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TRICARE
MANAGEMENT ACTIVITY

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CHANGE 5
6010.54-M
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PUBLICATIONS SYSTEM CHANGE TRANSMITTAL
FOR
TRICARE POLICY MANUAL (TPM)

The TRICARE Management Activity has authorized the following addition(s)/
revision(s) to the 6010.54-M, issued August 2002.

CHANGE TITLE: CONSOLIDATED

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

SUMMARY OF ADDITIONS/REVISIONS: The attached package includes standard of care changes; adds NAS elimination provisions; revises TAMP time-frames for eligibility; adds CPT 2002 update; removes Level III codes; allows dependents of reserve component members to enroll in prime if activated for 31 days or more; revises DRG effective date to 08/01/2003; adds clarifying language regarding duplicate items of DME; adds criteria for coverage of anesthesiologist assistant; provides requirements/interface process between TRICARE overseas claims processing contractor and TGRO contractor; provides requirements for processing overseas Navy and Marine Corps deployed and/or on liberty status personnel claims for remote and urgent care. See pages 6 through 15.

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


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

ATTACHMENT(S): 292 PAGE(S)
DISTRIBUTION: 6010.54-M

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REMOVE PAGE(S)

INTRODUCTION

pages 1 through 5

CHAPTER 1

Table of Contents, page i
Section 3.1, page 1
Section 5.1, pages 1 through 4
Section 6.1, pages 1 through 10
Section 7.1, pages 1 and 2
Section 9.1, pages 1 and 2

CHAPTER 2

Section 2.1, pages 1 and 2

CHAPTER 4

Table of Contents, pages i and ii
★ ★ ★ ★ ★ ★
Section 2.1, pages 1 through 3
★ ★ ★ ★ ★ ★
Section 5.1, pages 1 and 2
Section 5.6, pages 1 and 2
Section 6.1, pages 1 and 2
Section 9.2, page 1
Section 9.3, pages 1 and 2
Section 13.1, page 1
Section 14.1, pages 1 and 2
Section 15.1, pages 1 and 2
Section 17.1, pages 1 and 2
Section 18.5, pages 1 and 2

INSERT PAGE(S)

pages 1 through 5

Table of Contents, page i
Section 3.1, page 1
Section 5.1, pages 1 through 4
Section 6.1, pages 1 through 17
Section 7.1, pages 1 and 2
Section 7.1, pages 1 and 2

Section 2.1, pages 1 and 2

Table of Contents, pages i and ii
Section 1.1A, page 1
Section 2.1, pages 1 through 3
Section 2.1A, page 1
Section 5.1, pages 1 and 2
Section 5.6, pages 1 and 2
Section 6.1, pages 1 and 2
Section 9.2, pages 1
Section 9.3, pages 1 and 2
Section 13.1, page 1
Section 14.1, pages 1 and 2
Section 15.1, pages 1 and 2
Section 17.1, pages 1 and 2
Section 18.5, pages 1 and 2

REMOVE PAGE(S)

INSERT PAGE(S)

CHAPTER 4 (Continued)

Section 20.1, pages 1 through 4
Section 23.1, pages 1 through 10
Section 24.3, pages 1 through 5
Section 24.4, pages 1 through 5
Section 24.6, pages 1 through 4
Section 24.7, pages 1 through 5

Section 20.1, pages 1 through 4
Section 23.1, pages 1 through 10
Section 24.3, pages 1 through 5
Section 24.4, pages 1 through 5
Section 24.6, pages 1 through 4
Section 24.7, pages 1 through 5

CHAPTER 5

Section 1.1, pages 1 through 3
Section 2.1, pages 1 and 2
Section 3.1, pages 1 and 2
Section 4.1, pages 1 through 3

Section 1.1, pages 1 through 3
Section 2.1, pages 1 and 2
Section 3.1, pages 1 and 2
Section 4.1, pages 1 through 3

CHAPTER 7

Table of Contents, pages i and ii
Section 2.1, pages 1 and 2
Section 2.2, pages 1 through 6
Section 2.5, pages 1 and 2
Section 11.1, pages 1 and 2
Section 17.1, page 1
Section 18.2, pages 1 and 2
Section 18.3, pages 1 and 2
Section 22.1, pages 1 through 3

