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TRICARE
MANAGEMENT ACTIVITY

MB&RS

CHANGE 60
6010.54-M
JULY 17, 2007

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: REVISED PAPER CLAIMS FORMS

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): Changes to the TSM, TPM, TOM, & TRM in
accordance with the MCSC contracts (paragraph C-7.21.3) and the TDEFIC contract
(paragraph C-3.1). TRICARE requires that contractors and their claims processors
accept and process the nationally recognized paper claims forms and their
successors.

EFFECTIVE AND IMPLEMENTATION DATE: August 31, 2007.

This change is made in conjunction with Aug 2002 TOM, Change No. 52, Aug 2002
TRM, Change No. 63, and Aug 2002 TSM, Change No. 47.

Reta Michak
Chief, Office of Medical Benefits
and Reimbursement Systems

ATTACHMENT(S): 34 PAGE(S)
DISTRIBUTION: 6010.54-M

WHEN PRESCRIBED ACTION HAS BEEN TAKEN, FILE THIS TRANSMITTAL WITH BASIC DOCUMENT

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CHAPTER 1
SECTION 6.1

NONAVAILABILITY STATEMENT (DD FORM 1251) FOR INPATIENT CARE

ISSUE DATE: February 16, 1983

AUTHORITY: [32 CFR 199.4\(a\)\(9\)](#) and [32 CFR 199.7\(a\)\(7\)](#)

I. DEFINITION

A valid Nonavailability Statement (NAS) is an official Department of Defense document (DD Form 1251 ([Figure 1-6.1-1](#))) issued by the commander (or a designee) of a Uniformed Services Medical Treatment Facility (MTF) which certifies that a specific medical service was not available to a non-enrolled beneficiary at, or through, the MTF at the time the beneficiary sought the service.

II. POLICY

A. Effective for admissions on or after December 28, 2003, the NAS requirement is eliminated except for mental health admissions. A claim shall not be paid for nonemergency inpatient mental health care rendered to a non-enrolled beneficiary who resided at the time the care was rendered within a U.S. Postal Service Zip Code area listed as a part of an MTF catchment area in the zip code directory, unless the NAS authorization resides on the Enterprise Wide Referral and Authorization System (EWRAS) or the claim is accompanied by a valid NAS or, in the case of an electronic media claim (EMC) or [CMS 1450 UB-40](#) claim, there is an endorsement on the claim that the NAS is on file with the provider. See [paragraph III. EXCEPTIONS](#), below. For overseas NAS procedures, authorization and referral requirements, including requirements for EWRAS, see [Chapter 12, Section 2.1](#) and [12.1](#).

B. NAS for Maternity Care. For any maternity episode wherein the first prenatal visit occurs on or after December 28, 2003, no NAS is required. For a maternity episode wherein the first prenatal visit occurs between October 5, 1999 through December 27, 2003, for a beneficiary who lives in an MTF catchment area zip code and who is not enrolled in TRICARE Prime, an NAS shall be required for TRICARE/CHAMPUS cost-share of nonemergency health care services related to outpatient prenatal, outpatient or inpatient delivery, and outpatient postpartum care subsequent to the visit which confirms the pregnancy. Maternity services provided in a birthing center or at home shall also require an NAS for those maternity episodes wherein the first prenatal visit occurs between October 5, 1999 through December 27, 2003. An NAS shall not be required for a beneficiary who has other health insurance for primary coverage. The maternity NAS shall be subject to the same requirements as provided in [paragraph II.A](#).

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C. **NAS for Newborns.** No NAS will be required for newborns with admission or birth date of December 28, 2003, or after. For newborns with date of birth or admission prior to December 28, 2003, see paragraph II.G.4.

D. An NAS is not an authorization for TRICARE benefits. An NAS in no way authorizes the listed service or services as a TRICARE benefit.

E. Requirements for NAS. The policy in effect at the time the care is rendered apply in determining the applicable requirements for the NAS. The authority for issuing an NAS is limited to an MTF commander (or the commander's designee). The DoD Instruction 6015.23, "Delivery of Healthcare at Military Treatment Facilities: Foreign Service Care: Third-Party Collection; Beneficiary Counseling and Assistance Coordinators (BCACs)" (Figure 1-6.1-2) applies to NAS for inpatient mental health care.

F. **Waiver to NAS Elimination Requirement.** With the exception of maternity care, the ASD(HA) may require NASs for other than mental health services when:

1. Significant costs would be avoided by performing specific procedures at the affected MTFs, or
2. Specific procedures must be provided at the affected MTFs to ensure proficiency levels of the practitioners, or
3. The lack of NAS data would significantly interfere with TRICARE contract administration.

In exercising the above authority, the ASD(HA) must give 60-day notice to the Armed Services Committees of the House and the Senate and publish a notice in the Federal Register. The MTF, the TRICARE Region, and the contractors must publicize any NAS requirements to the affected beneficiaries.

G. NAS Validity.

1. An NAS is valid for a medically necessary hospital admission which occurs within 30 calendar days of issuance. The NAS shall remain valid from the date of admission until 15 days after discharge for any follow-on treatment which is directly related to the admission.

2. An NAS is valid for the adjudication of TRICARE claims for all related care otherwise authorized which is received from a civilian source while the beneficiary resided within the MTF catchment area which issued the NAS.

3. For maternity episodes wherein the first prenatal visit occurs between October 5, 1999 to December 27, 2003, or before March 26, 1998, for the purposes of NAS validity, the date of admission is the date when the patient entered into the prenatal care program with a civilian provider. For these episodes, the maternity NAS should be issued no earlier than 30 days before the first prenatal visit. The maternity NAS shall remain valid until 42 days following termination of the pregnancy.

OUTPATIENT OBSERVATION STAYS

ISSUE DATE: July 8, 1998

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

I. CPT¹ PROCEDURE CODES

99217, 99218 - 99220, 99234 - 99236

II. HCPCS CODES

Upon implementation of the Outpatient Prospective Payment System (OPPS): G0378, G0379

III. DESCRIPTION

Outpatient observation stays are those services furnished by a hospital on a hospital's premises, including the use of a bed and periodic monitoring by a hospital's nursing or other staff, which are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital as an inpatient. Such services are provided when ordered by a physician or another individual authorized by State licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient tests.

IV. POLICY

A. A person is considered a hospital inpatient if formally admitted as an inpatient with the expectation that he or she will remain at least overnight. When a hospital places a patient under observation, but has not formally admitted him or her as an inpatient, the patient initially is treated as an outpatient to determine the need for further treatment or for inpatient admission.

B. For observation stays prior to **implementation of OPSS**, the following provisions apply:

1. Cost-sharing of observation services, subsequent to ambulatory surgery reimbursement under the prospective ambulatory group payment, is covered if determined that placement on observation is medically necessary.

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CHAPTER 2, SECTION 3.3

OUTPATIENT OBSERVATION STAYS

2. Cost-sharing of outpatient observation services is covered following care provided in an emergency setting.
3. Cost-sharing at the observation level or outpatient level should be considered for inpatient denials when the services rendered are medically necessary, but provided at an inappropriate level of care.
4. Cost-sharing of outpatient mental health observation is covered.
5. Outpatient observation stays generally should not exceed 23 hours.
6. Up to 48 hours of outpatient observation services may be authorized by the Contractor when medical necessity has been clearly demonstrated.
7. Time spent in a recovery room following surgery should not be included in the 23 hour limit.
8. The time of admission to an observation bed is counted as the first hour of observation and is rounded to the nearest hour. The number of hours of observation should be indicated in the units field on the CMS 1450 UB-04 claim form. If the patient has more than 23 hours of observation show all hours of services provided in the units field.
9. Outpatient observation services are billed using the revenue code 0762 with the description listed as Observation Services. This code includes room and board services.

