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TRICARE
MANAGEMENT ACTIVITY

MB&RB

**CHANGE 122
6010.54-M
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**PUBLICATIONS SYSTEM CHANGE TRANSMITTAL
FOR
TRICARE POLICY MANUAL (TPM), AUGUST 2002**

The TRICARE Management Activity has authorized the following addition(s)/revision(s).

CHANGE TITLE: CODING AND CLARIFICATION UPDATES DECEMBER 2009

CONREQ: 14939

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): See page 3

EFFECTIVE AND IMPLEMENTATION DATE: Upon direction of the Contracting Officer.

This change is made in conjunction with Aug 2002 TOM, Change No. 97, Aug 2002 TRM, Change No. 115, and Aug 2002 TSM, Change No. 80.


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Chief, Medical Benefits and
Reimbursement Branch**

**ATTACHMENT(S): 15 PAGE(S)
DISTRIBUTION: 6010.54-M**

CHANGE 122
6010.54-M
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REMOVE PAGE(S)

CHAPTER 4

Section 20.1, pages 1 through 4

CHAPTER 6

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CHAPTER 7

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Section 6.1, pages 1 and 2

SUMMARY OF CHANGES

CHAPTER 4

1. Section 20.1. Added CPT code range 64702 - 64719. Paragraph II.S. deleted CPT code. Paragraph II.U. added exclusion: Spinal cord and deep brain neurostimulation in the treatment of chronic intractable headache or migraine pain is unproven.

CHAPTER 6

2. Table of Contents. Deleted "And Counseling" from Subject of Section 3.1.
3. Section 3.1. Deleted "And Counseling" from Subject of section. Deleted CPT Procedure Code paragraph (original paragraph I.) and renumbered subsequent paragraphs. Added clarification that genetic counseling must be provided by a TRICARE authorized provider and be submitted with appropriate Evaluation and Management (E&M) codes. Paragraph III.B. Added an exclusion for medical genetics and genetic counseling services, each 30 minutes face-to-face with patient/family (CPT code 96040).

CHAPTER 7

4. Section 16.2. Paragraph III. removed "by a clinical psychologist." Deleted Exclusion B. Patient meeting criteria for a psychiatric diagnosis.

CHAPTER 8

5. Section 9.1. Clarified that legend vitamins may be cost-shared only when used as a specific treatment of a medical condition. Prenatal vitamins requiring a prescription in the United States may be cost-shared for prenatal care only.

CHAPTER 10

6. Section 5.1. Clarified eligibility for TAMP eligibles who were also eligible for Operation Noble Eagle/Operation Enduring Freedom Demonstration benefits.
7. Section 6.1. Clarified eligibility for TRICARE for Life.

NERVOUS SYSTEM

ISSUE DATE: August 26, 1985

AUTHORITY: [32 CFR 199.4\(c\)\(2\)](#) and [\(c\)\(3\)](#)

I. CPT¹ PROCEDURE CODES

61000 - 61626, 61680 - 61860, 61863 - 63048, 63055 - 64484, 64505 - 64560, 64565 - 64580, 64600 - 64640, ~~64702 - 64719~~, 64730, 64732, 64753 - 64999, 95961, 95962, 95970 - 95975, 95978, 95979

II. DESCRIPTION

A. The nervous system consists of the central and peripheral nervous systems. The central is comprised of the brain and spinal cord and the peripheral includes all the other neural elements. The nervous system is the organ system which along with the endocrine system, correlates the adjustments and reactions of an organism to internal and environmental conditions.

B. Therapeutic embolization is a type of procedure that is commonly performed by interventional radiologist to occlude blood vessels. A microcatheter or balloon is threaded into a vein, or artery for the purposes of embolization, blocking a pathologic vascular channel.

C. Stereotactic implantation of depth electrodes is an invasive procedure in which needle-like electrodes are implanted through burr holes in the skull into the depths of specific brain areas to localize a seizure focus in patients who are candidates for surgery or to implant a brain stimulator in the thalamus to control tremors.