Table of Contents, pages i and ii
Section 2.1, pages 1 and 2
Section 2.2, pages 1 through 6
Section 2.5, pages 1 and 2
Section 11.1, pages 1 and 2
Section 17.1, page 1
Section 18.2, pages 1 through 3
Section 18.3, pages 1 and 2
Section 22.1, pages 1 through 4

CHAPTER 8

Section 1.1, pages 1 and 2
Section 2.1, pages 1 through 3
Section 7.1, pages 1 and 2

Section 1.1, pages 1 and 2
Section 2.1, pages 1 through 3
Section 7.1, pages 1 and 2

REMOVE PAGE(S)

INSERT PAGE(S)

CHAPTER 8 (Continued)

Section 8.1, pages 1 and 2

Section 8.1, pages 1 and 2

Section 9.1, pages 3 and 4

Section 9.1, pages 3 and 4

CHAPTER 9

Section 4.1, pages 1 and 2

Section 4.1, pages 1 and 2

Section 12.1, page 1

Section 12.1, page 1

Section 13.1, page 1

Section 13.1, page 1

Section 14.1, page 1

Section 14.1, page 1

CHAPTER 10

Section 2.1, pages 1 through 3

Section 2.1, pages 1 through 3

Section 3.1, pages 1 through 3

Section 3.1, pages 1 through 3

Section 4.1, pages 3, 4, 17 and 18

Section 4.1, pages 3, 4, 17 and 18

Section 5.1, pages 1 and 2

Section 5.1, pages 1 through 4

CHAPTER 11

Table of Contents, pages i and ii

Table of Contents, pages i and ii

Section 1.2, pages 1 and 2

Section 1.2, pages 1 and 2

Section 2.3, pages 1 through 4

Section 2.3, pages 1 through 4

Section 3.4, page 1

Section 3.4, pages 1 and 2

Section 7.1, pages 1 through 6

Section 7.1, pages 1 through 6

Section 11.1, page 1

Section 11.1, page 1

CHAPTER 12

Table of Contents, pages i and ii

Table of Contents, pages i and ii

Section 1.1, pages 1 through 5

Section 1.1, pages 1 through 7

Section 2.1, pages 1 through 8

Section 2.1, pages 1 through 8

Section 3.1, page 1

Section 3.1, page 1

Section 3.2, pages 1 through 3

Section 3.2, pages 1 through 3

REMOVE PAGE(S)

INSERT PAGE(S)

CHAPTER 12 (Continued)

Section 3.3, pages 1 and 2
Section 5.1, pages 1 and 2
Section 7.1, pages 1 through 3
Section 8.1, pages 1 and 2
Section 10.1, pages 1 and 2
Section 10.2, pages 1 and 2
Section 11.1, pages 1 through 28
Section 12.1, pages 1 through 4
Section 12.2, pages 3 through 35

Section 3.3, page 1
Section 5.1, pages 1 and 2
Section 7.1, pages 1 through 11
Section 8.1, pages 1 and 2
Section 10.1, pages 1 through 3
Section 10.2, pages 1 and 2
Section 11.1, pages 1 through 33
Section 12.1, pages 1 through 4
Section 12.2, pages 3 through 34