C. For observation stays on or after the implementation of OPSS, the following provisions apply:

1. Outpatient observation stays are separately payable when certain conditions are met for patients having diagnosis of chest pain, asthma, congestive heart failure or maternity (refer to the TRICARE Reimbursement Manual (TRM), Chapter 13, Section 2, paragraph III.H. for those specific conditions that must be met in order to receive separate payment under the hospital Outpatient Prospective Payment System (OPSS)). The above conditions will only apply to observation stays reimbursed under the OPSS.

2. All other observation stays will be packaged under the primary procedure for payment. Hospitals are to report these observation charges under revenue code 0762 - "Observation Room", and HCPCS code G0378. The above packaging requirement is specific for observation stays reimbursed under the OPSS.

3. Outpatient observation stays generally should not exceed 24 hours.

D. For OPSS exempt hospitals, up to 48 hours of outpatient observation services may be authorized by the contractor when medical necessity has been clearly demonstrated. If an observation stay is for more than 48 hours, the claim shall be processed as inpatient.

E. A separate authorization for outpatient observation is not required.

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CHAPTER 2, SECTION 6.1

EMERGENCY DEPARTMENT (ED) SERVICES

G. Admissions resulting from a psychiatric emergency should be reported to the TRICARE contractor within 24 hours of admission or the next business day after admission but must be reported within 72 hours of the admission. In the case of an emergency admission, authorization resulting from approval of a request made within 72 hours of the admission, the effective date of the authorization shall be the date of the admission. If it is determined that the case was not an emergency admission (but the admission can be authorized as medically or psychologically necessary), the effective date of the authorization shall be the date of the receipt of the request or the date of admission, whichever occurs first (Refer to the TRICARE Operations Manual).

H. Cost-sharing of emergency inpatient hospital services for non-enrolled MHS eligible beneficiaries will terminate 24 hours after written notice to the beneficiary that the nearest Uniformed Services Medical Treatment Facility (USMTF) capable of providing the required level-of-care has accepted the beneficiary for continued care. Neither the MCS contractor nor the MTF Commander may require a transfer until such time as the transfer is deemed medically safe.

I. Cost-sharing for TRICARE Prime beneficiaries shall follow the point-of-service cost-sharing provision 24-hours following receipt of written notice, by the contractor or MTF Commander, to the beneficiary (or responsible party) that transfer to a network facility is required to obtain maximum reimbursement. Neither the MCS contractor nor the MTF Commander may require a transfer until such time as the transfer is deemed medically safe.

J. ED services as defined in "POLICY" above are cost-shared as follows:

1. Outpatient care when the beneficiary is discharged home, regardless of any subsequent hospital admission related to the reason for the ED visit.

2. As inpatient care when:

a. An immediate inpatient admission for acute care follows the outpatient ED services.

(1) "Immediate" includes the time lapse associated with the beneficiary's direct transfer to an acute care facility more capable of providing the required level-of-care. ED care includes otherwise payable services of both the transferring and receiving facilities.

(2) This will be done even when the ED care is billed separately, as is required for all hospital services provided on an outpatient basis when the related inpatient stay is subject to the TRICARE DRG-based payment system. In determining if the ED care was immediately followed by an inpatient admission, the TRICARE contractor is required only to examine the claim for ED care for evidence of a subsequent admission and to examine its in-house claims records (history).

b. An ED patient dies while awaiting formal hospital admission for continued medically necessary acute care.

NOTE: See [paragraph VI](#) for Prime, Extra, and Standard-specific cost-sharing provisions for non-emergency care sought in an ED.

VI. LIMITATIONS

A. TRICARE PRIME Beneficiaries.

1. Prime enrollees must obtain all non-emergency primary health care from the Primary Care Manager (PCM) or from another provider to which the enrollee is referred by the PCM or the contractor. Therefore, if a TRICARE PRIME beneficiary seeks treatment in an ED and there was not a referral by his/her Primary Care Manager, and it is clearly a case of routine illness where the beneficiary's medical condition never was, or never appeared to be, a condition as defined in POLICY above, then payment shall be in accordance with the Point-of-Service option.

2. Claims shall not be denied or paid at the point-of-service option because a condition, which appeared to be a serious medical condition when presenting to the ED, turns out to be non-emergency in nature based on the final diagnosis (i.e., claims shall not be denied in situations where the beneficiary presents to the ED with a condition that would cause a prudent layperson to believe an emergency exists, but the final diagnosis is determined to be a non-emergency condition.) A common example of this situation is when a beneficiary seeks treatment in the ED for chest pain, but the final diagnosis is indigestion.

B. Non-Enrolled TRICARE Beneficiaries (Standard And Extra).

1. While TRICARE Extra/Standard beneficiaries have the freedom to choose a provider of care, all TRICARE benefits must be "medically necessary" and "appropriate medical care". (See the BACKGROUND section of this policy). If an Extra/Standard beneficiary seeks treatment in an ED and it was clearly a case of routine illness where the beneficiary's medical condition never was, or never appeared to be, a condition as defined in POLICY above, then the facility charge shall be denied (i.e., the ED fee billed on the CMS 1450 UB-04) and the professional services shall be allowed. Other professional ancillary services, including professional components of laboratory and radiology services, if appropriate can be also covered on an allowable charge basis. If an Extra or Standard beneficiary is referred to the ED by the contractor, (e.g., for after hours care), the care is to be allowed.

2. Claims shall not be denied because a condition, which appeared to be a serious medical condition upon presenting to the ED, turns out to be non-emergency in nature based on the final diagnosis. (i.e., claims shall not be denied in situations where the beneficiary presents to the ED with a condition that would cause a prudent layperson to believe an emergency exists, but the final diagnosis is determined to be a non-emergency condition.) A common example of this situation is when a beneficiary seeks treatment in the ED for chest pain, but the final diagnosis is indigestion.

VII. EXCLUSIONS

A. In the absence of other qualifying conditions, pain associated with pregnancy or incipient birth after the 34th week of gestation when associated with a pregnancy, are not emergency conditions for adjudication purposes.

authority is responsible for reviewing the claims to determine whether the beneficiary's condition meets the clinical criteria for the heart-lung or lung transplantation benefit. Charges for transplant and transplant-related services provided to TRICARE Prime enrollees who failed to obtain PCM referral and contractor authorization will be reimbursed only under Point of Service rules.

B. Benefits will only be allowed for transplants performed at a TRICARE or Medicare-certified heart, heart-lung or lung transplantation center. Benefits are also allowed for transplants performed at a pediatric facility that is TRICARE-certified as a heart, heart-lung, or lung transplantation center on the basis that the center belongs to a pediatric consortium program whose combined experience and survival data meet the TRICARE criteria for certification. The contractor is the certifying authority for transplant centers within its region. Refer to [Chapter 11, Section 7.1](#) for organ transplant center certification requirements.

