 18, Section 13

#### TRICARE Evaluation Of Centers For Medicare And Medicaid Services (CMS) Approved Laboratory Developed Tests (LDTs) Demonstration Project

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**8.3** Cost-shares and deductibles applicable to TRICARE shall also apply under the demonstration. For TRICARE Prime enrollees, including those enrolled in USFHP, applicable copays shall apply.

**8.3.1** Normal double coverage provisions apply to LDTs approved under the demonstration. Acceptable evidence of processing by the double coverage plan is outlined in [Chapter 4](#). In double coverage situations, the demonstration shall pay the balance after the Other Health Insurance (OHI) has paid.

**8.3.2** Claims for this demonstration shall be paid from the applicable non-underwritten bank account (see [Chapter 3](#)), and submitted through normal TRICARE Encounter Data (TED) processing as required in the TSM and in accordance with each respective contractor's agreement if claims data is not submitted through the TED system.

**8.3.3** Claims for this demonstration shall be submitted either by Electronic Media Claim, through the dedicated demonstration mailing address, or through the appropriate regional claims processing address(es).

#### **9.0 EFFECTIVE DATE**

This demonstration is effective for claims for services provided on or after the date the LDT was approved by the Director, **DHA** as defined in [Figure 18.13-1](#).

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**FIGURE 18.13-1 APPROVED LABORATORY DEVELOPED TESTS (LDTs)**

<b>LDT #1 Name:</b>	<b>Oncotype DX® Breast Cancer Assay (Oncotype DX®)</b>	
LDT #1 Effective Date of Coverage:	22 May 2012	
LDT #1 Manufacturer & Address:	Genomic Health, Inc. 301 Penobscot Road Redwood City, CA 94063  CLIA ID Number-05D1018272	
LDT #1 Coverage Guidelines:	Oncotype DX® is covered for the following: <ul style="list-style-type: none"> <li>• Estrogen Receptor (ER) positive (+), lymph node (N) negative (-) breast cancer who are considering whether to use adjuvant chemotherapy in addition to hormonal therapy.</li> <li>• ER+ (or progesterone receptor +), N-, human epidermal growth factor receptor 2 negative (HER2-) women with stage I or II breast cancer who are considering whether to have adjuvant chemotherapy.</li> </ul>	
CPT Coding when clinically indicated by Coverage Guidelines:	CPT <sup>4</sup> Code	84999 (unlisted chemistry procedure)
	HCPCS "S" Code required for LDT Demonstration	S3854 (Gene expression profiling panel for use in the management of breast cancer treatment)

<b>LDT #2 Name:</b>	<b>BRACAnalysis®</b>	
LDT #2 Effective Date of Coverage:	22 May 2012	
LDT #2 Manufacturer & Address:	Myriad Genetic Laboratories, Inc. 320 Wakara Way Salt Lake City, UT 84108  CLIA ID Number-46D0880690	

<sup>1</sup> Given the complexity of risk assessment and test interpretation, as well as the importance of adequate medical management, **genetic counseling is very important** for all individuals with or at risk of carrying a deleterious *BRCA1* or *BRCA2* gene variant. Genetic counseling may only be provided by TRICARE-authorized providers, in accordance with TRICARE Policy Manual (TPM) 6010.54-M, [Chapter 6, Section 3.1](#).

<sup>2</sup> Close blood relatives include first-, second-, and third-degree relatives as described in the National Comprehensive Cancer Network (NCCN) Guidelines Version 1.2012 Breast and/or Ovarian Cancer Genetic Assessment Pedigree: First-, Second-, and Third-degree relatives of Proband.

<sup>3</sup> Lynch syndrome-associated cancers include endometrial, ovarian, gastric, pancreas, ureter and renal pelvis, biliary tract, brain (usually glioblastoma), and small intestine cancers, as well as sebaceous gland adenomas/carcinomas and keratoacanthomas.

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<sup>5</sup> When current NCCN Guidelines™ for Colorectal Cancer Screening state "genetic testing" or "consider genetic testing."

## Department of Defense (DoD) Enhanced Access to Patient-Centered Medical Home (PCMH): Demonstration Project for Participation in the Maryland Multi-Payer Patient-Centered Medical Home Program (MMPCMHP)

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### 1.0 PURPOSE

**1.1** The goal of TRICARE participation in the MMPCMHP, administered by the Maryland Health Care Commission (MHCC), is to test if the PCMH model, in qualified primary care practices: (1) provides higher quality, and less costly care for TRICARE beneficiaries who receive care in Maryland; and (2) leads to higher satisfaction for patients, Nurse Practitioners (NPs), and Primary Care Physicians (PCPs). The demonstration seeks to reward medical homes for the additional services while creating a viable economic model for health care purchasers and maintaining administrative simplicity.

**1.2** TRICARE will pay claims using the traditional fee for service schedule and a fixed transformation, per TRICARE beneficiary per month, payment for enhanced care coordination and practice transformation, as defined herein. Additional incentive payments, expected to be budget neutral, will be made based upon calculated shared savings and measured quality improvements. The demonstration will be conducted under statutory authority provided in 10 United States Code (USC) 1092 and will continue for two years.

**1.3** Existing claims payment methodology for health care claims, whether non-underwritten or underwritten, is unchanged by TRICARE beneficiary participation in the MMPCMHP Demonstration. Claims for underwritten beneficiaries enrolled in the MMPCMHP Demonstration will be paid from the applicable underwritten Contract Line Item Number (CLIN) and submitted through normal TRICARE Encounter Data (TED) system processing as required in the TRICARE Systems Manual (TSM) with the applicable special processing code (MM) indicating participation in the MMPCMHP Demonstration. All existing TRICARE eligibility, reimbursement, co-payments, cost-shares and deductible rules apply for all beneficiaries enrolled in the MMPCMHP Demonstration.

**1.4** Shared Savings and Fixed Transformation payments shall be paid from non-financially underwritten funds.

**1.5** TRICARE for Life (TFL), Dual Eligible and beneficiaries with Other Health Insurance (OHI) are excluded from participation in the MMPCMHP.

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## 2.0 BACKGROUND

The Military Health System (MHS) defines the PCMH as a model of care adopted by the American Academy of Family Physicians, the American Academy of Pediatrics (AAP), the American College of Physicians (ACP), and the American Osteopathic Association (AOA) that seeks to strengthen the provider-patient relationship by replacing episodic care with coordinated care and a long-term healing relationship. TRICARE participation in the MMPCMHP offers a vehicle for TRICARE to participate in a state-wide initiative, share in PCMH project cost with other payers, promote enhanced provider practice education and training in PCMH concepts funded through Maryland state legislative initiatives as well as evaluate alternatives to current reimbursement methodologies. Additional information is available at <http://mhcc.maryland.gov/pcmh/>.

## 3.0 DEFINITIONS

The following definitions are applicable to terms used in the demonstration.

### 3.1 Maryland Health Care Commission (MHCC)

An independent regulatory agency whose mission is to plan for health system needs, promote informed decision-making, increase accountability, and improve access in a rapidly changing health care environment by providing timely and accurate information on availability, cost, and quality of services to policy makers, purchasers, providers, and the public. The Commission's vision for Maryland is to ensure that informed consumers hold the health care system accountable and have access to affordable and appropriate health care services through programs that serve as models for the nation.