INDEX

pages 1 - 4, 7, 8, 13, 14, 21 and 22

pages 1 - 4, 7, 8, 13, 14, 21 and 22

SUMMARY OF CHANGES

INTRODUCTION

1. Adds information on the TRICARE Dual Eligible Fiscal Intermediary Contract (TDEFIC).

CHAPTER 1

2. Table of Contents (**Administration**) revises Section 6.1 from Inpatient Admissions to Inpatient Care.
3. Section 3.1 (**Rare Diseases**) removes "TRICARE adopts the Food and Drug Administration definition of rare disease or condition" and changes to "TRICARE defines a rare disease as any disease or condition that affects less than 200,000 persons in the United States."
4. Section 5.1 (**Requirements for Documentation Of Treatment In Medical Records**) adds that medical record requirements are the same for computerized or electronic medical records as they are for paper.
5. Section 6.1 (**Nonavailability Statement [DD Form 1251] For Inpatient Care**) updates NAS provisions. Effective for admissions on or after December 28, 2003, the NAS requirement is eliminated except for mental health admissions. The NAS provisions for care prior to December 28, 2003, as related to maternity care, non-enrolled newborns, active-duty mother's newborn, illegitimate newborn of active-duty father and ineligible mother, and illegitimate newborn of retiree father and ineligible mother are clarified. The criteria for waiver of NAS elimination is clarified. A Note is added that newborns born into active duty service member families or retiree families where one parent is enrolled in TRICARE Prime are considered enrolled in Prime for 120 days and no NAS is required for such newborns. The DoD Instructions on Delivery of Healthcare at Military Treatment Facilities: Foreign Service care, Third-Party Collection; Beneficiary Counseling and Assistance Coordinators (BCACs) are updated in Figure 1-6.1-2. Adds cross reference to Chapter 12, Sections 2.1 and 12.1, for overseas NAS procedures and requirements. Changes "other insurance" to "other health insurance." Adds Prime enrollees are subject to the referral and authorization requirements.
6. Section 7.1 (**Special Authorization Requirements**) removes paragraph I.F. on preauthorization for outpatient psychotherapy beyond the eighth visit.
7. Section 9.1 (**Primary Care Managers**) removes paragraph regarding the first eight sessions of mental health care.

CHAPTER 2

8. Section 2.1 (**Home Services**) adds CPT codes and exclusions of home visit sleep studies (CPT 99508), home visit day life activities (CPT 99509), home visit counseling (CPT 99510) and home infusion for tocolytic therapy (CPT 99553).

SUMMARY OF CHANGES (Continued)

CHAPTER 4

9. Table of Contents (**Surgery**) adds new sections Category III Codes and General Surgery.
10. Section 1.1A (**Category III Codes**) adds new section on Category III Codes for use in the collection of data on emerging technology.
11. Section 2.1 (**Cosmetic, Reconstructive And Plastic Surgery - General Guidelines**) changes paragraph II.A. from cost-shared to allowed; adds the example of panniculectomy following a gastroplasty or a gastric-bypass procedure to paragraph II.B.; adds cross reference to Chapter 4, Section 5.6; and clarifies the exclusion of panniculectomies in paragraph III.H.
12. Section 2.1A (**General Surgery**) adds new section on General Surgery to conform to revision to CPT Manual.
13. Section 5.1 (**Integumentary System**) revises CPT code range.
14. Section 5.6 (**Breast Reconstruction As A Result Of A Congenital Anomaly**) clarifies policy on collateral breast surgery.
15. Section 6.1 (**Musculoskeletal System**) adds exclusion of trigger point injection for migraine headaches.
16. Section 9.2 (**Photopheresis**) moves general provision for coverage of other indications when proven to separate paragraph.
17. Section 9.3 (**Intracoronary Stents**) removes language on size of native vessels.
18. Section 13.1 (**Digestive System**) revises CPT code range to 40490 - 40831, 40899 - 47362, 47371, 47379, 47399 - 49999, 91123, 96570, 96571; adds radiofrequency ablation of one or more liver tumors (CPT 47370, 47380, 47382) to Exclusions.
19. Section 14.1 (**Urinary System**) adds CPT codes 64561, 64581, 64585, 64590, and 64595.
20. Section 15.1 (**Male Genital System**) adds CPT code 55970.
21. Section 17.1 (**Female Genital System**) clarifies POLICY paragraph III.A. by adding the following: Infertility testing and treatment, including correction of the physical cause of infertility, are covered under this provision. This does not include artificial insemination, which is excluded from coverage.
22. Section 18.5 (**Fetal Surgery**) removes CPT codes, adds cross reference to TRICARE Operations Manual, Chapter 20, Section 3 for the DOD In-Utero Fetal Surgical Repair of Myelomeningocele Clinical Trial Demonstration.