D. Psychosurgery is brain surgery directed at destroying normal and healthy brain tissue in order to relieve mental and psychic symptoms that other treatment modalities such as drug therapy and psychotherapy have been ineffectual in treating, for the purpose of changing or controlling behavior.

E. The Guglielmi Detachable Coil (GDC) is an extremely fine wire made from platinum, one of the softest metals, at the end of a longer stainless steel wire. In a controlled manner, the surgeon uses a micro-catheter to thread each coil through blood vessels to the aneurysm site. Application of a very-low-voltage electric current detaches and releases the coil into the aneurysm. Once in place, the GDC coils fill the aneurysm, isolating it from circulation to

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reduce the likelihood of rupture and hemorrhagic stroke. By applying a low voltage direct current to a stainless steel wire at the base of the coil, the platinum coil is detached. This applied current not only detaches the coil but also promotes electrothrombosis within the aneurysm.

III. POLICY

A. Services and supplies required in the diagnosis and treatment of illness or injury involving the nervous system are covered.

B. Therapeutic embolization (CPT² procedure code 61624) may be covered for the following indications. The list of indications is not all inclusive. Other indications are covered when documented by reliable evidence as safe, effective and comparable or superior to standard care (proven).

1. Cerebral Arteriovenous Malformations (AVMs).
2. Vein of Galen Aneurysm.
3. Inoperable or High-Risk Intracranial Aneurysms.
4. Dural Arteriovenous Fistulas.
5. Meningioma.

C. Implantation of depth electrodes is covered. Implantation of a U.S. Food and Drug Administration (FDA) approved vagus nerve stimulator as adjunctive therapy in reducing the frequency of seizures in adults and adolescents over 12 years of age, which are refractory to anti-epileptic medication is covered. Battery replacement is also covered.

D. Spinal cord and deep brain stimulation are covered in the treatment of chronic intractable pain. Coverage includes:

1. The accessories necessary for the effective functioning of the covered device.
2. Repair, adjustment, replacement and removal of the covered device and associated surgical costs.

E. The GDC may be cost-shared for embolizing unruptured intracranial aneurysms that, because of their morphology, their location, or the patient's general medical condition, are considered by the treating neurosurgical team to be:

1. Very high risk for management by traditional operative techniques; or
2. Inoperable; or

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3. For embolizing other vascular malformation such as **AVMs** and arteriovenous fistulae of the neurovasculature, to include arterial and venous embolizations in the peripheral vasculature.

IV. EXCLUSIONS

A. N-butyl-2-cyanoacrylate (Histacryl Bleu®), iodinated poppy seed oils (e.g., Ethiodol®), and absorbable gelatin sponges are not FDA approved.

B. Transcutaneous, percutaneous, functional dorsal column electrical stimulation in the treatment of multiple sclerosis or other motor function disorders is unproven.

C. Deep brain neurostimulation in the treatment of insomnia, depression, anxiety, and substance abuse is unproven.

D. Psychosurgery is not in accordance with accepted professional medical standards and is not covered.

E. Endovascular GDC treatment of wide-necked aneurysms and rupture is unproven.

F. Cerebellar stimulators/pacemakers for the treatment of neurological disorders are unproven.

G. Dorsal Root Entry Zone (DREZ) thermocoagulation or microcoagulation neurosurgical procedure is unproven.

H. Epidural steroid injections for thoracic pain are unproven.

I. Extraoperative electrocortigraphy for stimulation and recording in order to determine electrical thresholds of neurons as an indicator of seizure focus is unproven.

J. Neuromuscular **Electrical Stimulation (NMES)** for the treatment of denervated muscles is unproven.

K. Stereotactic cingulotomy is unproven.

L. Sacral nerve neurostimulator (CPT³ procedure codes 64561, 64581, 64585, and 64590). See [Chapter 4, Section 14.1](#) for coverage policy for the urinary system and the Sacral Nerve Root Stimulation (SNS).

M. Laminoplasty, cervical with decompression of the spinal cord, two or more vertebral segments with reconstruction of the posterior bony elements (CPT³ procedure codes 63050 and 63051).