C. Heart-lung, and lung transplantation will be paid under the DRG.

D. Claims for transportation of the donor organ and transplant team shall be adjudicated on the basis of billed charges, but not to exceed the transport service's published schedule of charges, and cost-shared on an inpatient basis. Scheduled or chartered transportation may be cost-shared.

E. Charges made by the donor hospital will be cost-shared on an inpatient basis and must be fully itemized and billed by the transplant center in the name of the TRICARE patient.

F. Acquisition and donor costs are not considered to be components of the services covered under the DRG. These costs must be billed separately on a standard **CMS 1450 UB-04** claim form in the name of the TRICARE patient.

G. When a properly preauthorized transplant candidate is discharged less than 24-hours after admission because of extenuating circumstances, such as the available organ is found not suitable or other circumstances which prohibit the transplant from being timely performed, all otherwise authorized services associated with the admission shall be cost-shared on an inpatient basis, since the expectation at admission was that the patient would remain more than 24 hours.

H. Heart-lung and lung transplants performed on an emergency basis in an unauthorized heart-lung or lung transplant facility may be cost shared only when the following conditions have been met:

1. The unauthorized center must consult with the nearest TRICARE or Medicare-certified heart-lung or lung transplantation center regarding the transplantation case; and

2. It must be determined and documented by the transplant team physician(s) at the certified heart-lung or lung transplantation center that transfer of the patient (to the certified heart-lung or lung transplantation center) is not medically reasonable, even though transplantation is feasible and appropriate.

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CHAPTER 4, SECTION 24.1

HEART-LUNG AND LUNG TRANSPLANTATION

V. EXCLUSIONS

A. Expenses waived by the transplant center, (e.g., beneficiary/sponsor not financially liable).

B. Services and supplies not provided in accordance with applicable program criteria (i.e., part of a grant or research program; unproven procedure).

C. Administration of an unproven immunosuppressant drug that is not FDA approved or has not received approval as an appropriate "off label" drug indication.

D. Pre- or post-transplant nonmedical expenses, (e.g., out-of-hospital living expenses, to include hotel, meal, privately owned vehicle for the beneficiary or family members).

E. Transportation of an organ donor.

VI. EFFECTIVE DATES

A. February 28, 1991, for heart-lung and lung transplantation.

B. May 1, 1996, for epoprostenol.

C. June 1, 1997, for living donor lobar lung transplantation.

- END -

13. The use of a donor heart, the long-term effectiveness of which might be compromised by such actions as the use of substantial vasopressors prior to its removal from the donor, its prolonged or compromised maintenance between the time of its removal from the donor and its implantation into the patient, or pre-existing disease.

14. Insulin-requiring diabetes mellitus (because the diabetes is often accompanied by occult vascular disease and because the diabetes and its complications are exacerbated by chronic corticosteroid therapy).

15. Asymptomatic severe peripheral or cerebrovascular disease (because of accelerated progression in some patients after cardiac transplantation and chronic corticosteroid treatment).

16. Peptic ulcer disease (because of the likelihood of early postoperative exacerbation); and

17. Current or recent history of diverticulitis (considered as a source of active infection which may be exacerbated with the initiation of immunosuppressant therapy).

D. Services and supplies related to heart transplantation are covered for:

1. Evaluation of a potential candidate's suitability for heart transplantation whether or not the patient is ultimately accepted as a candidate for transplantation.

2. Pre- and post-transplant inpatient hospital and outpatient services.

3. Pre- and post-operative services of the transplant team.

4. The donor acquisition team, including the costs of transportation to the location of the donor organ and transportation of the team and the donated organ to the location of the transplantation center.

5. The maintenance of the viability of the donor organ after all existing legal requirements for excision of the donor organ have been met.

6. Blood and blood products.

7. FDA approved immunosuppression drugs to include off-label uses when reliable evidence documents the off-label use is safe, effective, and provided in accordance with nationally accepted standards of practice in the medical community (proven).

8. Complications of the transplant procedure, including inpatient care, management of infection and rejection episodes.

9. Periodic evaluation and assessment of the successfully transplanted patient.

10. Cardiac rehabilitation.

11. DNA-HLA tissue typing in determining histocompatibility.

12. Donor costs.

13. Transportation of the patient by life support air ambulance and the services of a certified life support attendant.

E. Ventricular assist devices are covered if the device is FDA approved and used in accordance with FDA approved indications.

III. POLICY CONSIDERATIONS

A. For beneficiaries who reside in TRICARE regions but fail to obtain preauthorization for heart transplantation, benefits may be extended if the services or supplies otherwise would qualify for benefits but for the failure to obtain preauthorization. If preauthorization is not received, the appropriate preauthorizing authority is responsible for reviewing the claims to determine whether the beneficiary's condition meets the clinical criteria for the heart transplant. Charges for transplant and transplant-related services provided to TRICARE Prime enrollees who failed to obtain PCM referral and contractor authorization will be reimbursed only under Point of Service rules.

B. Benefits will only be allowed for transplants performed at a TRICARE or Medicare approved heart transplantation center. Benefits are also allowed for transplants performed at a pediatric facility that is TRICARE-certified as a heart transplantation center on the basis that the center belongs to a pediatric consortium program whose combined experience and survival data meet the TRICARE criteria for certification. The contractor in whose jurisdiction the center is located is the certifying authority for TRICARE authorization as a heart transplantation center. Refer to [Chapter 11, Section 7.1](#) for organ transplant center certification requirements.

C. Heart transplantation will be paid under the DRG.

D. Claims for transportation of the donor organ and transplant team shall be adjudicated on the basis of billed charges, but not to exceed the transport service's published schedule of charges, and cost-shared on an inpatient basis. Scheduled or chartered transportation may be cost-shared.

E. Charges made by the donor hospital will be cost-shared on an inpatient basis and must be fully itemized and billed by the transplant center in the name of the TRICARE patient.

F. Acquisition and donor costs are not considered to be components of the services covered under the DRG. These costs must be billed separately on a standard [CMS 1450 UB-04](#) claim form in the name of the TRICARE patient.

G. When a properly preauthorized transplant candidate is discharged less than 24-hours after admission because of extenuating circumstances, such as the available organ is found not suitable or other circumstances which prohibit the transplant from being timely performed, all otherwise authorized services associated with the admission shall be cost-shared on an inpatient basis, since the expectation at admission was that the patient would remain more than 24 hours.

to obtain PCM referral and contractor authorization will be reimbursed only under Point of Service rules.

B. Benefits will only be allowed for transplants performed at a center that is TRICARE or Medicare-certified for heart transplantation and Medicare-approved for renal transplantation. Benefits are also allowed for transplants performed at a pediatric facility that is TRICARE-certified as a heart transplantation center on the basis that the center belongs to a pediatric consortium program whose combined experience and survival data meet the TRICARE criteria for certification. The contractor is the certifying authority for transplant centers within its region. Refer to [Chapter 11, Section 7.1](#) for organ transplant center certification requirements.

C. Claims for institutional services and supplies related to the transplantation will be reimbursed based on billed charges until such time as a DRG is established. Effective August 1, 2003, CHKTs shall be paid under the assigned DRG based on the patient's diagnosis.

D. Claims for transportation of the donor organ and transplantation team shall be adjudicated on the basis of billed charges, but not to exceed the transport service's published schedule of charges, and cost-shared on an inpatient basis. Scheduled or chartered transportation may be cost-shared.