SUMMARY OF CHANGES (Continued)

CHAPTER 4 (Continued)

23. Section 20.1 (**Nervous System**) adds exclusion of magnetocephalography, sacral nerve neurostimulator, and clarifies effective dates.
24. Section 23.1 (**High Dose Chemotherapy and Stem Cell Transplantation**) paragraph III.A. adds "autologous" in front of PSCT and adds "with or without HDC" after allogeneic peripheral stem cell transplantation and allogeneic umbilical cord blood transplantation; paragraph III.B. adds "autologous" in front of PSCT; paragraph III.C. adds "allogeneic" in front of peripheral stem cell transplantation; paragraph V.A. adds "autologous" in front of PSCT, adds "or allogeneic PSCT, with or without HDC, or Allogeneic Umbilical Cord Blood Transplantation, with or without HDC"; adds Langerhans Cell Histiocytosis, refractory to conventional treatment, to covered indications for allogeneic bone marrow, allogeneic peripheral stem cell and allogeneic umbilical cord blood transplantation, with effective date of June 1, 2003.
25. Section 24.3 (**Combined Heart-Kidney Transplantation**) adds acronym CHKT to title and removes Level III code 39555; revises effective date of DRG to August 1, 2003.
26. Section 24.4 (**Small Intestine, Combined Small Intestine-Liver, And Multivisceral Transplantation**) adds HCPCS Procedure Codes S2053, S2054, S2055; revises the patient selection criteria and contraindications to be more in compliance with Medicare and other carriers; removes restriction on small intestine alone transplant to patients under the age of 16; and adds Effective Date of October 4, 2000, for small intestine alone transplant for patients age 16 and order.
27. Section 24.6 (**Combined Liver-Kidney Transplantation**) removes Level III procedure code 47150, adds CPT codes for liver transplantation and kidney transplantation (47133-47135, 50300, 50360, 50365); revises effective date of DRG to August 1, 2003.
28. Section 24.7 (**Simultaneous Pancreas-Kidney, Pancreas-After-Kidney, And Pancreas-Transplant-Alone**) removes Level III code 48170 and adds HCPCS Procedure Code S2065.

CHAPTER 5

29. Section 1.1 (**Diagnostic Radiology**) CPT code 70336 added; CPT code 72198 removed from MRI code range; revises recognized high risk factors for coverage of bone density studies to comply with American College of Obstetricians and Gynecologists (ACOG).
30. Section 2.1 (**Diagnostic Ultrasound**) revises recognized high risk factors for coverage of bone density studies to comply with ACOG.
31. Section 3.1 (**Radiation Oncology**) CPT code 61795 added.

SUMMARY OF CHANGES (Continued)

CHAPTER 5 (Continued)

32. Section 4.1 (**Nuclear Medicine**) revises recognized high risk factors for coverage of bone density studies to comply with ACOG.

CHAPTER 7

33. Table of Contents (**Medicine**) adds Figure 7-22.1-1 - Telehealth Originating Site Facility Fee.
34. Section 2.1(**Clinical Preventive Services - TRICARE Standard**) revises CPT code range and adds CPT code 87340.
35. Section 2.2 (**Clinical Preventive Services - TRICARE Prime**) revises CPT code range for mammography, sigmoidoscopy, and colonoscopy; removes immunization CPT codes and removes NOTE re immunization codes.
36. Section 2.5 (**Well-Child Care**) removes reference to NAS.
37. Section 11.1 (**Cardiac Rehabilitation**) removes exclusion of non-hospital based cardiac rehabilitation.
38. Section 17.1 (**Dermatological Procedures - General**) revises phototherapy to photodynamic therapy.
39. Section 18.2 (**Physical Medicine/Therapy**) adds CPT code range 96000 - 96004, changes CPT code range 97010 - 97350 to 97012 - 97530, removes CPT codes 97010 and 97011; adds exclusion of athletic training evaluation.
40. Section 18.3 (**Occupational Therapy**) adds CPT code 97150.
41. Section 22.1 (**Telemedicine/Telehealth**) adds psychiatric diagnostic interview examinations (CPT 90801), clarifies reporting of CPT codes and modifiers; adds cross reference to Figure 7-22.1-1 Telehealth Originating Site Facility Fee; adds outpatient cost-share rules apply to this fee. Added Figure 7-22.1-1 (Telehealth Originating Site Facility Fee) to section adding telehealth originating site facility fee and Medicare Economic Index increase for FY2002 and FY2003.

CHAPTER 8

42. Section 1.1 (**Ambulance**) revises CPT code range; adds ambulance transfer to and from skilled nursing facilities; old paragraphs III.F.1 and 2 removed.
43. Section 2.1 (**Durable Medical Equipment - Basic Program**) adds clarifying language regarding duplicate items of durable medical equipment.