N. Balloon angioplasty, intracranial, percutaneous (CPT³ procedure code 61630) is unproven. Effective January 1, 2006.

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O. Transcatheter placement of intravascular stent(s) intracranial, (e.g., atherosclerotic stenosis) including angioplasty, if performed (CPT⁴ procedure code 61635) is unproven. Effective January 1, 2006.

P. Balloon dilation of intracranial vasospasm, initial vessel (CPT⁴ procedure code 61640) each additional vessel in same family (CPT⁴ procedure code 61641) or different vascular family (CPT⁴ procedure code 61642) is unproven. Effective January 1, 2006.

Q. Sphenopalatine ganglion block (CPT⁴ procedure code 64505) for the treatment of chronic migraine headaches and neck pain is unproven.

R. Radiofrequency ablation (percutaneous radiofrequency facet denervation, percutaneous facet coagulation, percutaneous radiofrequency neurotomy, radiofrequency facet rhizotomy, radiofrequency articular rhizolysis) (CPT⁴ procedure codes 64622, 64623, 64626, 64627) for the treatment of chronic spinal pain is unproven. Pulsed radiofrequency ablation for spinal pain is unproven.

S. Implantation of Occipital Nerve Stimulator for the treatment of chronic intractable migraine headache is unproven.

T. Cryoablation of Occipital Nerve (CPT⁴ procedure code 64640) for the treatment of chronic intractable headache is unproven.

U. Spinal cord and deep brain neurostimulation in the treatment of chronic intractable headache or migraine pain is unproven.

V. EFFECTIVE DATES

A. January 1, 1989, for PAVM.

B. April 1, 1994, for therapeutic embolization for treatment of meningioma.

C. July 14, 1997, for GDC.

D. The date of FDA approval of the embolization device for all other embolization procedures.

E. June 1, 2004, for Magnetoencephalography.

- END -

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PATHOLOGY AND LABORATORY

SECTION	SUBJECT
1.1	General
2.1	Transfusion Services For Whole Blood, Blood Components And Blood Derivatives
3.1	Diagnostic Genetic Testing

DIAGNOSTIC GENETIC TESTING

ISSUE DATE: March 10, 2000

AUTHORITY: [32 CFR 199.4\(a\)\(1\)\(i\)](#)

I. DESCRIPTION

Genetic testing intended to be confirmatory of a clinical diagnosis which is already suspected based on the patient's symptoms.

II. POLICY

A. Diagnostic genetic testing when medically proven and appropriate and when the results of the test will influence the medical management of the individual is a TRICARE benefit.

B. The following diagnostic tests are covered. This is not an all inclusive list, but provides examples of covered diagnostic tests.

1. Chromosome analysis (to include karyotyping and/or high resolution chromosome analysis) in some cases of habitual abortion or infertility.

2. Testing for Marfan Syndrome and chromosome analysis (to include karyotyping and/or high resolution chromosome analysis) of children. Common indications for chromosome analysis in children to include ambiguity of external genitalia, small-for-gestational age infants, multiple anomalies and failure to thrive.

3. Other medically necessary genetic diagnostic tests.

C. Services should be billed using the appropriate Evaluation and Management (E&M) codes.

III. EXCLUSIONS

A. Routine genetic testing that does not influence the beneficiary's medical management.

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DIAGNOSTIC GENETIC TESTING

B. CPT¹ procedure code 96040 medical genetics and genetic counseling services, each 30 minutes face-to-face with patient/family.

- END -

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HEALTH AND BEHAVIOR ASSESSMENT/INTERVENTION

ISSUE DATE: March 11, 2002

AUTHORITY: [32 CFR 199.4\(a\)\(1\)](#)

I. CPT¹PROCEDURE CODE RANGE

96150 - 96154

II. DESCRIPTION

Health and behavior assessment procedures are used to identify the psychological, behavioral, emotional, cognitive, and social factors important to the prevention, treatment, or management of physical health problems. The focus of the assessment is not on mental health but on the biopsychosocial factors important to physical health problems and treatment.