### 3.2 Fixed Transformation Payment

The semi-annual lump sum payment made by the **Defense Health Agency (DHA)** through the Managed Care Support Contractor (MCSC) to a practice.

### 3.3 Shared Savings or Incentive Payment

The payment a practice receives which is derived from the difference between a practice's historical medical expenses and the total medical expenses per patient in the current year, adjusted for inflation. Incentive payments are subject to further revision by TRICARE.

### 3.4 Medical Expenses

Carrier reimbursements and patient liabilities for hospital inpatient services, hospital outpatient services, freestanding medical facility services, health care professional services, nursing homes care, Skilled Nursing Facility (SNF) care, Home Health Care (HHC), hospice services, and Durable Medical Equipment (DME). TRICARE expects to include pharmacy costs as part of "medical expenses" and will be using pharmacy costs as part of the shared savings calculation for analysis purposes.

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#### 3.5 Physician Practice Connections Patient-Centered Medical Home (PPC-PCMH)

The PPC-PCMH program operated by the National Committee for Quality Assurance (NCQA) in accordance with standards published at: <http://www.ncqa.org/tabid/631/default.aspx>.

#### 3.6 Participating Patient

A qualifying individual who is a person covered under TRICARE and is a patient of a participating practice.

#### 3.7 Patient Enrollment List/File

The list of all of a practice's participating patients who have been attributed to the Program. TRICARE's MCSC will generate this list and provide it to the relevant participating practice.

#### 3.8 Practice

A primary care practice or federally qualified health center organized by or including pediatricians, general internal medicine physicians, family medicine physicians, or NPs.

#### 4.0 MCSC ROLE

The MCSC shall attribute/assign patients to the demonstration, make fixed transformation payments and make shared savings or incentive payments to the participating practices based on guidance in [paragraph 5.0](#).

#### 5.0 DEADLINES AND MILESTONES

Within 30 business days after the **Federal Register** notice period ends and every six months thereafter for the duration of the demonstration, MHCC will provide **DHA** a National Provider ID (NPI) List ([Figure 18.14-1](#)) of MMPCMHP participating providers. **DHA** will convey the NPI List to the MCSC. At a minimum, the NPI List will contain the individual NPI, the organizational NPI, the provider's name, the practice size, practice location, practice address, and NCQA Recognition Level.

**5.1** Within 20 business days of receipt of the NPI List or 20 business days after the beginning of the current attribution cycle, whichever is later, the MCSC will verify eligibility, attribute/assign TRICARE Prime and TRICARE Standard beneficiaries to the PCMH Demonstration project, calculate fixed transformation payments, and submit completed [Figure 18.14-2](#) and [Figure 18.14-3](#) to **DHA** for approval.

##### 5.1.1 Attribution and Assignment

To attribute TRICARE Prime and TRICARE Standard beneficiaries to the PCMH Demonstration project.

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#### 5.1.1.1 For TRICARE Prime Enrollees

The MCSC will assign/attribute beneficiaries to the PCMH Demonstration project based on current TRICARE Prime enrollment with the participating practices on the NPI List.

#### 5.1.1.2 For TRICARE Standard Beneficiaries

The MCSC will assign/attribute beneficiaries based on evidence of Evaluation & Management (E&M) services provided by participating practices/providers on the NPI List during the previous year.

The MCSC shall:

- Count the number of visits (all same day services count as one) for the E&M codes (Current Procedural Terminology (CPT)<sup>1</sup> codes 99201 - 99205; 99211 - 99215; 99381 - 99387; 99391 - 99397; Office Consult 99241 - 99245) for patients using each MMPCMHP practice or practice site.
- Select the practice with the highest number of visits in the year as the attributed practice.
- **In the event of** a tie, the MCSC shall attribute the beneficiary to the practice with the most recent visit.

5.1.1.3 The MCSC shall complete [Figure 18.14-2](#) for each attributed patient.

#### 5.1.2 Fixed Transformation Payment Calculation

To calculate the fixed transformation payment:

- For each fixed transformation payment, the MCSC will use [Figure 18.14-1](#) and [Figure 18.14-4](#) to determine the specific payment for each practice.
- The MCSC will select the Physician Practice Site Size, NCQA Recognition Level and determine the per patient transformation payment.
- The MCSC will multiply the payment listed by the number of TRICARE Prime and TRICARE Standard **beneficiaries** who are attributed to the practice. Information from this process and [Figure 18.14-1](#) will be used to create the Patient Enrollment File ([Figure 18.14-3](#)).
- **The MCSC will contact the Contracting Officer's Representative (COR) or designee should issues arise that require clarification, e.g., non-matching NPIs, address discrepancies, duplicate records for beneficiaries, etc.**

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- Beneficiaries over the age of 65, as of the first day of the six month period for which fixed transformation payments are being made, shall be excluded from participation.
- Beneficiaries whose address is other than Maryland, Delaware, District Of Columbia, Pennsylvania, Virginia or West Virginia shall be excluded from participation.
- If a beneficiary is found to be listed in Defense Enrollment Eligibility Reporting System (DEERS) more than once (i.e., listed under more than one person ID), include the beneficiary only once for attribution. Duplicative information (i.e., all Social Security Number (SSN) and/or person ID combinations) should be included in [Figure 18.14-2](#).
- The MCSC will submit completed [Figure 18.14-2](#) and [Figure 18.14-3](#) through the Performance Assessment Tracking (PAT) database for COR's review and approval. After COR review, the MCSC will be notified of approval or of requested changes.
- Within two business days of notification of approval by the COR, the MCSC will submit a voucher to the Contract Resource Management (CRM) office, with a copy to the COR, for approval to release payments (follow standard manual approval process).
- Within two business days after **DHA** notification of COR/CRM approval to release payments, the MCSC will send [Figure 18.14-2](#) and the fixed transformation payment to each practice. Each practice shall only receive information pertaining to their patients and/or practice.

**5.1.3** Within two business days of payment, the MCSC will advise the COR or designee of the amount and date that the fixed transformation payments were sent to the practices. Every six months thereafter, for the duration of the PCMH Demonstration, the MCSC will repeat steps in [paragraphs 5.0](#) through [5.1.3](#).

## **5.2 Shared Savings or Incentive Payments**

**5.2.1** Shared savings or incentive payments can be earned by participating practices and are calculated as listed below. Practices that meet the annual performance criteria specified by MHCC will be qualified to receive the defined percent of any savings generated by the Practice during TRICARE Demonstration Years 1 and 2.

**5.2.2** Practices shall report the criteria defined in [Figure 18.14-4](#) to MHCC. **DHA** will calculate the difference between a practice's historical medical expenses and the total medical expenses per patient in the current year, adjusted for inflation. This difference will serve as the basis of the shared savings or incentive payment calculation. Should there be no savings, the practice will not be eligible for an incentive payment, nor will it be required to repay the fixed transformation payments.