SUMMARY OF CHANGES (Continued)

CHAPTER 8 (Continued)

44. Section 7.1 (**Nutritional Therapy**) corrects the website address for the Enteral Nutrition Product Classification List.
45. Section 8.1 (**Diabetes Outpatient Self-Management Training Services**) adds Effective Date of July 1, 1998.
46. Section 9.1 (**Pharmacy Benefits Program**) changes exclusion paragraph on Treatment Investigational New Drugs (INDs) to correspond with the language in 32 CFR 199.4(g)(15) regarding cost-sharing of medical care related to the use of treatment INDs.

CHAPTER 9

47. Section 4.1 (**Eligibility - General**) changes paragraph I.A.2 to; A former member of a Uniformed Service of the United States when the child or spouse is the victim of physical or emotional abuse. (Benefits are limited to the period that the abused dependent is in receipt of transitional compensation under section 1059 of Title 10 U.S.C.)
48. Section 12.1 (**Institutional Care Benefit**) removes Level III codes 98000, 98010; adds CPT to paragraph I. title and adds CPT code 99199.
49. Section 13.1 (**Transportation**) adds CPT to paragraph I title and moves CPT code 99082 to this paragraph; adds paragraph II title HCPCS Procedure Codes and codes A0100-A0140, A0170.
50. Section 14.1 (**Adjunct Services**) removes Level III code 98559; adds CPT to paragraph I title and adds CPT code 99199.

CHAPTER 10

51. Section 2.1 (**Prime - Enrollment**) changes provision to allow dependents of reserve component members to enroll in Prime if the reserve component member is activated for 31 days or more. Previously the activation had to be for 179 days or more. Also the paragraphs on Effective Date of Enrollment are revised to clarify the provisions for re-enrollment for those who were enrolled in Prime immediately prior to a change in their status and who retire other than the first of the month or separate other than the first of the month and continue to be eligible (e.g., spouse of active duty member or eligible for TAMP).

SUMMARY OF CHANGES (Continued)

CHAPTER 10 (Continued)

52. Section 3.1 (**Prime And Status Changes**) adds “or re-enrollment” to paragraph I.C.1.; changes provision to allow dependents of reserve component members to enroll in Prime if the reserve component member is activated for 31 days or more. Previously the activation had to be for 179 days or more. Also adds cross reference to TRICARE Operations Manual, Chapter 6, Section 1 for enrollment fee refunds. Adds to paragraph I.: “Unless the family enrollment becomes an individual enrollment due to death of one or more family members as stated in the TOM, Chapter 6, Section 1, paragraph 11.3.”.
53. Section 4.1 (**Continued Health Care Benefits Program**) adds provision to allow payment by credit card; Figure 10-4.1-1, paragraphs 2.1. and 5.a., are revised to limit using only the last four digits of the SSN in reports.
54. Section 5.1 (**Transitional Assistance Management Program**) changes Eligible Groups to Covered Groups; revises/clarifies the provisions for Time Frames for Eligibility and separates into the provisions for Separation Prior to December 28, 2001, and Separation On or After December 28, 2001; clarifies that eligibility is determined based on total active federal military service; clarifies provisions on determining eligibility--must be based on DEERS determinations and MCSCs are responsible for confirming DEERS eligibility status; adds/clarifies provisions regarding eligibility and effective dates of enrollment and re-enrollment in TRICARE Prime for TAMP eligibles; adds that while the TRICARE Prime Remote (TPR) and TRICARE Prime Remote Active Duty Family Member (TPRADFM) are not available to TAMP eligibles, these programs are considered a “Prime-like” benefit and enrollment or re-enrollment in Prime shall be available to them; adds quarterly premiums for coverage under CHCBP are approximately \$933 for one person and \$1996 for family and adds cross reference to Chapter 10, Section 4.1 for more information on CHCBP; adds provisions on Dental Coverage—dental benefits for TAMP-eligibles are limited to space available care in the DTF.