III. POLICY

Health and behavior assessment performed in conjunction with the medical or surgical treatment of a covered illness or injury is covered.

IV. EXCLUSION

Family evaluation and assessment (without the patient present) (CPT¹ procedure code 96155).

- END -

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PHARMACY BENEFITS PROGRAM

- a. The drug is approved for marketing by the U.S. Food and Drug Administration;
 - b. The drug is prescribed by a provider, acting within the scope of his/her license, for its labeled indication; and
 - c. The drug is furnished by a provider in accordance with all applicable state laws and licensing requirements.
2. Off-label use. Drugs may be cost-shared for off-label uses when determined, by the contractor with responsibility for the venue distributing the drugs, that reliable evidence demonstrates such usage is safe and effective. As presented in order of relative weight in [32 CFR 199.2](#), reliable evidence means:
- a. Well controlled studies of clinical meaningful endpoints, published in refereed medical literature.
 - b. Published formal technology assessments.
 - c. Published reports of national professional medical associations.
 - d. Published national medical policy organizations.
 - e. Published reports of national expert opinion organizations.
3. Drugs grandfathered by the Federal Food, Drug and Cosmetic Act of 1938 may be cost-shared as if FDA approved.
4. Insulin and related supplies may be cost-shared for diabetic patients, regardless of whether or not a prescription is required under state law.
5. Orphan Drugs. Pharmaceutical agents with FDA “orphan drug” designation and marketing approval may be cost-shared when used in the treatment of a rare disease or condition. For the purpose of the pharmacy benefits program, TRICARE adopts the FDA definition of the term “rare disease or condition”.
6. **Legend** vitamins may be cost-shared only when used as a specific treatment of a medical condition. **In addition, prenatal vitamins that require a prescription in the United States may be cost-shared. Prenatal vitamins requiring a prescription are covered for prenatal care only.**
7. Some drugs require prior authorization. For these drugs, prior authorization request forms and criteria, in addition to other formulary information, are available at: <http://www.pec.ha.osd.mil> or http://www.pec.ha.osd.mil/PA_Criteria_and_forms.htm.

D. Eligibility

1. Uniformed Service members who are on active duty;

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2. All beneficiaries authorized TRICARE benefits per [32 CFR 199.3](#);

3. Medicare eligible beneficiaries:

a. Pursuant to Section 711 of the FY 2001 National Defense Authorization Act, Medicare Eligible beneficiaries based on age, whose TRICARE eligibility is determined by 10 U.S.C. Section 1086, are eligible for Medicare Part A and, except as provided in [paragraph III.B.](#) below, are enrolled in Medicare Part B, are eligible for the TRICARE pharmacy benefits program, effective April 1, 2001.

b. Individuals, who before April 1, 2001, have attained the age of 65 and who are not enrolled in Medicare Part B are eligible for the TRICARE Senior Pharmacy Program; and

4. Overseas TRICARE beneficiaries listed in DEERS (with APO or FPO address) are eligible for the TRICARE Mail Order Program. For these beneficiaries a prescription is required for a U.S. Food and Drug Administration approved prescription drug from an authorized provider who is licensed to practice in the United States.

E. Reimbursement

1. The prescription drug claims for eligible beneficiaries will be reimbursed in accordance with the applicable reimbursement sections of the TRICARE Reimbursement Manual. Beneficiaries shall pay a co-pay in accordance with [Chapter 12, Section 11.1](#) or TRICARE Reimbursement Manual, [Chapter 2, Addendum A](#) as appropriate. All deductibles and co-pays apply towards the catastrophic cap.

