



TRICARE
MANAGEMENT ACTIVITY

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
HEALTH AFFAIRS

16401 EAST CENTRETECH PARKWAY
AURORA, COLORADO 80011-9066

MB&RB

**CHANGE 151
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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: NATIONAL DEFENSE AUTHORIZATION ACT (NDAA) FISCAL YEAR (FY) 2010, SECTION 702, EXPANSION OF EARLY ELIGIBILITY BENEFIT FOR RESERVE AND NATIONAL GUARD (NG) FAMILY MEMBERS FROM 90 TO 180 DAYS

CONREQ: 15452

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): This change expands the maximum period of early eligibility TRICARE from 90 to 180 days for members of the Reserve and NG who are issued delayed-effective-date active-duty orders.

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

This change is made in conjunction with Aug 2002 TOM, Change No. 134 and Aug 2002 TRM, Change No. 144 .


Ann N. Fazzini
Chief, Medical Benefits and
Reimbursement Branch

ATTACHMENT(S): 13 PAGE(S)
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CHAPTER 1

Section 17.1, pages 1 and 2

CHAPTER 9

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HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS) "C" AND "S" CODES

ISSUE DATE: November 6, 2007

AUTHORITY:

I. HCPCS "C" AND "S" CODES

C1000 - C9999; S0000 - S9999

II. DESCRIPTION

A. HCPCS "C" codes include device categories, new technology procedures, and drugs, biologicals and radiopharmaceuticals that do not have other HCPCS assigned.

B. HCPCS "S" codes are temporary codes used by the private sector to report drugs, services, and supplies for which there are no national codes.

III. POLICY

A. Upon implementation of TRICARE's Outpatient Prospective Payment System (OPPS), HCPCS "C" codes shall be paid according to OPPS guidelines as outlined in the TRICARE Reimbursement Manual (TRM), [Chapter 13](#). For Hospital Outpatient Department (HOPD) services provided on or before May 1, 2009 (implementation of TRICARE's OPPS), and thereafter, for services by exempt OPPS hospitals, the contractor shall allow payment of HCPCS "C" codes consistent with current policy as stated in the TRM, [Chapter 1, Section 24, paragraph II.B](#).

B. Under TRICARE, "S" codes are not reimbursable except as follows:

1. S9122, S9123, and S9124 for the ECHO respite care benefit and the ECHO Home Health Care (EHHC) benefit; and

2. S0812, S1030, S1031, S1040, S2066, S2067, S2068, S2075, S2076, S2077, S2083, S2202, S2235, S2325, S2360, S2361, S2401, S2402, S2403, S2405, S2411, S3620, S3818, S3819, S3820, S3822, S3823, S8030, S8185, S8265, S8270, and S9430 for all beneficiaries; and

3. S5108 for direct Educational Interventions for Autism Spectrum Disorders (EIA) services provided to TRICARE beneficiaries under the Department of Defense (DoD) Enhanced Access to Autism Services Demonstration. (See the TRICARE Operations Manual (TOM), [Chapter 20, Section 9](#)).

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"S" CODES

4. S2400 for prenatal surgical intervention of temporary tracheal occlusion of Congenital Diaphragmatic Hernia (CDH) for fetuses with prenatal diagnosis of CDH shall be determined on a case-by-case basis, based on the Rare Disease policy, effective October 1, 2009. Procedural guidelines for review of rare disease are contained in [Chapter 1, Section 3.1](#).

5. S0189 for testosterone pellets as provided in [Chapter 4, Section 5.1](#).

C. Under TRICARE, HCPCS code S9999 is a recognized code for purposes of reporting sales tax but is not payable.

IV. EXCLUSIONS

HCPCS "C" codes are not allowed to be billed by independent professional providers.

- END -

SPECIAL EDUCATION

ISSUE DATE: July 3, 1997

AUTHORITY: [32 CFR 199.5\(c\)\(4\)](#)

I. CPT¹ PROCEDURE CODES

99199, 99600

II. POLICY

A. Special education, within the meaning of such term as used in the Individuals with Disabilities Education Act (IDEA) and its implementing regulations and policies, may be cost-shared subject to all applicable ECHO requirements, and in particular, the requirement that other public programs and facilities be used to the extent available and adequate.