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**5.2.3** Shared Savings or Incentive Payment Calculation

To calculate the shared savings or incentive payment:

- **DHA** will notify the MCSC of the shared savings achieved for each practice. **DHA** will provide the MCSC information (Items #1 through 4) in [Figure 18.14-5](#).
- Within 10 business days of notification of the shared savings achieved, the MCSC will prepare the incentive payments for eligible practices, and will submit a voucher to the COR for acceptance of service and to **DHA** CRM for approval to release payments (follow standard manual voucher approval process). Within two business days after notification of **DHA** approval of shared savings payment release, the MCSC will send the shared saving payments to each practice.
- Within five business days of payment, the MCSC will submit a copy of [Figure 18.14-5](#) (Items #1 through 5 completed) to the COR or designee.

**5.2.4** Every year thereafter, for the duration of the PCMH Demonstration, the MCSC will repeat steps in [paragraph 5.2](#).

**FIGURE 18.14-1 NPI LIST - SUBMITTED BY MHCC TO THE MCSC**

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1. Individual NPI
2. Organization NPI
3. Federal Tax ID
4. Practice Registration Number
5. Practice Size (S=< 10,000 Patients, M=10,001-<=20,000, L=+20,001 and above)
6. NCQA Recognition Level
7. Provider First and Last Name
8. Practice Site Name
9. MMPCMHP Practice Location/Address

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## Department Of Defense (DoD) Applied Behavior Analysis (ABA) Pilot For Non-Active Duty Family Members (NADFMs)

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### 1.0 PURPOSE

Under authority of 10 United States Code (USC) 1092, TRICARE will continue to offer the benefits of the "ABA Pilot" offers a supplemental benefit for NADFMs with an Autism Spectrum Disorder (ASD) by allowing bachelors-level Board Certified Assistant Behavior Analysts (BCaBAs) and paraprofessional "ABA Tutors" working under the supervision of masters-level Board Certified Behavior Analysts (BCBAs) or Board Certified Behavior Analysts - Doctoral (BCBA-Ds) to conduct ABA reinforcement that is often provided by parents. ABA Pilot coverage of ABA reinforcement for NADFMs will be implemented as a separate interim benefit from the coverage of ABA benefits currently provided under the TRICARE Basic Program to both Active Duty Family Members (ADFM) and NADFMs with ASD, and separate from the Extended Care Health Option (ECHO) Enhanced Access to Autism Services Demonstration available by law only to ADFMs.

ABA for ASD has been covered when provided by masters-level (or above) behavior analysts (or licensed independent behavioral or medical health care providers authorized to provide ABA within the scope of their license and privileges) for ADFMs, but not NADFMs, under the Program for Persons with Disabilities (PFPWD) since 2001 and then under ECHO since 2008. In 2008 the Department implemented the Enhanced Access to Autism Services Demonstration (the "Autism Demonstration") to give ADFMs under ECHO access to supplemental ABA reinforcement under an alternative tiered service delivery model using minimally-trained paraprofessional "ABA Tutors" as parent/caregiver extenders working under the supervision of masters-level BCBAs, doctoral-level BCBA-Ds or bachelors-level BCaBAs who were authorized as ECHO-only ABA providers.

Under 10 USC 1092, all TRICARE beneficiaries – ADFMs and NADFMs alike – are eligible under the TRICARE Basic Program to receive the ABA provided only from those providers who meet TRICARE Basic Program certification standards (i.e., Board Certified Behavior Analysts only masters-level or above BCBAs, BCBA-Ds, or other licensed independent behavioral or medical health care providers authorized to provide ABA within the scope of their license and privileges). ABA that is now covered as a benefit under the TRICARE Basic Program (when based on a proper ASD diagnosis from a qualified ABA-diagnosing provider, when rendered by an authorized ABA provider, and when appropriate for a particular beneficiary) includes: a baseline assessment of functioning; development and implementation of an ABA treatment plan; education/training of parents/caregivers in ABA reinforcement techniques; and follow-up assessment of treatment progress.

The provisions of 10 USC 1092, give the Department the authority to offer enhanced access to ABA (i.e., the tiered service delivery model) to designated TRICARE beneficiaries under a separate program other than ECHO.

## **2.0 BACKGROUND**

**2.1** The Military Health System (MHS) includes 59 military hospitals, over 350 military health clinics, and an extensive network of private sector health care partners, that provide medical care for more than nine million beneficiaries.

**2.2** ASDs affect essential human behaviors such as social interaction, the ability to communicate ideas and feelings, imagination, and the establishment of relationships with others. For a description of ASD and applicable diagnostic codes, see the TRICARE Policy Manual (TPM), [Chapter 7, Section 3.17](#).

**2.3** ABA has been introduced to ameliorate the negative impact of autism. Currently, ABA is accepted within the MHS as showing promise to reduce or eliminate specific problem behaviors and teach new skills to certain (but not all) individuals with ASD. ABA reinforcement requires family member involvement as the parent(s) or caregiver(s) must consistently implement the ABA reinforcement interventions in the home setting in accordance with the prescribed treatment plan.

NADFM)s wanting to participate in the ABA Pilot must meet all requirements for the authorization and provision of ABA under the TRICARE Basic Program outlined in the TPM, [Chapter 7, Section 3.17](#).

**2.4** Only those individuals who meet the requirements specified in [paragraph 3.4](#) working under the supervisory oversight of an ABA provider licensed or certified by a State or certified by the BACB (<http://www.bacb.com>) as a BCBA (ABA Supervisors) are eligible to provide ABA reinforcement.

**2.5** The BCBA)s clinical, supervisory, and case management activities are often supported by other staff such as Board Certified Assistant Behavior Analysts (BCaBA) working within the scope of their training, practice, and competence. The BCaBA assists BCBA)s or BCBA-D)s in various roles and responsibilities as determined appropriate by BCBA)s or BCBA-D)s and delegated to the BCaBA. Under the ABA Pilot, the BCaBA serves in a clinical support role and may supervise ABA Tutors, but not independently. BCaBA)s also may provide ABA reinforcement for more complex cases. Only those individuals who meet the requirements specified in [paragraph 3.3](#) working under the supervisory oversight of an ABA provider licensed or certified by a State or certified by the BACB (<http://www.bacb.com>) as a BCBA or BCBA-D (ABA Supervisors) are eligible to provide ABA reinforcement.

**2.6** The ABA Pilot allows TRICARE reimbursement for ABA reinforcement delivered by supervised bachelor's level BCaBA)s and paraprofessional providers (ABA Tutors) under a modified Corporate Services Provider (CSP) model that: (a) meets the TRICARE definition of a CSP under 32 CFR 199.6(e)(2)(ii)(B); and (b) meets the requirements specified in [paragraph 3.1](#).

## EXPIRED As Of September 30, 2015 - Pilot Program for Refills of Maintenance Medications for TRICARE For Life (TFL) Beneficiaries through the TRICARE Mail Order Program (TMOP)

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### 1.0 PURPOSE

This pilot program will allow the Department of Defense (DoD) to evaluate potential cost savings by shifting a portion of the TRICARE for Life (TFL) retail prescription refills to the TRICARE Mail Order Program (TMOP).