E. Charges made by the donor hospital will be cost-shared on an inpatient basis and must be fully itemized and billed by the transplantation center in the name of the TRICARE patient.

F. Acquisition and donor costs are not considered to be components of the services covered under the DRG and will be reimbursed based on billed charges. These costs must be billed separately on a standard [CMS 1450 UB-04](#) claim form in the name of the TRICARE patient.

G. When a properly preauthorized candidate is discharged less than 24 hours after admission because of extenuating circumstances, such as the available organ is found not suitable or other circumstances which prohibit the transplant from being timely performed, all otherwise authorized services associated with the admission shall be cost-shared on an inpatient basis, since the expectation at admission was that the patient would remain more than 24 hours.

H. Combined heart-kidney transplants performed on an emergency basis in an unauthorized renal and heart transplant facility may be cost-shared by TRICARE only when the following conditions have been met:

1. The unauthorized center must consult with the nearest center that is TRICARE or Medicare-certified for heart transplantation and Medicare-approved for renal transplantation regarding the transplantation case; and

2. It must be determined and documented by the transplant team physician(s) at the center that is TRICARE or Medicare certified for heart transplantation and Medicare-approved for renal transplantation that transfer of the patient (to a center that is TRICARE or Medicare-certified for heart transplantation and Medicare-approved for renal

transplantation) is not medically reasonable, even though transplantation is feasible and appropriate.

III. EXCLUSIONS

Combined heart-kidney transplantation is excluded:

A. When any of the following contraindications exist:

1. Severe pulmonary hypertension (pulmonary vascular resistance above 5 Wood units or pulmonary artery systolic pressure over 65 mm Hg) not reversible with intravenous agents.

2. Active infection.

3. HIV positivity.

4. Active alcohol or other substance abuse including current use of tobacco (verified abstinence for six months is mandatory).

5. Active malignant disease.

6. Hepatic dysfunction not explained by the underlying heart failure and not deemed reversible.

7. Symptomatic or asymptomatic cerebrovascular disease.

8. Systemic hypertension, either at transplantation or prior to development of end stage cardiac disease, that is not controlled, even with multi-drug therapy.

9. History of noncompliance or psychiatric illness of such magnitude as to jeopardize postoperative compliance.

10. Recent and unresolved pulmonary infarction or undiagnosed pulmonary nodules.

11. Any chronic systemic illness that will limit or preclude survival and rehabilitation after transplantation.

12. Current or recent history of diverticulitis or current peptic ulcer disease require evaluation by a gastroenterology specialist prior to determining candidacy.

B. For:

1. Expenses waived by the transplantation center (e.g., beneficiary/sponsor not financially liable).

2. Services and supplies not provided in accordance with applicable program criteria (i.e., part of a grant or research program; unproven procedure).

5. FDA approved immunosuppression drugs to include off-label uses when determined to be medically necessary for the treatment of the condition for which it is administered, according to accepted standards of medical practice.
6. Complications of the transplant procedure, including inpatient care, management of infection and rejection episodes.
7. Periodic evaluation and assessment of the successfully transplanted patient.
8. The donor acquisition team, including the costs of transportation to the location of the donor organ and transportation of the team and the donated organ to the location of the transplantation center.
9. The maintenance of the viability of the donor organ after all existing legal requirements for excision of the donor organ have been met.
10. Donor costs.
11. Hepatitis B and pneumococcal vaccines for patients undergoing transplantation.
12. DNA-HLA tissue typing in determining histocompatibility.
13. Transportation of the patient by air ambulance and the services of a certified life support attendant.

IV. POLICY CONSIDERATIONS

A. For beneficiaries who fail to obtain preauthorization for SI, SI/L, or multivisceral transplantation, TRICARE benefits may be extended if the services or supplies otherwise would qualify for benefits but for the failure to obtain preauthorization. If preauthorization is not received, the appropriate preauthorizing authority is responsible for reviewing the claims to determine whether the beneficiary's condition meets the clinical criteria for the SI, SI/L, or multivisceral transplantation benefit. Charges for transplant and transplant-related services provided to TRICARE Prime enrollees who failed to obtain PCM referral and contractor authorization will be reimbursed only under POS rules.

B. Benefits will only be allowed for transplants performed at a TRICARE-certified SI or Medicare-certified SI transplantation center. Benefits are also allowed for transplants performed at a pediatric facility that is TRICARE-certified as an SI transplantation center on the basis that the center belongs to a pediatric consortium program whose combined experience and survival data meet the TRICARE criteria for certification. The contractor is the certifying authority for transplant centers within its region. Refer to [Chapter 11, Section 7.1](#) for organ transplant center certification requirements.

C. Effective for admissions on or after October 1, 2001, SI, SI/L, and multivisceral transplantations shall be reimbursed under the assigned DRG based on the patient's diagnosis. Claims for admissions prior to October 1, 2001, shall be reimbursed based on billed charges.

TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 4, SECTION 24.4

SMALL INTESTINE, COMBINED SMALL INTESTINE-LIVER, AND MULTIVISCERAL TRANSPLANTATION

D. Claims for transportation of the donor organ and transplantation team shall be adjudicated on the basis of billed charges, but not to exceed the transport service's published schedule of charges, and cost-shared on an inpatient basis. Scheduled or chartered transportation may be cost-shared.

E. Charges made by the donor hospital will be cost-shared on an inpatient basis and must be fully itemized and billed by the transplantation center in the name of the TRICARE patient.

F. Acquisition and donor costs are not considered to be components of the services covered under the DRG and will be reimbursed based on billed charges. These costs must be billed separately on a standard CMS 1450 UB-04 claim form in the name of the TRICARE patient.

G. When a properly preauthorized transplantation candidate is discharged less than 24 hours after admission because of extenuating circumstances, such as the available organ is found not suitable or other circumstances which prohibit the transplantation from being timely performed, all otherwise authorized services associated with the admission shall be cost-shared on an inpatient basis, since the expectation at admission was that the patient would remain more than 24 hours.

H. SI, SI/L, or multivisceral transplants performed on an emergency basis in an unauthorized SI facility may be cost shared only when the following conditions have been met:

1. The unauthorized center must consult with the nearest TRICARE-certified or Medicare-certified SI transplantation center regarding the transplantation case; and
2. It must be determined and documented by the transplant team physician(s) at the certified SI transplantation center that transfer of the patient (to the certified SI transplantation center) is not medically reasonable, even though transplantation is feasible and appropriate.

V. EXCLUSIONS

A. SI, SI/L, or multivisceral transplantation is excluded when any of the following contraindications exist:

1. Ability to ingest oral nutrition.
2. Serious, uncontrolled psychiatric illness that would hinder compliance with any stage of the transplant process.
3. Significant cardiopulmonary insufficiency.
4. History or presence of aggressive and/or incurable malignancy.
5. Persistent abdominal or systemic infection.

TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 4, SECTION 24.4

SMALL INTESTINE, COMBINED SMALL INTESTINE-LIVER, AND MULTIVISCERAL TRANSPLANTATION

6. Severe autoimmune disease.
7. Severe immunodeficiency disease.
8. Active alcohol or chemical dependency that interferes with compliance to strict treatment regimen.
9. Inability or unwillingness of the patient or legal guardian to give signed consent and to comply with regular follow-up requirements.