B. Identification of appropriate public facilities. The local educational agency with responsibility for the beneficiary is the sole public facility to provide public facility use certification for special education services.

C. The educational modality known as “Applied Behavioral Analysis (ABA)” is included as a benefit under this issuance when provided by a TRICARE-authorized provider. Payable services include periodic evaluation of the beneficiary, development of a treatment plan, and training of individuals to provide services in accordance with the treatment plan. TRICARE can also pay for the “hands-on” ABA services when provided by a TRICARE authorized provider. However, TRICARE can not pay for such services when provided by family members, trainers or other individuals who are not TRICARE-authorized providers (see [Chapter 9, Section 17.1](#)).

D. Services cost-shared through the ECHO may be provided by an authorized institutional or individual professional provider on an inpatient or outpatient basis and rendered in the beneficiary’s natural environment. This includes at home, at school, or other location that is suitable for the type of services being rendered.

E. See the TRICARE Operations Manual (TOM), [Chapter 20, Section 9](#) for information about the Department of Defense (DoD) Enhanced Access to Autism Services Demonstration.

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CHAPTER 9, SECTION 9.1

SPECIAL EDUCATION

III. EXCLUSION

Special education services available under the TRICARE Basic Program are not eligible to be cost-shared under the ECHO.

IV. EFFECTIVE DATE September 1, 2005.

- END -

PROVIDERS

ISSUE DATE: August 4, 1988
AUTHORITY: 32 CFR 199.6(e)

I. POLICY

A. Services and items cost-shared through the ECHO must be rendered by TRICARE authorized providers.

B. ECHO inpatient care providers: Inpatient care providers under the ECHO must:

1. Be a not-for-profit organization which primarily provides services to the disabled,
OR

2. Be a facility operated by the state or under state contract, AND

3. Meet all applicable licensing or certification requirements that are extant in the state, county, municipality, or other political jurisdiction in which the provider is located.

C. ECHO outpatient care providers. A provider of ECHO outpatient, ambulatory, or in-home services shall be:

1. An authorized provider of services as defined in 32 CFR 199.6, OR

2. An individual, corporation, foundation, or public entity that predominantly renders services of a type uniquely allowable as a ECHO benefit and not otherwise allowable as a benefit of 32 CFR 199.4, that meets all applicable licensing or other regulatory requirements that are extant in the state, county, municipality, or other political jurisdiction in which the ECHO service is rendered.

D. Individual professional providers authorized by 32 CFR 199.6 for the Basic Program are also authorized providers for the ECHO. Individual professional providers who can be authorized only under the ECHO must meet all applicable licensing and other regulatory requirements that are extant in that state, county, municipality, or other political jurisdiction in which the ECHO service is rendered, or, in the absence of such licensing or regulatory requirements, as determined by the Director, TRICARE Management Activity or designee.

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PROVIDERS

E. For the purpose of services rendered in conjunction with Applied Behavioral Analysis (ABA) under the ECHO Special Education benefit (see [Chapter 9, Section 9.1](#)), TRICARE-authorized providers are those that:

1. Have a current State license to provide ABA services; or
2. Are currently State-certified as an Applied Behavioral Analyst; or
3. Where such State license or certification is not available, are certified by the Behavioral Analyst Certification Board (BACB) as either a Board Certified Behavior Analyst or a Board Certified Associate Behavior Analyst; and
4. Otherwise meet all applicable requirements of TRICARE-authorized providers.

F. ECHO vendor. A provider of an allowable ECHO item, supply, equipment, orthotic, or device shall be deemed to be an authorized vendor for the provision of the specific item, supply, equipment, orthotic, or device when the vendor supplies such information as the Managed Care Support Contractor (MCSC) or Director, TRICARE Area Office (TAO) determines necessary to adjudicate a specific claim.

G. Provider requirements for the Department of Defense (DoD) Enhanced Access to Autism Services Demonstration are indicated in the TRICARE Operations Manual (TOM), [Chapter 20, Section 9](#).