2. Beneficiary appeal rights are governed by [32 CFR 199.10](#).

III. EXCLUSIONS

A. Drugs prescribed or furnished by a member of the patient's immediate family.

B. Drugs, including compounded preparations, that are available over the counter.

C. Group C Designation. Investigational drugs with FDA "Group C" designation have reproducible efficacy in one or more specific tumor types. Such a drug has altered or is likely to alter the pattern of treatment of the disease and can be safely administered by properly trained physicians without specialized supportive care facilities. TRICARE may not cost-share use of Group C designated drugs because authorization for Group C distribution for a specific indication is not equivalent to formal FDA approval for that indication. Medical care related to the use of Group C designated drugs may be cost-shared only when the care would have been provided in the absence of the use of the Group C designated drug.

D. Orphan drugs without marketing approval, but which are made available on a compassionate use basis, may not be cost-shared.

E. Treatment Investigational New Drugs (IND). Under the FDA treatment IND (investigational new drug) regulations enacted in 1987, drugs that are in controlled clinical trials can be provided outside those trials to treat patients with serious or immediately life-

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threatening diseases for which no comparable or satisfactory alternate therapy exists. TRICARE may not cost-share treatment INDs because they have not received FDA marketing approval. However, medical care related to the use of treatment INDs may be cost-shared when the patient's medical condition warrants their administration and the care is provided in accordance with generally accepted standards of medical practice.

F. Irinotecan (Camptosar®) for treatment of metastatic esophageal cancer is unproven.

IV. EFFECTIVE DATES

A. Labeled uses: the date of FDA approval for the specific indication.

B. Off-labeled uses: the date that reliable evidence establishes the safety and efficacy of the drug for that specific use.

C. Orphan drugs: the date of FDA marketing approval.

- END -

processed by the contractor using the same rules and cost-shares that apply to active duty dependents.

E. Change in eligibility status of a beneficiary during an inpatient hospital stay (see the TRICARE Reimbursement Manual (TRM), [Chapter 6, Section 2](#)).

F. In cases involving the existence of Other Health Insurance (OHI) for dependents and/or sponsors, treat as double coverage as required by the TRICARE Reimbursement Manual.

G. TRICARE Prime:

1. Enrollment in Prime. TAMP eligibles may enroll or re-enroll in TRICARE Prime.
2. Effective Date of Enrollment in TRICARE Prime is as follows:

a. TAMP eligibles (including the former active duty member) who were enrolled in Prime immediately prior to their change in status may continue their enrollment in TRICARE Prime with no break in coverage. A reenrollment application must be completed prior to the TAMP expiration period in order to continue with TRICARE Prime. The effective date shall be the date the sponsor separated from active duty as the intent is to ensure that Prime coverage is seamless. See [Chapter 10, Section 2.1](#) for further information on the effective date of enrollment.

b. TAMP eligibles who were not enrolled in Prime (including **TRICARE Prime Remote (TPR)** and **TRICARE Prime Remote Active Duty Family Member (TPRADFM)**) immediately prior to their change in status may choose to enroll in TRICARE Prime while receiving TAMP coverage but such enrollment is subject to the “twentieth of the month rule”. That is, if an application for an initial enrollment is received after the twentieth day of the month, Prime enrollment will begin on the first day of the second month after the month in which the application was received by the contractor. See [Chapter 10, Section 2.1](#) for further information on the effective date of enrollment.

c. TAMP eligibles whose sponsor is called to active duty.

(1) TAMP eligible family members who were enrolled in Prime immediately prior to their sponsor’s change in status to active duty may continue their reenrollment in TRICARE Prime with no break in coverage if they reenroll in TRICARE Prime within 30 days of the return to active duty status. If reenrollment is accomplished within 30 days of the return to active duty status, the reenrollment will be retroactive to the date of the change in status from TAMP to active duty. If reenrollment is not accomplished within 30 days of the return to active duty status, the twentieth of the month rule will apply.

(2) TAMP eligible family members not enrolled in Prime immediately prior to reactivation (i.e., return to active duty) may choose to enroll in Prime but such initial enrollment is subject to the twentieth of the month rule. That is, if an application for an initial enrollment in Prime is received after the twentieth of the month, Prime enrollment will begin on the first day of the second month after the month in which the application was received by

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TRANSITIONAL ASSISTANCE MANAGEMENT PROGRAM (TAMP)

the contractor. See [Chapter 10, Section 2.1](#) for further information on effective date of initial enrollments and reenrollments.