B. Also excluded are:

1. Expenses waived by the transplantation center (e.g., beneficiary/sponsor not financially liable).
2. Services and supplies not provided in accordance with applicable program criteria (i.e., part of a grant or research program; unproven procedure).
3. Administration of an unproven immunosuppressant drug that is not FDA approved or has not received approval as an appropriate "off-label" drug indication.
4. Pre- or post-transplantation nonmedical expenses (e.g., out-of-hospital living expenses, to include hotel, meals, privately owned vehicle for the beneficiary or family members).
5. Transportation of an organ donor.

VI. EFFECTIVE DATES

- A. January 1, 1996, for small intestine alone transplants for patients under the age of 16 and combined small intestine-liver transplants for pediatric and adult patients.
- B. February 1, 1998, for multivisceral transplants.
- C. October 4, 2000, for small intestine alone transplants for patients age 16 and older.

- END -

determine whether the beneficiary's condition meets the clinical criteria for the transplantation. TRICARE Prime enrollees who failed to obtain preauthorization will be reimbursed only under Point of Service rules.

B. Benefits will only be allowed for transplantations performed at a TRICARE or Medicare-certified liver transplantation center. Benefits are also allowed for transplants performed at a pediatric facility that is TRICARE-certified as a liver transplantation center on the basis that the center belongs to a pediatric consortium program whose combined experience and survival data meet the TRICARE criteria for certification. The contractor in whose jurisdiction the center is located is the certifying authority for TRICARE authorization as a liver transplantation center. Refer to [Chapter 11, Section 7.1](#) for organ transplantation center certification requirements.

C. Liver transplantation will be paid under the DRG.

D. Claims for transportation of the donor organ and transplantation team shall be adjudicated on the basis of billed charges, but not to exceed the transport service's published schedule of charges, and cost-shared on an inpatient basis. Scheduled or chartered transportation may be cost-shared.

E. Charges made by the donor hospital will be cost-shared on an inpatient basis and must be fully itemized and billed by the transplantation center in the name of the TRICARE patient.

F. Acquisition and donor costs are not considered to be components of the services covered under the DRG. These costs must be billed separately on a standard [CMS 1450 UB-04](#) claim form in the name of the TRICARE patient.

G. When a properly preauthorized transplantation candidate is discharged less than 24 hours after admission because of extenuating circumstances, such as the available organ is found not suitable or other circumstances which prohibit the transplantation from being timely performed, all otherwise authorized services associated with the admission shall be cost-shared on an inpatient basis, since the expectation at admission was that the patient would remain more than 24 hours.

H. Liver or LDLT performed on an emergency basis in an unauthorized liver transplantation facility may be cost shared only when the following conditions have been met:

1. The unauthorized center must consult with the nearest TRICARE or Medicare-certified liver transplantation center regarding the transplantation case;
2. It must be determined and documented by the transplantation team physician(s) at the certified liver transplantation center that transfer of the patient (to the certified liver transplantation center) is not medically reasonable, even though transplantation is feasible and appropriate; and
3. All other TRICARE contractual requirements have been met.

IV. EXCLUSIONS

A. Liver transplantation and LDLT is excluded when any of the following contraindications exist:

1. Significant systemic or multisystemic disease (other than hepatorenal failure) which limits the possibility of full recovery and may compromise the function of the newly transplanted organs.

2. Active alcohol or other substance abuse.

a. Benefits may be allowed if:

(1) The patient has been abstinent (for at least six months prior to the transplantation is recommended); and

(2) There is no evidence of other major organ debility (e.g., cardiomyopathy); and

(3) There is evidence of ongoing participation in a social support group such as Alcoholics Anonymous; and

(4) There is evidence of a supportive family/social environment.

3. Malignancies metastasized to or extending beyond the margins of the liver.

B. The following are also excluded:

1. Expenses waived by the transplantation center (e.g., beneficiary/sponsor not financially liable).

2. Services and supplies not provided in accordance with applicable program criteria (i.e., part of a grant or research program; unproven procedure).

3. Administration of an unproven immunosuppressant drug that is not FDA approved or has not received approval as an appropriate "off-label" drug indication.

4. Pre- or post-transplantation nonmedical expenses (e.g., out-of-hospital living expenses, to include hotel, meals, privately owned vehicle for the beneficiary or family members).

5. Transportation of an organ donor.

C. Artificial assist devices that are not FDA approved and that are not used in compliance with FDA approved indications.

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CHAPTER 4, SECTION 24.6

COMBINED LIVER-KIDNEY TRANSPLANTATION

B. Benefits will only be allowed for transplants performed at a TRICARE or Medicare-certified liver transplantation center. Benefits are also allowed for transplants performed at a pediatric facility that is TRICARE-certified as a liver transplantation center on the basis that the center belongs to a pediatric consortium program whose combined experience and survival data meet the TRICARE criteria for certification. The contractor in whose jurisdiction the center is located is the certifying authority for TRICARE approval as a liver transplantation center. Refer to [Chapter 11, Section 7.1](#) for organ transplant center certification requirements.

C. Claims for services and supplies related to the transplant will be reimbursed based on billed charges. Effective August 1, 2003, CLKTs shall be paid under the assigned DRG based on the patient's diagnosis.

D. Claims for transportation of the donor organ and transplant team shall be adjudicated on the basis of billed charges, but not to exceed the transport service's published schedule of charges, and cost-shared on an inpatient basis. Scheduled or chartered transportation may be cost-shared.

E. Acquisition and donor costs are not considered to be components of the services covered under the DRG. These costs must be billed separately on a standard **CMS 1450 UB-04** claim form in the name of the TRICARE patient.

F. When a properly preauthorized candidate is discharged less than 24-hours after admission because of extenuating circumstance, such as the available organ is found not suitable or other circumstances which prohibit the transplant from being timely performed, all otherwise authorized services associated with the admission shall be cost-shared on an inpatient basis, since the expectation at admission was that the patient would remain more than 24 hours.

G. CLKTs performed on an emergency basis in an unauthorized liver transplant facility may be cost shared only when the following conditions have been met:

1. The unauthorized center must consult with the nearest TRICARE or Medicare-certified liver transplantation center regarding the transplantation case; and

2. It must be determined and documented by the transplant team physician(s) at the certified liver transplantation center that transfer of the patient (to the certified liver transplantation center) is not medically reasonable, even though transplantation is feasible and appropriate.

H. This policy does not apply to beneficiaries who become eligible for Medicare coverage due to isolated renal disease. This policy applies only to those individuals suffering from concomitant hepatic and renal failure. Coordination of benefits with Medicare is not required for CLKTs.

IV. EXCLUSIONS

A. Combined liver-kidney transplantation is excluded when the following contraindications exist:

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CHAPTER 4, SECTION 24.6

COMBINED LIVER-KIDNEY TRANSPLANTATION

1. Significant systemic or multisystemic disease (other than hepatorenal failure) which limits the possibility of full recovery and may compromise the function of the newly transplanted organs.

2. Active alcohol or other substance abuse.

a. Benefits may be allowed if:

(1) The patient has been abstinent (at least six months prior to transplantation is recommended); and

(2) There is no evidence of other major organ debility (e.g., cardiomyopathy).

(3) There is evidence of ongoing participation in a social support group such as Alcoholics Anonymous; and

(4) There is evidence of a supportive family/social environment.