### 2.0 BACKGROUND

In Fiscal Year (FY) 2012, 70 million prescriptions were filled for TRICARE beneficiaries through the TRICARE retail pharmacy benefit at a net cost of \$3.8 billion to the government. Of those prescriptions, 33 million or 47% were filled for TFL beneficiaries at a cost of \$2.2 billion to the government. On average, the government pays 17% less for maintenance medications filled at TMOP than through the retail program. There is potential for significant savings to the government by shifting a portion of the TFL prescription refills to TMOP.

### 3.0 POLICY AND ELIGIBILITY

**3.1** The National Defense Authorization Act (NDAA) for FY 2013 establishes a pilot program requiring TFL beneficiaries to obtain retail prescription refills for select maintenance medications from the TMOP. TFL beneficiaries are not restricted from using the Military Treatment Facility (MTF) for prescription fills.

**3.2** TFL beneficiaries are identified per [Chapter 20, Section 1](#). Active Duty (AD), Active Duty Family Members (ADFM), retirees and their family members are not required to participate in this program. TRICARE Overseas Program (TOP) TFL beneficiaries, with the exception of those beneficiaries residing in the U.S. territories, may not be eligible for this pilot program. In order to be eligible they need to be residing in a country that allows use of TMOP, have prescriptions written by a U.S. licensed provider, and have an APO/FPO mailing address.

**3.3** Maintenance medications are defined as medications prescribed for a chronic, long-term condition that is taken on a regular, recurring basis. Those maintenance medications which are clinically appropriate and cost-effective to dispense at TMOP will be included in the program as select maintenance medications.

**3.4** A refill is defined as either a subsequent filling of an original prescription under the same prescription number (or other authorization as the original prescription), or a new original

## TRICARE Operations Manual 6010.56-M, February 1, 2008

### Chapter 18, Section 16

EXPIRED As Of September 30, 2015 - Pilot Program for Refills of Maintenance Medications for TRICARE For Life (TFL) Beneficiaries through the TRICARE Mail Order Program (TMOP)

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prescription for the same medication, strength and form issued at or near the end date of an earlier prescription.

**3.5** Defense Health Agency (DHA) will establish, maintain, and periodically revise and update a list of select maintenance medications accessible at <http://www.health.mil/SelectDrugList> and by telephone through the pharmacy contractors call center.

**3.6** The NDAA authorizes a waiver of the mail order requirement based on patient needs and other appropriate circumstances. There is a blanket waiver for prescription medications that are for acute care needs. There is also a blanket waiver for prescriptions covered by Other Health Insurance (OHI). This waiver is obtained through an administrative override request to the TRICARE pharmacy contractor under procedures established by the Director, DHA.

**3.7** The pharmacy contractor will notify beneficiaries of the new rules and the mechanisms which allow them to receive adequate medication during their transition to TMOP.

**3.8** The pharmacy contractor will provide a toll free number to assist beneficiaries in transferring their prescriptions from retail pharmacies to TMOP.

**3.9** Beneficiaries will be advised that they may receive up to two, 30-day fills at a retail pharmacy while they transition their prescription. The beneficiary will be contacted after each of these two fills and advised that the prescription must be transferred. Requests for a third fill at retail will be blocked and the beneficiary advised to call the pharmacy contractor for assistance.

**3.10** Beneficiaries may opt out of the pilot program after one year of participation. The one year participation is calculated based on the first date of service (after program implementation) the beneficiary has a maintenance medication prescription filled at TMOP. The beneficiary may exercise his or her right to opt out of the program by contacting the pharmacy contractor. Following an opt out, the beneficiary may obtain prescriptions from a retail pharmacy, subject to the normal limitations and procedures under the TRICARE Pharmacy Benefits Program.

#### **4.0 EFFECTIVE DATE**

This demonstration expires effective September 30, 2015. The NDAA FY 2015, Section 702 mandates beneficiaries to obtain select brand name maintenance medications from the TMOP or the MTF pharmacy beginning October 1, 2015 (see TRICARE Policy Manual (TPM), [Chapter 8, Section 9.1](#)).

- END -

## Defense Health Agency (DHA) Evaluation Of Non-United States Food and Drug Administration (FDA) Approved Laboratory Developed Tests (LDTs) Demonstration Project

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### 1.0 PURPOSE

The purpose of this demonstration project is to improve the quality of health care services for TRICARE beneficiaries. This demonstration is intended to evaluate whether it is feasible for the Department of Defense (DoD) to review Laboratory Developed Tests (LDTs) which have not received U.S. Food and Drug Administration (FDA) medical device 510(k) clearance or premarket approval (therefore considered non-FDA approved) to determine if they meet TRICARE requirements for safety and effectiveness according to the hierarchy of reliable evidence (32 CFR 199.4(g)(15)(i)(C)) and 32 CFR 199.2(b)), or TRICARE's rare disease policy (32 CFR 199.4(g)(15)(ii)) in the case of LDTs used in the diagnosis or medical management of a rare disease, and otherwise meet TRICARE criteria for coverage. Those that do will be covered as a benefit under this demonstration. The demonstration project will evaluate feasible alternatives to FDA approval to support modifications to 32 CFR 199.4(g)(15)(i)(A) to allow coverage for non-FDA approved LDTs that otherwise meet the TRICARE requirements for safety and effectiveness. The DoD currently has an ongoing demonstration project to test this same provision for LDTs with a Centers for Medicare and Medicaid Services (CMS) national or local coverage determination that were submitted by laboratories for consideration for coverage under TRICARE. However, this new demonstration is being conducted in order to evaluate the feasibility of establishing a cost-effective and efficient way to review an expanded pool of non-FDA approved LDTs prioritized based on their potential high utilization and clinical utility within the TRICARE population. This new demonstration project will also extend coverage for preconception and prenatal Cystic Fibrosis (CF) carrier screening, when provided in accordance with the most current American College of Obstetricians and Gynecologists (ACOG) guidelines in order to allow the DoD to establish whether there is a benefit to offering such testing to TRICARE beneficiaries. The demonstration project will operate throughout the continental United States, and in the TRICARE overseas regions.

### 2.0 BACKGROUND

**2.1** On June 18, 2014, a notice was published in the **Federal Register** (79 FR 34726) announcing the start of a demonstration project in which the Defense Health Agency (DHA) will review LDTs which have not received FDA clearance or approval to determine if they meet TRICARE requirements for safety and effectiveness according to the hierarchy of reliable evidence or TRICARE's rare disease policy as stated above and approve those that do for cost-sharing under this demonstration. An annual evaluation of the new demonstration will be conducted to determine how many of these non-FDA approved LDTs were provided to beneficiaries across all TRICARE regions. The evaluation will also include a review of the LDT examination and recommendation process to assess feasibility, resource requirements, and cost-effectiveness of the DHA establishing

Defense Health Agency (DHA) Evaluation Of Non-United States Food and Drug Administration (FDA) Approved Laboratory Developed Tests (LDTs) Demonstration Project

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an internal safety and efficacy review process for these LDTs for TRICARE cost-sharing purposes. These results will provide an evaluation of the potential improvement of the quality of health care services for beneficiaries who would not otherwise have access to these safe and effective tests. Based on the results, a recommendation will be made on whether to modify [32 CFR 199.4\(g\)\(15\)\(i\)\(A\)](#) to remove the restriction for non-FDA approved LDTs and permit TRICARE cost-sharing of LDTs that are found to otherwise meet TRICARE requirements for safety and effectiveness.