CHAPTER 11

55. Table of Contents (**Providers**) changes Section 3.4 from Nurse Anesthetist to Nonphysician Anesthetist.
56. Section 1.2 (**Institutional Provider Individual Provider And Other Non-Institutional Provider Participation**) corrects grammar and adds effective date of August 1, 2003.
57. Section 2.3 (**Birth Centers**) adds NAS is not required for any maternity episode wherein the first prenatal visit occurs on or after December 28, 2003. For those episodes wherein the first prenatal visit occurs between October 5, 1999 through December 27, 2003, an NAS is required; updates addresses for the Joint Commission on Accreditation of Healthcare Organizations, the accreditation Association for Ambulatory Healthcare, and the Commission for the accreditation of Birth Centers

SUMMARY OF CHANGES (Continued)

CHAPTER 11 (Continued)

58. Section 3.4 (**Nonphysician Anesthetist**) changes title from Nurse Anesthetist to Nonphysician Anesthetist; adds criteria for coverage of anesthesiologist assistant.
59. Section 7.1 (**Certification Of Organ Transplant Centers**) provides clarification of certification requirements for small intestine (SI) transplant centers to be in compliance with Medicare requirements.
60. Section 11.1 (**Birth Center Accreditation**) corrects the addresses for the Joint Commission on Accreditation of Healthcare Organizations, the Accreditation Association for Ambulatory Health Care, and the Commission for the Accreditation of Birth Centers.

CHAPTER 12

61. Table of Contents (**TRICARE Overseas Program**) adds Section 7.1, Enclosure 1 Sample of Regional Director TOP Preferred Provider Network Agreements; changes Figure 12-12.2-4 to List of Overseas Remote, Non-Remote & MTF Countries by Region; changes Figure 12-12.2-5 to List of Overseas Remote Areas by Region; changes Figure 12-12.2-6 to MTF Countries; changes Figure 12-12.2-11 to TOP and TDP Point of Contact Program Booklet; changes Figure 12-12.2-12 to TRICARE Global Remote Overseas (TGRO) Contractor Provider Certification Request Letter; changes Figure 12-12.2-13 to TRICARE Global Remote Overseas (TGRO) Contractor TRICARE Provider Agreement Application; adds Figure 12-12.2-14 TRICARE Overseas Remote DMIS-ID by Region; adds Figure 12-12.2-15 TRICARE Global Remote Overseas (TGRO) Contractor Claim form.
62. Section 1.1 (**Introduction**) changes three overseas regions to three overseas areas. Incorporates the requirements/interface processes between the TRICARE Overseas Claims Processing Contractor and the TRICARE Global Remote Overseas (TGRO) Contractor for processing Overseas Active Duty Member and Active Duty Family Member healthcare claims in remote overseas areas. Clarifies that all provisions of the TRICARE Policy Manual, TRICARE Reimbursement Manual, TRICARE Operations Manual, and TRICARE Systems Manual apply to the TOP, unless otherwise specifically stated in the Chapter. Clarifies the responsibilities of the TOP Overseas Regional Directors to include oversight and administration of contracted tasks, such as monitoring oversight and performance monitoring for the TGRO. Adds TOP will have three overseas Regional Directors. Clarifies the jurisdictional responsibilities of the Overseas Managed Care Support Contractor. Incorporates requirements for processing Navy and Marine Corps deployed and/or deployed on liberty claims in remote overseas areas. Clarifies the Overseas Benefit Package to include TOP Prime Plan, TOP Standard, TOP TRICARE for Life and TRICARE Plus. Clarifies the provisions of geographic availability on a commercial ship. Adds TOP Claims Processing Responsibility provisions. Adds eligibility provisions for TOP. Clarifies enrollment provisions. Changes effective date to September 1, 2003; adds cross-reference to Chapter 12, Section 11.1 for processing guidelines for beneficiaries who are enrolled or reside stateside and receive overseas health care while traveling overseas.

SUMMARY OF CHANGES (Continued)

CHAPTER 12 (Continued)