(3) For information on the effective dates of enrollments for Active Duty Service Member (ADSM) see the TRICARE Operations Manual (TOM), [Chapter 6, Section 1](#).

d. While the TPR and TPRADFM are not available to TAMP eligibles, these programs are considered a “Prime-like” benefit and enrollment or reenrollment in Prime shall be available to them as stated above.

H. The Continued Health Care Benefit Program (CHCBP) may be available to members (and their dependents) after the expiration of TAMP entitlement. The CHCBP is a program that requires enrollment and the payment of quarterly premiums. Application for CHCBP must occur within 60 days of loss of TAMP eligibility. See [Chapter 10, Section 4.1](#) for further information.

I. Dental Coverage

1. Dental benefits for TAMP-eligibles are limited to space available care in the Dental Treatment Facility (DTF).

2. The TRICARE Dental Program (TDP) is a voluntary dental insurance program that is available to Active Duty Family Members (ADFM)s, Selected Reserve and Individual Ready Reserve members, and their eligible family members. The TDP is not part of the benefits offered under TAMP. Sponsors who were enrolled in the TDP prior to being activated, who then return to Reserve status, may be eligible to re-enroll in the TDP.

J. Demonstrations.

1. TAMP eligibles who were also eligible for the benefits of the Operation Noble Eagle/Operation Enduring Freedom Demonstration shall retain those benefits during their TAMP eligibility if the Demonstration is still active. See the TOM, [Chapter 20, Section 4](#). **The demonstration was effective for claims for services provided on or after September 14, 2001, and before November 1, 2009. The provisions of the demonstration were made permanent by section 704 and 705 of the National Defense Authorization Act (NDAA) for Fiscal Year 2005. See [Chapter 10, Section 8.1](#).**

2. TAMP eligibles with a DEERS indicator “B” for Bosnia shall retain the same special demonstration benefits available to them while on active duty during their TAMP eligibility.

- END -

TRICARE FOR LIFE

ISSUE DATE: September 25, 2001

AUTHORITY: 10 USC 1086(d)

I. DESCRIPTION

Pursuant to Section 712 of the **Fiscal Year (FY) 2001 National Defense Authorization Act (NDAA)**, Medicare eligible beneficiaries based on age, whose TRICARE eligibility is determined by 10 **United States Code (USC) Section 1086**, are eligible for Medicare Part A, and are enrolled in Medicare Part B, are eligible for the TRICARE benefit effective October 1, 2001. **Beneficiaries under age 65 who are also Medicare eligible, are also eligible for TRICARE For Life (TFL) (see the TRICARE Operations Manual (TOM), Chapter 22, Section 1, paragraphs 2.3. and 2.4.).**

II. POLICY

A. Introduction:

Section 712 extends TRICARE eligibility to persons who would otherwise have lost their TRICARE eligibility due to attainment of entitlement to hospital insurance benefits under Part A of Medicare based on age. In order for these individuals to retain their TRICARE eligibility, they must be enrolled in the supplementary medical insurance program under Part B of Medicare. In general, in the case of medical or dental care provided to these individuals for which payment may be made under both Medicare and TRICARE, Medicare is the primary payer and TRICARE will normally pay the actual out-of-pocket costs incurred by the person.

B. Eligibility.

The contractors shall determine from the Defense Enrollment Eligibility Reporting System (DEERS) if the individual is eligible for the TRICARE benefit.

C. **Under certain conditions TFL beneficiaries may enroll in TRICARE Prime (see the TOM, Chapter 6, Section 1, paragraph 8.4. through 8.4.2.).**

D. Claims will be reimbursed with the applicable reimbursement sections of the TRICARE Policy, Reimbursement, and Operations manuals.

E. Appeal rights are covered in the **TOM, Chapter 13.**

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CHAPTER 10, SECTION 6.1

TRICARE FOR LIFE

F. The contractor shall educate beneficiaries about this benefit as identified by the government.

- END -