**2.2** This new demonstration project also extends coverage for preconception and prenatal CF carrier screening, when provided in accordance with the most current ACOG guidelines. This demonstration project will allow the DoD to establish whether there is a benefit to offering such testing for purposes of determining whether to permanently establish coverage as part of the family planning genetic testing benefit at [32 CFR 199.4\(e\)\(3\)\(ii\)](#), the maternity benefit at [32 CFR 199.4\(e\)\(16\)](#), or otherwise as a special benefit. By extending coverage for CF carrier screening in accordance with the most current ACOG guidelines under this demonstration project, the DoD will be able to gather the necessary data to evaluate whether there is a benefit to offering such screening, including evaluating the impact on follow-on care that a patient is given based on testing results and any other identified benefits of the testing. The Director, DHA, or designee, shall issue guidelines for collection of data involving individual cases of CF carrier screening covered under this demonstration as necessary for evaluation of the benefits resulting from such screening.

**2.3** According to [32 CFR 199.4\(g\)\(15\)\(i\)\(A\)](#), the DHA may not cost-share medical devices, including LDTs, if the tests are non-FDA approved, that is, they have not received FDA marketing 510(k) clearance or premarket approval. LDTs with FDA approval are available for cost-sharing under the TRICARE Basic Program as long as they otherwise meet TRICARE criteria for coverage.

**2.4** An LDT is an In Vitro Diagnostic (IVD) that is designed, manufactured, and used within a single laboratory. In the past, these were relatively simple tests used within a single laboratory, usually at a local large hospital or academic medical center, to diagnose rare diseases or for other uses to meet the needs of a local patient population. Today, these tests may be highly complex. LDTs range from identifying one specific gene to identifying just a variant of the gene, while others can assess a person's risk of developing specific cancers or diseases. For purposes of this demonstration, LDTs approved for coverage under the TRICARE Program will be identified by the specific gene they test for as detailed in [Figure 18.17-1](#).

**2.5** Laboratories are assessed and accredited under minimum quality standards set by CMS under the Clinical Laboratory Improvement Amendments (CLIA) of 1988. CMS regulates laboratories that use non-FDA approved LDTs as well as FDA approved tests. Laboratories performing moderate or high complexity tests are subject to specific regulatory standards governing certification, personnel, proficiency testing, patient test management, quality assurance, quality control, and inspections. CLIA certification and periodic inspections evaluate whether the laboratory has determined the analytical validity of the tests they offer, including LDTs. Analytical validity refers to how well a test performs in the laboratory; that is, how well the test measures the properties or characteristics it is intended to measure. CLIA certification does not, however, assure a device is safe and effective for its intended use, or impose any type of post-market surveillance or adverse event reporting requirements.

## Department Of Defense (DoD) Comprehensive Autism Care Demonstration

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### 1.0 PURPOSE

The Comprehensive Autism Care Demonstration (“Autism Care Demonstration”) combines all TRICARE-covered Applied Behavior Analysis (ABA) services under one demonstration and provides TRICARE reimbursement for ABA and related services to TRICARE eligible beneficiaries diagnosed with Autism Spectrum Disorder (ASD). Beneficiary eligibility is outlined in [paragraph 7.0](#). This demonstration incorporates ABA services that were provided under the TRICARE Basic Program (i.e., the medical benefits authorized under [32 CFR 199.4](#)), the Enhanced Access to Autism Services Demonstration (i.e., the supplemental ABA benefits authorized for certain Active Duty Family Members (ADFM)s under [32 CFR 199.5](#)), and the ABA Pilot (i.e., the supplemental ABA benefits authorized for certain Non-Active Duty Family Members (NADFM)s including retiree dependents--under the National Defense Authorization Act for Fiscal Year 2013, Section 705 (NDAA FY 2013 §705)). The purpose of the Autism Care Demonstration is to further analyze and evaluate the appropriateness of the ABA tiered-delivery model under TRICARE in light of current and anticipated certification board guidelines. Currently, there are no established uniform ABA coverage standards in the United States. The Autism Care Demonstration seeks to establish appropriate provider qualifications for the proper diagnosis of ASD and the provisions of ABA, assess the feasibility and advisability of establishing a beneficiary cost-share for the treatment of ASD, and develop more efficient and appropriate means of increasing access and delivery of ABA services under TRICARE while creating a viable economic model and maintaining administrative simplicity. The overarching goal of this demonstration is to analyze, evaluate, and compare the quality, efficiency, convenience and cost effectiveness of those autism-related services that do not constitute proven medical care provided under the medical benefit coverage requirements that govern the TRICARE Basic Program.

### 2.0 BACKGROUND

**2.1** ASD affects essential human behaviors such as social interaction, the ability to communicate ideas and feelings, imagination, and the establishment of relationships with others. The TRICARE Basic Program offers a comprehensive health benefit providing a full array of medically necessary services to address the needs of all TRICARE beneficiaries with a diagnosis of ASD. The TRICARE Basic Program provides Occupational Therapy (OT) to promote the development of self-care skills; Physical Therapy (PT) to promote coordination/motor skills; Speech-Language Pathology (SLP) services to promote communication skills; child neurology and child psychiatry to address psychopharmacological needs; clinical psychology for psychotherapy and psychological testing; and neurodevelopmental and developmental-behavioral pediatrics for developmental assessments. The full range of medical specialties to address the additional medical conditions common to this population are covered.

**2.2** ABA is a form of therapy that applies the principles of behavior modification, which consists of processes such as operant and respondent conditioning, to socially significant behavior in the real-world setting. ABA is based on the principle that an individual's behavior is determined by past and current environmental events in conjunction with organic variables such as the individual's genetic endowment and ongoing physiological variables. ABA, by a licensed and/or certified behavior analyst, focuses on treating behavior difficulties by changing an individual's environment (i.e., shaping behavior patterns through reinforcement and consequences). ABA is delivered optimally when family members/caregivers participate by consistently reinforcing the ABA interventions in the home setting in accordance with the prescribed Treatment Plan (TP) developed by the behavior analyst.

**2.3** Although the **Behavior Analyst Certification Board (BACB)** has established national guidelines for behavior analysts and assistant behavior analysts, **the 2014 BACB publication for credentialing of Behavior Technicians (BTs) established** national competency standards and registration for the BTs (formerly ABA Tutors) who interact with ASD-diagnosed beneficiaries for multiple hours per day. The Qualified Applied Behavior Analysis (QABA) certification board also offers a certification for BTs, the Applied Behavior Analysis Technician (ABAT), as well as a certification for assistant behavior analysts, Qualified Autism Services Practitioner (QASP). **The Behavioral Intervention Certification Council (BICC) certification for BTs (Board Certified Autism Technician, BCAT) is also acceptable.** Only a limited number of states currently license or certify the behavior analysts who evaluate, develop TPs, and supervise the delivery of ABA interventions for ASD-diagnosed beneficiaries. The national certification standards are in the process of evolving. The American Medical Association (AMA) implemented Category III Current Procedural Terminology (CPT) codes (i.e., a temporary set of codes for emerging technologies, services, and procedures) for ABA (effective July 1, 2014), for the purpose of allowing time for data collection to determine the case for widespread usage of the ABA codes as established "medical" treatment.