63. Section 2.1 (**Benefits And Beneficiary Payments**) adds TOP TRICARE for Life. Inserts the NAS provisions that were erroneously removed. A Note is added providing the definition of overseas catchment areas of an USMTF. Incorporates the requirements/ interface processes between the TRICARE Overseas Claims Processing Contractor and the TRICARE Global Remote Overseas (TGRO) Contractor for processing Overseas Active Duty Member and Active Duty Family Member healthcare claims in remote overseas areas. Clarifies copayment provisions. Adds Program for Persons with Disabilities fees are applicable under the TOP. Changes the effective date for benefit payments in the attachment to September 3, 2003. Adds Home therapy to Outpatient Mental Health. Revises Retail Pharmacy Benefits and adds TRICARE Retail Pharmacy (T-REX) Structure for Overseas Claims Processing. Clarifies the cost-share provisions for retirees, their members and survivors for inpatient overseas services to 25% cost-share of billed charges for institutional services, plus 25% cost-share of allowable for separately billed professional charges. Clarifies Point of Service (POS) payment.
64. Section 3.1 (**Eligibility Requirements**) adds TRICARE for Life eligibility requires Medicare Part B enrollment.
65. Section 3.2 (**Enrollment (Prime/TRICARE Plus)**) adds TOP Prime enrollees will be provided an enrollment card through Defense Manpower Data Center (DMDC). Revises TOP enrollment is effective the date of acceptance of the enrollment. Clarifies retroactive enrollment by adding to the exceptions for newborns "after 120 days of conditional enrollment (see Chapter 10, Section 3.1 and TRICARE Operations Manual, Chapter 6, Section 1)". Requires the MCS contractor responsible for processing foreign claims to process TOP standard beneficiaries residing overseas stateside claims. Clarifies Point of Service Option is not applicable for TOP Prime beneficiaries who receive care during temporary absences from an overseas area and during permanent transfer prior to enrollment in their new region. Adds the Regional Directors will monitor the overseas remote program and the TRICARE Global Remote Overseas Prime (TGROP) enrollment activities and establish a designated contact for enrollment issues related to overseas remote areas.
66. Section 3.3 (**Prime And Status Changes**) adds Note: The automatic enrollment in TOP Prime of a new family member does not apply in the case of a reservist who has been called to active duty for a period of less than 30 days, since the dependents of the reservist are not eligible to enroll in TRICARE Prime. Clarifies that TOP ADFM may disenroll from TOP Prime at any time if the enrollee is moving from OCONUS to CONUS or is a demobilized reservist.
67. Section 5.1 (**Health Care Finder (HCF)**) adds remote overseas areas call centers and TGRO call centers. Adds "in overseas remote areas care authorizations are not required for TOP Prime enrollees.

SUMMARY OF CHANGES (Continued)

CHAPTER 12 (Continued)

68. Section 7.1 (**Regional Director Requirements**) adds TOP Regional Directors may contract directly for support services or include their requirements in the regional MCS contract. Adds Regional Directors are responsible for encouraging overseas beneficiaries when traveling to CONUS to utilize CONUS MTFs and current CONUS TRICARE network providers whenever possible. Adds TGRO oversight and administration responsibilities. Adds responsibilities for monthly reporting and performance monitoring of the TOP Service Center, overseas toll-free lines, including TGRO. Adds Enclosure 1 - Sample of Overseas Regional Director TOP Preferred Provider Network Agreement.
69. Section 8.1 (**Authorization Requirements**) removes: "The Regional Director or designee shall preauthorize all outpatient psychotherapy beyond the eighth (8th) visit in a fiscal year when required." Revises paragraph to "TOP enrolled ADFMs are not required to obtain authorization for stateside non-emergent/non-urgent care except for stateside non-emergent/urgent inpatient mental health care. Revises paragraph to "Stateside non-emergent inpatient mental health pre-authorizations/authorizations will be performed by the MCSC responsible for processing overseas claims stateside mental health review contractor for TOP standard and TOP enrolled ADFM. Adds paragraph "Overseas claims for drugs or diagnostic/ancillary services are exempt from the TOP authorization requirements." Revises paragraph to "TRICARE Global Remote Overseas (TGRO) contractor claims do not require authorization by the overseas MCSC responsible for processing overseas claims.
70. Section 10.1 (**Payment Policy**) adds Puerto Rico claims shall be reimbursed following stateside reimbursement guidelines. Clarifies the provisions for payment of skilled nursing facility (SNF) claims. Adds TGRO claims submitted for ADFMs not enrolled in TOP Prime shall be paid following TOP standard cost-sharing provisions.
71. Section 10.2 (**Point of Service (POS) Option Prime**) adds TOP Point of Service does not apply to TRICARE Global Remote Overseas (TGRO) Contractor claims.