3. Malignancies metastasized to or extending beyond the margins of the liver and/or kidney.

B. The following are also excluded:

1. Expenses waived by the transplant center, (i.e., beneficiary/ sponsor not financially liable.)

2. Services and supplies not provided in accordance with applicable program criteria, (i.e., part of a grant or research program, unproven procedure).

3. Administration of an unproven immunosuppressant drug that is not FDA approved or has not received approval as an appropriate "off-label" drug indication.

4. Pre- or post-transplant nonmedical expenses (i.e., out-of-hospital living expenses, to include, hotel, meals, privately owned vehicle for the beneficiary or family members).

5. Transportation of an organ donor.

V. EFFECTIVE DATES

A. November 12, 1992.

B. November 1, 1994, for hepatitis C.

C. December 1, 1996, for hepatitis B.

- END -

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CHAPTER 4, SECTION 24.7

SIMULTANEOUS PANCREAS-KIDNEY, PANCREAS-AFTER-KIDNEY, AND PANCREAS-TRANSPLANT-ALONE

4. The donor acquisition team, including the costs of transportation to the location of the donor organ and transportation of the team and the donated organ to the location of the transplantation center.
5. The maintenance of the viability of the donor organ after all existing legal requirements for excision of the donor organ have been met.
6. Donor costs.
7. Blood and blood products.
8. FDA approved immunosuppression drugs to include off-label uses when reliable evidence documents that the off-label use is safe, effective and in accordance with the national standards of practice in the medical community (proven). Mycophenolate Mofetil (Cellcept) and Tacrolimus (Prograf) for the prophylaxis of organ rejection in patients receiving SPK, PAK, and PTA are covered.
9. Complications of the transplantation procedure, including inpatient care, management of infection and rejection episodes.
10. Periodic evaluation and assessment of the successfully transplanted patient.
11. Hepatitis B and pneumococcal vaccines for patients undergoing transplantation.
12. DNA-HLA tissue typing in determining histocompatibility.
13. Transportation of the patient by air ambulance and the services of a certified life support attendant.

IV. POLICY CONSIDERATIONS

A. For beneficiaries who fail to obtain preauthorization for SPK, PAK, and PTA benefits may be extended if the services or supplies otherwise would qualify for benefits but for the failure to obtain preauthorization. If preauthorization is not received, the appropriate preauthorizing authority is responsible for reviewing the claims to determine whether the beneficiary's condition meets the clinical criteria for the SPK transplantation benefit. Charges for transplant and transplant-related services provided to TRICARE Prime enrollees who failed to obtain PCM referral and contractor authorization will be reimbursed only under Point of Service rules.

B. Benefits for SPK, PAK, or PTA transplantation will only be allowed for transplants performed at a Medicare-approved renal transplantation center.

C. Effective for admissions on or after October 1, 1999, SPK, PAK, and PTA transplantations shall be reimbursed under the assigned DRG. Claims for admissions prior to October 1, 1999, shall be reimbursed based on billed charges.

D. Claims for transportation of the donor organ and transplantation team shall be adjudicated on the basis of billed charges, but not to exceed the transport service's published

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SIMULTANEOUS PANCREAS-KIDNEY, PANCREAS-AFTER-KIDNEY, AND PANCREAS-TRANSPLANT-ALONE

schedule of charges, and cost-shared on an inpatient basis. Scheduled or chartered transportation may be cost-shared.

E. Charges made by the donor hospital will be cost-shared on an inpatient basis and must be fully itemized and billed by the transplantation center in the name of the TRICARE patient.

F. Acquisition and donor costs are not considered to be components of the services covered under the DRG and will be reimbursed based on billed charges. These costs must be billed separately on a standard CMS 1450 UB-04 claim form in the name of the TRICARE patient.

G. When a properly preauthorized candidate is discharged less than 24 hours after admission because of extenuating circumstances, such as the available organ is found not suitable or other circumstances which prohibit the transplant from being timely performed, all otherwise authorized services associated with the admission shall be cost-shared on an inpatient basis, since the expectation at admission was that the patient would remain more than 24 hours.

H. SPKs, PAKs, or PTAs performed on an emergency basis in an unauthorized renal transplant facility may be cost-shared only when the following conditions have been met:

1. The unauthorized center must consult with the nearest Medicare-certified renal transplant center regarding the transplantation case; and
2. It must be determined and documented by the transplant team physician(s) at the Medicare-approved renal transplantation center that transfer of the patient (to a Medicare-approved renal transplantation center) is not medically reasonable, even though transplantation is feasible and appropriate.

V. EXCLUSIONS

A. SPKs, PAKs, and PTAs are excluded when any of the following contraindications exist:

1. Significant systemic or multisystemic disease (other than pancreatic-renal dysfunction) which limits the possibility of full recovery and may compromise the function of the newly transplanted organs.
2. Active alcohol or other substance abuse.
3. Malignancies metastasized to or extending beyond the margins of the kidney and/or pancreas.
4. Significant coronary artery disease.

B. The following are also excluded:

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SIMULTANEOUS PANCREAS-KIDNEY, PANCREAS-AFTER-KIDNEY, AND PANCREAS-TRANSPLANT-ALONE

1. Expenses waived by the transplantation center (e.g., beneficiary/sponsor not financially liable).
2. Services and supplies not provided in accordance with applicable program criteria (i.e., part of a grant or research program; unproven procedure).
3. Administration of an unproven immunosuppressant drug that is not FDA approved or has not received TRICARE approval as an appropriate "off-label" drug indication.
4. Pre- or post-transplantation nonmedical expenses (e.g., out-of-hospital living expenses, to include hotel, meals, privately owned vehicle for the beneficiary or family members).
5. Transportation of an organ donor.
6. Autologous islet cell transplantation (CPT² procedure code 48160) for the treatment of chronic pancreatitis. Allogeneic islet cell transplantation for the treatment of diabetes mellitus.

VI. EFFECTIVE DATES

- A. October 1, 1995, for SPK transplants.
- B. January 1, 1996, for PAK and PTA transplants.

- END -

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KIDNEY TRANSPLANTATION

ISSUE DATE: February 27, 1996

AUTHORITY: [32 CFR 199.4\(e\)\(5\)](#)

I. CPT¹ PROCEDURE CODE RANGE

50300 - 50380

II. POLICY

A. Cadaver and living donor kidney transplantation is covered when the transplant is performed at a Medicare-certified kidney transplantation center (pediatric consortia are not applicable for kidney transplantation at this time), for beneficiaries who:

1. Are suffering from concomitant, irreversible renal failure; and
2. Have exhausted more conservative medical and surgical treatment; and
3. Have plans for long-term adherence to a disciplined medical regimen that are feasible and realistic.

B. Benefits may be allowed for services and supplies during the Medicare waiting period for those beneficiaries who qualify for Medicare coverage as a result of end stage renal disease.

C. Services and supplies related to kidney transplantation are covered for:

1. Evaluation of potential candidate's suitability for kidney transplantation, whether or not the patient is ultimately accepted as a candidate for transplantation.
2. Pre- and post-transplant inpatient hospital and outpatient services.
3. Pre- and post-operative services of the transplant team.
4. The donor acquisition team, including the costs of transportation to the location of the donor organ and transportation of the team and the donated organ to the location of the transplantation center.