### **3.0 DEMONSTRATION GOALS**

Demonstration goals include:

**3.1** Analyzing and evaluating the appropriateness of the Autism Care Demonstration under TRICARE in light of current and future BACB Guidelines for "Applied Behavior Analysis Treatment of Autism Spectrum Disorder: Practice Guidelines for Healthcare Funders and Managers" (2014 or current edition);

**3.2** Determining the appropriate provider qualifications for the proper diagnosis of ASD and for the provision of ABA, and assessing the added value of assistant behavior analysts and BTs beyond ABA provided by Board Certified Behavior Analysts (BCBAs);

**3.3** Assessing, across the three TRICARE regions and overseas locations (see [paragraph 9.0](#)), the ASD beneficiary characteristics associated with full utilization of the Autism Care Demonstration's tiered delivery model versus utilization of sole provider BCBA services only, or non-utilization of any ABA services, and isolating factors contributing to significant variations across TRICARE regions and overseas locations in delivery of ABA;

**3.4** Determining what beneficiary age groups utilize and benefit most from ABA interventions;

## Pilot Program On Urgent Care For TRICARE Prime/TRICARE Prime Remote (TPR) Beneficiaries

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### 1.0 PURPOSE

The purpose of the Pilot is to meet requirements set forth in the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2016, Section 725 and to determine if the elimination of the requirement to obtain a referral or preauthorization for urgent care visits improves access to urgent care, helps enrollees to choose the most appropriate source for the health care they need (such as a TRICARE-authorized Urgent Care Center (UCC) rather than the Emergency Room (ER)), potentially lowers health care costs for the Department of Defense (DoD) and/or improves patient satisfaction.

### 2.0 BACKGROUND

**2.1** Access to primary health care for acute episodic primary care continues to be in high demand by TRICARE Prime enrollees. The TRICARE manual guidance and the process by which Prime enrollees currently access primary health care is defined under the [32 CFR 199.17](#) and the TRICARE Policy Manual (TPM), [Chapter 1, Section 8.1](#). Historically, the Defense Health Agency (DHA) has required that Prime enrollees obtain a referral for primary or urgent care if they seek that care from someone other than their Primary Care Manager (PCM). As a result, when an enrollee needs urgent care after hours or when the PCM in the Military Treatment Facility (MTF) does not have available appointments, they have been seeking care from civilian sources such as the ER or with a UCC, including Convenience Clinics (CCs).

**2.2** In an effort to avoid overuse of ER care and meet the demand for acute primary care, many facilities have expanded acute care hours within the MTFs or worked with the Managed Care Support Contractors (MCSCs) to utilize provider groups or UCCs in their network. However, these visits outside the MTF require an authorization. Seeking emergency care in an ER does not require authorization. Additionally, the cost of care in a civilian ER for non-emergent reasons is higher than any other source of care.

### 3.0 POLICY AND ELIGIBILITY

**3.1** Under the Pilot, Active Duty Service Members (ADSMs) who are enrolled in TRICARE Prime Remote (TPR), Active Duty Family Members (ADFMs) who are enrolled in TRICARE Prime, TRICARE Young Adult (TYA) Prime, or TRICARE Prime Remote for Active Duty Family Members (TPRADFM), retirees and their family members who are enrolled in Prime or TYA Prime within the 50 United States or the District of Columbia and TRICARE Overseas Program (TOP) enrollees traveling/seeking stateside care will be allowed to self-refer, without an authorization, to a TRICARE network provider or TRICARE-authorized UCC provider, for urgent care. All the aforementioned categories, except overseas, will be allowed two unauthorized urgent care visits per fiscal year, per individual,

including services provided when the enrollee is out of their enrollment area. Overseas enrollees seeking stateside urgent care will not be held to the two visit cap. For the allowed unmanaged visits, no referral from their PCM or authorization by a Health Care Finder (HCF) will be required and no Point of Service (POS) deductibles and cost shares shall apply. Referral requirements for specialty care and inpatient authorizations shall remain as currently required by [Chapter 8, Section 5](#).

**3.2** Enrollees are encouraged to notify their PCM of any urgent/acute care visits outside the PCM within 24 hours of the visit or the first business day following the visit and to schedule follow-up treatment, if indicated, with their PCM. The contractor shall provide beneficiary and provider information on this process, to include information on how to schedule follow-up appointments, and how to coordinate care.

**3.3** If more than the two visits allowed under this Pilot are used or if the enrollee seeks care from a non-network provider (except a TRICARE-authorized UCC), the usual POS deductible and cost-shares shall apply. The usual POS exceptions are still applicable and include:

- Emergency care;
- ADSMs (in accordance with [Chapters 16 and 17](#));
- Newborns and adopted children during the first 60 days (120 days, if overseas) after birth or adoption;
- TRICARE Prime clinical preventive services received from a network provider (in accordance with TPM, [Chapter 7, Section 2.2](#));
- TRICARE Prime enrollees who obtain outpatient mental health care from a network provider without a referral from their PCM (in accordance with TPM, [Chapter 7, Section 3.8](#)); and
- Enrollees with Other Health Insurance (OHI).

**3.4** The Pilot shall encourage and incentivize the use of the Nurse Advise Line (NAL) to direct enrollees to the source of the most appropriate level of health care required to treat the medical conditions of the enrollee. The NAL will provide advice to all enrollees and will facilitate referrals for Direct Care (DC) enrollees who receive an urgent care recommendation. For incentive purposes, urgent care accessed via a NAL recommendation that leads to a PCM referral shall not be counted against the allowable self-referred visits provided under the Pilot.

#### **4.0 GENERAL DESCRIPTION OF ADMINISTRATIVE PROCESS**

**4.1** Referral (authorization) requirements for up to two urgent care visits per fiscal year, per individual, shall be waived for ADSMs who are enrolled in TPR, ADFMs who are enrolled in TRICARE Prime, TPRADFM, or TYA Prime and retirees and their family members who are enrolled in Prime within the 50 United States or the District of Columbia. Referral (authorization) requirements are also waived for an uncapped number of visits for TOP enrollees traveling/seeking care in the

Continental United States (CONUS) when services are rendered by a TRICARE network provider or TRICARE-authorized UCC. Providers must have one of the following primary specialty designations:

- Family Practice;
- Internal Medicine;
- General Practice;
- Pediatrician; and
- UCC or CC.

**Note:** In accordance with TPM, [Chapter 1, Section 8.1](#), Obstetricians/Gynecologists (OB/GYNs), Physician Assistants (PAs), Nurse Practitioners (NPs), and Certified Nurse Midwives (CNMs) can be considered Primary Care Providers (PCPs) and may be designated PCMs, too.

**4.2** All claims shall be vouchered and paid as prescribed by existing policy for both underwritten and non-underwritten care. The unauthorized urgent care visits permitted under this pilot shall be considered “authorized care” for purposes of [Chapter 8, Section 5, paragraph 2.6](#).