II. EFFECTIVE DATE September 1, 2005.

- END -

ELIGIBILITY AND ENROLLMENT

SECTION	SUBJECT
1.1	Eligibility Requirements For TRICARE Beneficiaries
2.1	Prime - Enrollment
3.1	Prime And Status Changes
4.1	Continued Health Care Benefit Program (CHCBP) FIGURE 10-4.1-1 CHCBP Implementing Instructions
5.1	Transitional Assistance Management Program (TAMP)
6.1	TRICARE For Life
7.1	Transitional Survivor Status and Survivor Status
8.1	TRICARE Reserve And National Guard (NG) Family Member Benefits
9.1	Early Eligibility Benefits For Reserve And National Guard (NG)

TRICARE RESERVE AND NATIONAL GUARD (NG) FAMILY MEMBER BENEFITS

ISSUE DATE: June 5, 2009

AUTHORITY: [32 CFR 199.4\(f\)\(2\)\(i\)\(H\)](#), Public Law 108-375, Sections 704 and 705

I. DESCRIPTION

A. The provisions of this section apply to family members who become eligible for TRICARE as a result of their Reserve Component (RC) sponsor (including those with delayed effective date orders up to 180 days) being called or ordered to active duty for more than 30 days in support of a federal contingency operation and choose to participate in TRICARE Standard or Extra, rather than enroll in TRICARE Prime.

B. These provisions help ensure timely access to health care and maintain clinically appropriate continuity of health care to family members of Reservists and NG members activated in support of a federal contingency operation, limit the out-of-pocket health care expenses for those family members, and remove potential barriers to health care access by NG and Reserve families.

II. BACKGROUND

A. Section 704 of the National Defense Authorization Act for Fiscal Year 2005 (NDAA FY 2005) (Public Law 108-375) established the authority to waive the annual TRICARE Standard deductible for RC family members who became eligible for TRICARE as a result of their sponsor's activation in support of a contingency operation. By law, the TRICARE Standard deductible for Active Duty Family Members (ADFM) is \$150 per individual, \$300 per family (\$50/\$100 for E-4s and below). Waiving the TRICARE deductible appropriately limits out-of-pocket expenses for these RC family members, many of whom may have already paid annual deductibles under their civilian health plans.

B. Section 705 of the NDAA FY 2005 established the authority to increase TRICARE payments up to 115% of the TRICARE maximum allowable charge, less the applicable patient cost share if not previously waived under the provisions of Section 704, for covered inpatient and outpatient health care services received from a provider that does not participate (accept assignment) under TRICARE. This allows this group of RC family members to continue to see civilian providers with whom they have established relations and promotes access and clinically appropriate continuity of care.

C. The provisions outlined above were previously provided to RC family members under the provisions of the Operation Noble Eagle/Operation Enduring Freedom Reservist and National Guard Benefits Demonstration (TRICARE Operations Manual (TOM), [Chapter](#)

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TRICARE RESERVE AND NATIONAL GUARD (NG) FAMILY MEMBER BENEFITS

20, Section 4). This demonstration was effective for claims for services provided on or after September 14, 2001, and before November 1, 2009.

III. POLICY

A. This benefit is authorized for family members of RC members who are called or ordered to active duty for a period of more than 30 days, or NG members who are called or ordered to full-time federal NG duty for a period of more than 30 days in support of a contingency operation (as defined in 10 United States Code (USC) 101(a)(13)).

NOTE: This special benefit does not apply to Prime beneficiaries. Family members of Reservists or members of the NG who are called to active duty in support of operations identified in paragraph III.A. and who are enrolled in Prime will be protected when they receive services outside the network under the provisions of TOM, Chapter 8, Section 5.

B. 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.

C. 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 benefit. 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.

D. The TRICARE Encounter Data (TED) record for each claim received subsequent to policy specified in paragraph III.A. must reflect the Special Processing Code "EF".

E. TED records submitted for 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.

F. All Non-Availability Statement (NAS) requirements are waived for beneficiaries identified by Health Care Delivery Program (HCDP) Special Entitlement codes "02" or "03".