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CHAPTER 4, SECTION 24.8

KIDNEY TRANSPLANTATION

5. The maintenance of the viability of the donor organ after all existing legal requirements for excision of the donor organ have been met.
6. Donor costs.
7. Blood and blood products.
8. FDA approved immunosuppression drugs to include off-label uses when reliable evidence documents that the off-label use is safe, effective and in accordance with nationally accepted standards of practice in the medical community (proven).
9. Complications of the transplant procedure, including inpatient care, management of infection and rejection episodes.
10. Periodic evaluation and assessment of the successfully transplanted patient.
11. Transportation of the patient by air ambulance and the services of a certified life support attendant.
12. DNA-HLA tissue typing determining histocompatibility.

III. POLICY CONSIDERATIONS

A. Kidney transplants are paid under the DRG.

B. For kidney transplants performed inside the Continental United States (CONUS), benefits will only be allowed for transplants performed at a Medicare approved kidney transplant center. Refer to [Chapter 11, Section 7.1](#) for organ transplant certification center requirements.

C. Acquisition and donor costs are not considered to be components of the services covered under the DRG. These costs must be billed separately on a standard **CMS 1450 UB-04** claim form in the name of the TRICARE patient.

D. The appropriate hospital standard kidney acquisition costs (live donor or cadaver) required for Medicare in every instance must be used as the acquisition cost for purposes of providing TRICARE benefits.

IV. EXCLUSIONS

Kidney transplantation is excluded as a benefit if any of the following contraindications exist:

A. Malignancies metastasized to or extending beyond the margins of the kidney.

G. Claims

1. Billing. HHAs will use itemized billing for EHHC services, including those items that will be cost-shared under the TRICARE Basic Program, that are identified on the beneficiary's plan of care

2. Primary Agency. When necessary, multiple HHAs may be involved in providing the services indicated in the beneficiary's plan of care. When such is the case, the MCSC will designate one such agency as the Primary Agency. In addition to being responsible for providing the services in the plan, the primary agency is also responsible for:

a. Negotiating the reimbursement rate with the MCSC having jurisdiction where the beneficiary lives;

b. Arranging for the services to be provided by other HHAs;

c. Insuring the qualifications of the other HHAs;

d. Insuring that services provided by other HHAs are in accordance with the plan of care; and

e. Reimbursing the other HHAs that provide services.

3. The MCSCs will deny claims from other than the primary agency for services and items provided as described herein.

4. The EHHC and respite care benefits will not use the "Requests for Anticipated Payment."

5. All claims for EHHC services or items will be submitted only after such services or items are provided.

6. EHHC and respite care services will be coded using the appropriate procedure codes shown in [paragraph I](#).

7. The EHHC and respite care benefits will operate on the platform of existing TRICARE claims processing systems.

8. Hours of services provided in accordance with the beneficiary's plan of care will become the unit of reimbursement and tracking in the claims processing systems. The EHHC and respite care benefits require that services be recorded in 1 hour increments.

9. HHAs providing EHHC services will submit claims using the CMS 1500 (08/05), either in paper form or electronic version.

a. Frequency of submitting claims is at the discretion of the MCSC, that is, the HHA may be required by the MCSC to submit claims weekly, monthly, or at such other intervals as the MCSC determines is appropriate.

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CHAPTER 9, SECTION 15.1

ECHO HOME HEALTH CARE (EHHC)

b. The monthly (or other billing period as specified by the MCSC) claim will indicate the total hours for each type of service, that is, skilled services, skilled therapy services, home health aide services, and medical social services, will be grouped according to the professional level of the individuals providing such services. The totals will be entered on separate lines of the CMS 1500 (08/05).

10. The following, although required to be included in the plan of care and when provided by the HHA, will be itemized billed separately from the allowed home health care services and will be cost-shared through the TRICARE Basic Program or the ECHO as appropriate. The amount reimbursed for these items do not accrue to the EHHC fiscal year benefit cap established under [paragraph VI.H](#).

- a. Rental or purchase of durable equipment and durable medical equipment;
- b. FDA approved injectable drugs for osteoporosis;
- c. Pneumococcal pneumonia, influenza virus and hepatitis B vaccines;
- d. Oral cancer drugs and antiemetics;
- e. Orthotics and prosthetics;
- f. Ambulance services operated by the HHA;
- g. Enteral and parenteral supplies and equipment; and
- h. Other drugs and biologicals administered by other than oral method.

H. Reimbursement. Reimbursement for the services described in this issuance will be made on the basis of allowable charges or negotiated rates between the MCSCs and the HHAs.

1. Benefit cap. Coverage for the EHHC benefit is capped on a fiscal year basis.

2. Basis of the cap. The purpose of the EHHC benefit is to assist eligible beneficiaries in remaining at their primary residence rather than being confined to institutional facilities, such as a SNF or other acute care facility. Therefore, TRICARE has determined that the appropriate EHHC benefit cap is equivalent to what TRICARE would reimburse if the beneficiary was in a SNF.

a. Annually, the MCSCs will calculate the EHHC cap for each beneficiary's area of primary residence as follows:

(1) Obtain the annual notice, published in the Federal Register, of the Centers for Medicare and Medicaid Services (CMS) Prospective Payment System and Consolidated Billing for SNFs--Update for the upcoming fiscal year. (From time to time the update notice may be known by another name but will contain the same information.)

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CHAPTER 11, SECTION 12.1

CORPORATE SERVICES PROVIDER CLASS

supplies which account for only 10 to 20 percent of the total program charges for autologous bone marrow transplants. The remaining 70 to 80 percent of the charges will be attributable to technical and/or facilities fees. The services will include but are not limited to: 1) laboratory charges; 2) pre-conditioning chemotherapy; 3) growth factor; 4) home health; 5) catheter placement; 6) blood products; and 7) recovery post discharge. Under the above alternative reimbursement provisions, contractors will be given the flexibility of negotiating with network providers (i.e., freestanding outpatient bone marrow transplant centers who agree to become network providers) for outpatient bone marrow transplants at rates below those performed in a hospital setting, which would include CMAC rates for professional fees plus the DRG amount.

c. The following minimal requirements should be adhered to in the establishment of alternative reimbursement methodologies for in-system/network corporate services providers in order to ensure quality of care and fiscal accountability:

(1) Alternative reimbursement methodologies may include and/or be a combination of fee schedules, discounts from usual and customary fees or CHAMPUS maximum allowable charge amounts (CMAC), flat fee arrangements (negotiated all inclusive rates), capitation arrangements, discounts off of DRGS, per diems; or such other method as is mutually agreed upon, provided such alternative payments do not exceed what would have otherwise been allowed under Standard TRICARE payment methodologies in another setting (e.g., comparable services rendered in a hospital inpatient or outpatient setting).

(2) Payments in full (e.g., negotiated flat fees, all-inclusive global fees, capitation arrangements, discounts off of DRGs and per diems) are prospective reimbursement systems which may include items related or incidental to the treatment of the patient but for which coverage is not normally extended under TRICARE. These incidental services are to be included in the negotiated prospective payment rate; i.e., they can neither be billed to the beneficiary or deducted from the negotiated global rate.