## **5.0 POLICY CONSIDERATIONS**

The inclusion of ADSM in TPR does not limit/change their overall TPR benefit (as specified in [Chapter 16](#)).

## **6.0 MCSC RESPONSIBILITIES**

**6.1** The contractors shall verify the TRICARE eligibility of the patient on the Defense Enrollment Eligibility Reporting System (DEERS).

**6.2** The contractors shall search for any submitted urgent care referral and when an urgent care referral is identified the contractor shall not count the urgent care visit against the allowable self-referred visits provided under the Pilot.

**6.3** The contractors shall develop a process to track the number of unmanaged urgent care visits used per enrollee/per fiscal year. This process shall incorporate a means to share that number with other contractors when enrollment transfers occur.

**6.4** DHA Communications will provide all educational materials regarding the pilot to MCSCs. The educational materials will encourage enrollees seeking access to care to use the MTF first and to use the NAL to guide them to the source of the most appropriate level of healthcare required to treat their medical condition.

**6.5** The contractors shall ensure that pilot information is made available on their primary Internet web sites.

**6.6** TRICARE Encounter Data (TED) Record Special Processing Code (SPC) “**UC**-Urgent Care Pilot” shall be coded on all TED records where one of the two self-referred authorizations allowed under this Pilot is used. If the TED SPC is implemented in the contractor’s system after May 23, 2016, the contractor shall search for previously processed Urgent Care Pilot TED records and adjust those records to show SPC “**UC**.”

## **7.0 APPLICABILITY**

This Pilot is limited to ADSMs who are enrolled in TPR, ADFMs who are enrolled in TRICARE Prime, TYA Prime, or TPRADFM, retirees and their family members who are enrolled in Prime or TYA Prime within the 50 United States or the District of Columbia and TOP enrollees traveling/seeking stateside care.

## **8.0 EXCLUSIONS**

This Pilot does not apply to referral requirements for specialty care and inpatient authorizations as currently required by [Chapter 8, Section 5](#). This Pilot excludes TOP Prime enrollees unless they are traveling stateside. This pilot excludes Uniformed Services Family Health Plan (USFHP) enrollees.

## **9.0 EFFECTIVE DATE**

Per requirements set forth in the NDAA for FY 2016, Section 725, the Secretary is required to carry out the Pilot Program for a period of three years. Implementation is to commence no later than 180 days after the date of the enactment of the Act, and hence the Pilot will begin May 23, 2016, and will continue until May 23, 2019.

- END -

Chapter 18

Addendum A

Participation Agreement For Autism Demonstration  
Corporate Services Provider (ACSP)

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**NAME OF ACSP:**

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**ADDRESS:**

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**TELEPHONE:**

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**TAX IDENTIFICATION NUMBER  
(TIN) OR SOCIAL SECURITY  
NUMBER (SSN):**

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**ARTICLE 1**

**RECITALS**

1.1 IDENTIFICATION OF PARTIES

This Autism Demonstration Corporate Services Provider (ACSP) Participation Agreement ("Participation Agreement") is between the United States of America through the **Defense Health Agency (DHA)**, a field activity of the Office of the Assistant Secretary of Defense (Health Affairs) (OASD(HA)) and \_\_\_\_\_, doing business as \_\_\_\_\_ (hereinafter "ACSP").

1.2 AUTHORITY FOR ACSPs AS TRICARE-AUTHORIZED PROVIDERS

The authority to designate ACSPs as authorized TRICARE providers resides with the Department of Defense (DoD) Demonstration authority under 10 U.S.C. 1092. This authority ceases upon termination of the Enhanced Access to Autism Services Demonstration Project ("Demonstration") as determined by the Director, **DHA** or designee.

1.3 PURPOSE OF PARTICIPATION AGREEMENT

The purpose of this Participation Agreement is to:

(a) Establish the undersigned ACSP as an authorized provider of Educational Interventions for Autism Spectrum Disorders (EIA) services;

(b) Establish the terms and conditions that the undersigned ACSP must meet to be an authorized provider under the Demonstration.

**ARTICLE 2**

**REFERENCES**

2.1 REQUIREMENTS

By reference, the requirements set forth in the TRICARE Operations Manual (TOM), [Chapter 18, Section 8](#), are incorporated into this Participation Agreement and shall have the same force and effect as if fully set out herein.

2.2 GENERAL AGREEMENT

The undersigned ACSP agrees to render appropriate EIA services to eligible beneficiaries as specified in the TOM, [Chapter 18, Section 8](#).

### ARTICLE 3

#### REIMBURSEMENT

- 3.1 Claims for Demonstration services will be submitted on a Centers for Medicare and Medicaid Services (CMS) 1500 Claim Form by the ACSP in accordance with the TOM, [Chapter 18, Section 8, paragraph 9.0](#).
- 3.2 The ACSP shall:
- (a) Submit claims to the appropriate TRICARE Managed Care Support Contractor (MCSC) in accordance with [paragraph 3.1](#) and the TOM, [Chapter 18, Section 8](#); and
  - (b) Collect the monthly sponsor cost-share specified in the TRICARE Policy Manual (TPM), [Chapter 9, Section 16.1](#); and
  - (c) Not bill the sponsor/beneficiary for:
    - (1) Services for which the provider is entitled to TRICARE reimbursement; and
    - (2) Services that are denied due to provider non-compliance with all applicable requirements in the TOM, [Chapter 18, Section 8](#).

### ARTICLE 4

#### TERM, TERMINATION, AND AMENDMENT

##### 4.1 TERM

The term of this agreement shall begin on the date this agreement is signed and shall continue in effect until terminated or superseded as specified herein.

##### 4.2 TERMINATION OF AGREEMENT BY DHA

(a) The Director, **DHA** or designee, may terminate this agreement upon written notice, for cause, if the ACSP is found not to be in compliance with the provisions set forth in [32 CFR 199.6](#), or is determined to be subject to the administrative remedies involving fraud, abuse, or conflict of interest as set forth in [32 CFR 199.9](#). Such written notice of termination shall be an initial determination for purposes of the appeal procedures set forth in [32 CFR 199.10](#).

(b) In addition, the Director, **DHA** or designee, may terminate this agreement without cause by giving the ACSP written notice not less than 45 days prior to the effective date of such termination.

##### 4.3 TERMINATION OF AGREEMENT BY THE ACSP

The ACSP may terminate this agreement by giving the Director, **DHA** or designee, written notice not less than 45 days prior to the effective date of such termination. Effective the date of

**TRICARE Operations Manual 6010.56-M, February 1, 2008**

Chapter 18, Addendum A

Participation Agreement For Autism Demonstration Corporate Services Provider (ACSP)

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termination, the ACSP will cease being a TRICARE-authorized provider of Demonstration services. Subsequent to termination, an ACSP may be reinstated as a TRICARE- authorized provider of Demonstration services only by entering into a new Participation Agreement.