SUMMARY OF CHANGES (Continued)

CHAPTER 12 (Continued)

72. Section 11.1 (**Managed Care Support Contractor Responsibilities For Claims Processing**) adds the provisions for retail pharmacy claims for Puerto Rico, Guam, the U.S. Virgin Islands and American Samoa. Adds paragraph I.D. "The TRICARE Prime Remote for Active Duty Family Members (TPRADFM) stateside program (see the TRICARE Operations Manual, Chapter 17, Section 6) does not apply to ADFM enrollees in areas outside the 50 United States. Adds paragraph I.E. "Reserve demonstration projects may also be applicable to overseas areas and the U.S. Territories, as outlined in the specific guidance for these programs." Clarifies TOP processing standards. Changes the time frame in paragraph II.2 for submission of TED data and required documents from once every seven days to daily. Adds overseas claims are excluded from interest payment requirements. Incorporates the requirements for processing Navy and Marine Corps deployed and/or deployed on liberty claims in remote overseas areas. Adds NOTE: "The overseas MCSC claims processor shall work with the TGRO contractor to develop a process for the clarification of Navy/Marine Corps ADSM claims identified in (b) & (c) above upon submission to the MCSC claims processor." Changes not-at-risk to non-financially underwritten and at-risk to financially underwritten. Incorporates the requirements/interface processes between the TRICARE Overseas Claims Processing Contractor and the TRICARE Global Remote Overseas (TGRO) Contractor for processing Overseas Active Duty Member and Active Duty Family Member healthcare claims in remote overseas areas. Clarifies TOP Jurisdiction provisions and Host Nation Provider Requirements. Adds TRICARE Enterprise Wide Referral and Authorization System (EWRAS) provisions. Clarifies claim development. Clarifies provisions for drugs and durable medical equipment. Clarifies provisions for EOB Summary Vouchers. Adds "Pay all beneficiary-submitted healthcare claims for TRICARE covered services for care received at an overseas embassy health clinic." Clarifies the tables of inpatient and outpatient claims remote and non-remote for mental health care, retail pharmacy, PFPWD, TGRO and stateside care. Clarifies refund and recoupment provisions. Clarifies reporting and audit requirements. Adds limitation of using only the last four digits of SSN in reports.

SUMMARY OF CHANGES (Continued)

CHAPTER 12 (Continued)

73. Section 12.1 (**Point of Contact (POC) Program**) revises section III POC Responsibilities by adding paragraph A - Assist all Uniformed Services, TRICARE beneficiaries, and active duty members, regardless of Service affiliation, and host nation providers with completion of and filing TOP and TDP claims with the appropriate claims processor. Adds paragraph B - See also the TOP and TDP Point of Contact Program booklet at Figure 12-12.2-11 for additional POC duties and responsibilities. This booklet should be used as a guide by TMA designated POCs in the performance of their POC duties. Revises NOTE to: Foreign drafts are good for 190 days and may be cashed at any time. U.S. dollar checks are good for a limited period of time and upon request may be reissued by the overseas MCSC upon expiration of the check before the check can be cashed. The expired check must be included with the request for reissuance of the check in order for the contractor to reissue an expired check. Adds "Pay all beneficiary-submitted healthcare claims for TRICARE covered services for care received at an overseas embassy clinic to the beneficiary. The contractor shall not make payments directly to the embassy health clinic.
74. Section 12.2 (**Figures**) revises Figures 12-12.2-3 to last 4 digits of SSN. Figure 12-12.2-4 is changed to List of Overseas Remote, Non-Remote & MTF Countries by Region. Figure 12-12.2-5 is changed to List of Overseas Remote Areas by Region. Figure 12-12.2-6 is changed to MTF Countries. Figure 12-12.2-7 is revised to last 4 digits of SSN. SSN is removed from Figure 12-12.2-10. Figure 12-12.2-11 TOP and TDP Point of Contact Program Booklet revises the date to January 2003 and updates/revises the Booklet. Figure 12-12.2-12 is changed to TRICARE Global Remote Overseas (TGRO) Contractor Provider Certification Letter. Figure 12-12.2-13 is changed to TRICARE Global Remote Overseas (TGRO) Contractor TRICARE Provider Application. Figure 12-12.2-14 TRICARE Overseas Remote DMIS-ID by Region and Figure 12-12.2-15 TRICARE Global Remote Overseas (TGRO) Contractor Claim Form are added.