G. The TRICARE Standard and Extra deductible is waived for all beneficiaries identified by HCDP Special Entitlement codes "02" or "03".

- END -

EARLY ELIGIBILITY BENEFITS FOR RESERVE AND NATIONAL GUARD (NG)

ISSUE DATE: January 10, 2012

AUTHORITY: [32 CFR 199.3\(b\)\(5\)](#); Department of Defense Instruction (DoDI) 7730.54; Public Law 108-136, Section 703; Public Law 108-375, Section 703; and Public Law 111-84, Section 702

I. DESCRIPTION

A. The provisions of these sections, while not creating any new classes of beneficiaries or changes in coverage, do serve to expand the period of TRICARE eligibility previously applicable to certain existing classes of beneficiaries under current provisions. Members of the Reserve and NG who are called or ordered to active duty for more than 30 days in support of a federal contingency operation and are issued delayed-effective-date active-duty orders become eligible for TRICARE up to 180 days before the active duty commences.

II. BACKGROUND

A. Section 703 of the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2004 (Public Law 108-136) established temporary authority to expand the period of time that a reservist is considered to be on active duty for the purpose of TRICARE eligibility.

B. Section 703 of the NDAA for FY 2005 (Public Law 108-375) made the authority permanent.

C. Section 702 of the NDAA for FY 2010 (Public Law 111-84) extended the maximum period of early eligibility from 90 days to 180 days.

III. POLICY

A. A Reserve Component (RC) member who is issued a delayed-effective-date active-duty order on October 28, 2009 or later will be considered as being on active duty for more than 30 days beginning on the later of the date that is:

1. The date of issuance of the order; or
2. One hundred and eighty days before the date on which the period of active duty is to commence.

B. The secretaries of the military departments are responsible for ensuring accurate and timely submission of early TRICARE eligibility data to the Defense Enrollment Eligibility

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EARLY ELIGIBILITY BENEFITS FOR RESERVE AND NATIONAL GUARD (NG)

Reporting System (DEERS) as specified in DoDI 7730.54, "Reserve Component Common Personnel Data System" (RCCPDS). The TRICARE Early Identification (EID) program for early TRICARE eligibility transactional data defined in RCCPDS, based on the delayed-effective-date active-duty order, is the authoritative source for establishing, maintaining, and terminating early TRICARE eligibility in the DEERS. Uniformed services personnel offices are responsible for ensuring that DEERS changes have been effectuated to reflect correct eligibility information for all affected individuals. If the delayed-effective-date active-duty orders are rescinded before the active duty commences, the military departments are responsible for terminating the member's and dependents' eligibility for TRICARE in DEERS.

C. Affected individual members of the RC and their family members are eligible for TRICARE under this section. The provisions available under the TRICARE Reserve and NG family member benefits ([Chapter 10, Section 8.1](#)) shall apply to those eligible for care under this section. This eligibility includes family member eligibility for TRICARE Prime/Overseas Prime and for TRICARE Prime Remote (TPR)/Overseas Prime Remote for Active Duty Family Members (ADFMs). This eligibility also includes service member eligibility for TRICARE Prime with a Military Treatment Facility (MTF) Primary Care Manager (PCM) if the member lives near an MTF; TPR for the member is not authorized during this early eligibility period. A non-enrolled service member may seek covered primary care from a TRICARE authorized civilian provider. Prior to obtaining any specialty care, the RC member should contact the appropriate TRICARE regional or overseas Managed Care Support Contractor (MCSC) to request authorization.

1. The periods of TRICARE eligibility for the affected individuals will be reflected in DEERS. Contractors will continue to rely upon DEERS for eligibility determination.

2. The contractor shall verify the patient's eligibility in DEERS.

D. In the event that the contractor should become aware that payment has been made for services rendered during a period for which the patient was subsequently determined to be ineligible recoupment action shall be initiated. Recoupment procedures are specified in TRICARE Operations Manual (TOM), [Chapter 11, Section 3](#) or [4](#) as appropriate.

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