4.4 AMENDMENT BY **DHA**

(a) The Director, **DHA** or designee, may amend the terms of this Participation Agreement by giving 120 days notice in writing of the proposed amendment(s) except when necessary to amend this agreement from time to time to incorporate changes to the 32 CFR 199. When changes or modifications to this agreement result from changes to the 32 CFR 199 through rulemaking procedures, the Director, **DHA** or designee, is not required to give 120 days written notice. Any such changes to 32 CFR 199 shall automatically be incorporated herein on the date the regulation amendment is effective.

(b) An ACSP who does not accept the proposed amendment(s), including any amendment resulting from changes to 32 CFR 199 accomplished through rulemaking procedures, may terminate its participation as provided for in this Article. However, if the ACSP notice of intent to terminate its participation is not given at least 30 days prior to the effective date of the proposed amendment(s), the proposed amendment(s) shall be incorporated into this agreement for services furnished by the ACSP between the effective date of the amendment(s) and the effective date of termination of this agreement.

**ARTICLE 5**

**EFFECTIVE DATE**

5.1 DATE SIGNED

This Participation Agreement is effective on the date signed by the Director, **DHA** or designee.

**DHA**

ACSP

\_\_\_\_\_  
By: Typed Name and Title

\_\_\_\_\_  
By: Typed Name and Title

Executed on \_\_\_\_\_, 20\_\_\_\_

- END -

Chapter 18

Addendum B

Participation Agreement For Comprehensive Autism Care  
Demonstration Corporate Services Provider (ACSP)

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**NAME OF ACSP:**

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**ADDRESS:**

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**TELEPHONE:**

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**TAX IDENTIFICATION NUMBER  
(TIN) OR SOCIAL SECURITY  
NUMBER (SSN):**

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**TRICARE Operations Manual 6010.56-M, February 1, 2008**

Chapter 18, Addendum B

Participation Agreement For Comprehensive Autism Care Demonstration Corporate Services  
Provider (ACSP)

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**ARTICLE 1**

**RECITALS**

1.1 IDENTIFICATION OF PARTIES

This Comprehensive Autism Care Demonstration Corporate Services Provider (ACSP) Participation Agreement ("Participation Agreement") is between the United States of America through the **Defense Health Agency (DHA)**, a field activity of the Office of the Assistant Secretary of Defense (Health Affairs) (OASD(HA)) and \_\_\_\_\_, doing business as \_\_\_\_\_ (hereinafter "ACSP").

1.2 AUTHORITY FOR ACSPs AS TRICARE-AUTHORIZED PROVIDERS

The authority to designate ACSPs as authorized TRICARE providers resides with the Department of Defense (DoD) Demonstration authority under 10 U.S.C. 1092. This authority ceases upon termination of the Comprehensive Autism Care Demonstration Project ("Demonstration") as determined by the Director, **DHA**, or designee.

1.3 PURPOSE OF PARTICIPATION AGREEMENT

The purpose of this Participation Agreement is to:

(a) Establish the undersigned ACSP as an authorized provider of Applied Behavior Analysis (ABA) services;

(b) Establish the terms and conditions that the undersigned ACSP must meet to be an authorized provider under the Demonstration.

**ARTICLE 2**

**REFERENCES**

2.1 REQUIREMENTS

By reference, the requirements set forth in the TRICARE Operations Manual (TOM), [Chapter 18, Section 18](#), are incorporated into this Participation Agreement and shall have the same force and effect as if fully set out herein.

2.2 GENERAL AGREEMENT

The undersigned ACSP agrees to render appropriate ABA services to eligible beneficiaries as specified in the TOM, [Chapter 18, Section 18](#).

**TRICARE Operations Manual 6010.56-M, February 1, 2008**

Chapter 18, Addendum B

Participation Agreement For Comprehensive Autism Care Demonstration Corporate Services  
Provider (ACSP)

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**ARTICLE 3**

**REIMBURSEMENT**

3.1 Claims for Demonstration services will be submitted on a Centers for Medicare and Medicaid Services (CMS) 1500 Claim Form by the ACSP in accordance with the TOM, [Chapter 18, Section 18, paragraph 11.0](#).

3.2 The ACSP shall:

(a) Submit claims to the appropriate TRICARE Managed Care Support Contractor (MCSC) in accordance with the TOM, [Chapter 18, Section 18, paragraph 11.0](#); and

(b) Collect the monthly sponsor cost-share in accordance with TOM, [Chapter 18, Section 18, paragraph 14.0](#); and

(c) Not bill the sponsor/beneficiary for:

(1) Services for which the provider is entitled to TRICARE reimbursement; and

(2) Services that are denied due to provider non-compliance with all applicable requirements in the TOM, [Chapter 18, Section 18](#).

**ARTICLE 4**

**TERM, TERMINATION, AND AMENDMENT**

4.1 TERM

The term of this agreement shall begin on the date this agreement is signed and shall continue in effect until terminated or superseded as specified herein.

4.2 TERMINATION OF AGREEMENT BY DHA

(a) The Director, **DHA**, or designee, may terminate this agreement upon written notice, for cause, if the ACSP is found not to be in compliance with the provisions set forth in [32 CFR 199.6](#), or is determined to be subject to the administrative remedies involving fraud, abuse, or conflict of interest as set forth in [32 CFR 199.9](#). Such written notice of termination shall be an initial determination for purposes of the appeal procedures set forth in [32 CFR 199.10](#).

(b) In addition, the Director, **DHA**, or designee, may terminated this agreement without cause by giving the ACSP written notice not less than 45 days prior to the effective date of such termination.

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Provider (ACSP)

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4.3 TERMINATION OF AGREEMENT BY THE ACSP

The ACSP may terminate this agreement by giving the Director, **DHA**, or designee, written notice not less than 45 days prior to the effective date of such termination. Effective the date of termination, the ACSP will cease being a TRICARE-authorized provider of Demonstration services. Subsequent to termination, an ACSP may be reinstated as a TRICARE-authorized provider of Demonstration services only by entering into a new Participation Agreement.

4.4 AMENDMENT BY **DHA**

(a) The Director, **DHA**, or designee, may amend the terms of this Participation Agreement by giving 120 days notice in writing of the proposed amendment(s) except when necessary to amend this agreement from time to time to incorporate changes to the 32 CFR 199. When changes or modifications to this agreement result from changes to the 32 CFR 199 through rulemaking procedures, the Director, **DHA**, or designee, is not required to give 120 days written notice. Any such changes to 32 CFR 199 shall automatically be incorporated herein on the date the regulation amendment is effective.

(b) An ACSP who does not accept the proposed amendment(s), including any amendment resulting from changes to 32 CFR 199 accomplished through rulemaking procedures, may terminate its participation as provided for in this Article. However, if the ACSP notice of intent to terminate its participation is not given at least 30 days prior to the effective date of the proposed amendment(s), the proposed amendment(s) shall be incorporated into this agreement for services furnished by the ACSP between the effective date of the amendment(s) and the effective date of termination of this agreement.

**ARTICLE 5**

**EFFECTIVE DATE**

5.1 DATE SIGNED

This Participation Agreement is effective on the date signed by the Director, **DHA**, or designee.

**DHA**

ACSP

\_\_\_\_\_  
By: Typed Name and Title

\_\_\_\_\_  
By: Typed Name and Title

Executed on \_\_\_\_\_, 20\_\_\_\_

- END -

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