3. All billing for Corporate Services Providers should be submitted on a CMS 1500 (08/05). TRICARE Management Activity (TMA) will assign special processing codes (e.g., assigning a special processing code "P" for non-institutional per diem rates) to accommodate approved alternative reimbursement systems. The contractor should designate the coding that it wants to use as part of the alternative reimbursement request submitted to the Executive Director, TMA or designee for review and approval.

4. The contractor will determine the appropriate procedural category of a qualified organization and may change the category based upon the provider's TRICARE claim characteristics. The category determination is conclusive and may not be appealed.

5. The corporate entity will not be allowed additional facility charges that are not already incorporated into the professional services fee structure (i.e., facility charges that are not already included in the overhead and malpractice cost indices used in establishing locally-adjusted CMAC rates).

6. While the expanded provider category will allow coverage of professional services for corporate entities qualifying for provider authorization status under the provisions of this policy, it will at the same time restrict coverage of professional services for

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CHAPTER 11, SECTION 12.1

CORPORATE SERVICES PROVIDER CLASS

those corporate entities which cannot meet the criteria for corporate services provider status under TRICARE.

C. Conditions for Coverage/Authorization

1. Be a corporation or a foundation, but not a professional corporation or professional association;
2. Be institution-affiliated or freestanding;
3. Provide services and related supplies of a type rendered by TRICARE individual professional providers employed directly or contractually by a corporation, or diagnostic technical services and related supplies of a type which requires direct patient contact and a technologist who is licensed by the state in which the procedure is rendered or who is certified by a Qualified Accreditation Organization;
4. Provide the level of care that does not necessitate that the beneficiary be provided with on-site sleeping accommodations and food in conjunction with the delivery of the services except for sleep disorder diagnostic centers in which on-site sleeping accommodations are an integral part of the diagnostic evaluation process.
5. Render services for which direct or indirect payment is expected to be made by TRICARE only after obtaining written authorization (i.e., comply with applicable TRICARE authorization requirements before rendering designated services or items for which TRICARE cost-share/copayment may be expected);
6. Comply with all applicable organizational and individual licensing or certification requirements that are extent in the state, county, municipality, or other political jurisdiction in which the corporate entity provides services;
7. Maintain Medicare approval for payment when the contractor determines that a category, or type, of provider is substantially comparable to a provider or supplier for which Medicare has regulatory conditions of participation or conditions of coverage, or when Medicare approved status is not required, be accredited by a qualified accreditation organization, as defined in [Chapter 11, Section 12.2](#); and
8. Has entered into a negotiated provider contract with a network provider or a participation agreement with a non-network provider which at least complies with the minimum participation agreement requirements set forth in [Chapter 11, Section 12.3](#). The participation agreement will accompany the application form (Application for TRICARE-Provider Status: CORPORATE SERVICES PROVIDER) sent out as part of the initial authorization process for non-network providers as described below.

D. Application Process

1. The information collected on the "Application for TRICARE-Provider Status: CORPORATE SERVICES PROVIDERS" (i.e., the information collection form for which the provider is seeking TRICARE authorization status) will be used by the contractor in determining whether the provider meets the criteria for authorization as a corporate services

ENCLOSURE 2

APPENDIX B

SAMPLE

CLAIMS SUBMISSION REQUIREMENTS

To facilitate the processing of Partnership Claims, the following guidelines must be followed.

1. Each claim must be identified by a large, bold "Partnership" stamp that does not obscure the claim information. If claims are not identified in this manner, they will be processed as TRICARE claims since it is impossible for the TMA claims processor to otherwise distinguish them.
2. All Partnership claims are to be submitted on either a CMS 1500 (08/05) or DD 2642 claims form. No beneficiary-submitted claims will be processed.
3. The claim form must clearly indicate that it is from a participating provider by checking the "Yes" block next to "participating" on the appropriate TRICARE-approved claim form.
4. Only TRICARE-approved procedure codes are to be used to bill for all services provided.
5. Only procedures/services that are within the scope of the approved Agreement are to be billed.
6. The procedures/services billed to TRICARE are only those provided to TRICARE-eligible beneficiaries.
7. All partnership procedures/services are to be performed within the Military Treatment Facility (MTF), and the appropriate block on the TRICARE claim form must indicate that the procedures/services were provided in the MTF.
8. If a beneficiary has other health insurance (OHI), the claims for Partnership procedures/services must first be filed with the other coverage before being submitted to TRICARE. Documentation of the action taken by the OHI plan must accompany the partnership claim submitted to TRICARE.
9. The beneficiary must not be billed for any deductibles or cost-shares.
10. Only the fees specified in the Partnership Agreement are to be billed to TRICARE.

ENCLOSURE 2

APPENDIX C

SAMPLE

NEGOTIATED RATES

**LETTER OF AGREEMENT
BETWEEN
(MTF Name)
AND
(Health Care Provider Name)**

SUBJECT: List of Providers, Locations, Specialties and Costs

1. The Health Care Provider agrees to provide pediatric, primary care, and family practice physician services for \$XX.XX per visit, and Physician Assistant Services at \$XX.XX per visit.
 - a. XXXXX Clinic: Family Practice and Pediatrics.
 - b. XXXXX Clinic: Pediatrics and Family Practice.
 - c. XXXXX MTF: Primary Care Services and Physician Assistant Services.
 - d. XXXXXX Clinic: Family Practice Service, to include obstetric care up to the 36th week of gestation, and Physician Assistant Services.
 - e. XXXXXX Clinic: Primary Care and Pediatrics.
 - f. Psychology Services at XXXXXX, XXXXXXXX and XXXXXX Clinics as listed below:

<u>CPT CODE</u> ¹	<u>PROCEDURE</u>	<u>RATE:</u>
90801	Diagnostic Interview (90 min)	\$XXX.XX
90804	Psychotherapy (30 min)	\$ XX.XX
90806	Psychotherapy (50 min)	\$ XX.XX
90808	Psychotherapy (80 min)	\$XXX.XX
90846	Family Therapy (w/o patient)	\$ XX.XX
90847	Family Therapy (with patient)	\$ XX.XX
90853	Group Therapy	\$ XX.XX
96100	Psychological Testing	\$ XX.XX
96115	Neurobehavioral Exam	\$ XX.XX
90901	Biofeedback Training	\$ XX.XX
90887	Exam Interpretation	\$ XX.XX

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ENCLOSURE 3

APPENDIX A

SAMPLE

**HEALTH CARE PROVIDER/ASSOCIATED SUPPORT PERSONNEL STAFFING
LETTER OF AGREEMENT
BETWEEN
(MTF Name)
AND
(Health Care Provider/Contractor)**

SUBJECT: Items Negotiated between the Two Parties

1. The **(MTF Name)** or Health Care Provider will endeavor to provide adequate nursing assistants, receptionists, and billing support for care provided under this Agreement. Nursing support personnel will attend a one day Newcomer's Orientation class, a three-day Nursing Orientation class, and all other training which the MTF normally requires of its own nursing support personnel. Such training may consist of courses on direct patient care, safety, and systems & security, but will not include military-related courses. Additionally, new receptionists/nursing assistants will contact the MTF or clinic Health Benefits Advisor for a briefing on TRICARE requirements and TRICARE eligibility. The MTF will be responsible for providing appointment and ancillary support services.
2. The Health Care Provider agrees to receive all TRICARE eligible patients. Patients who are determined to be TRICARE ineligible will be referred back to the MTF for reappointment.
3. The **(MTF Name)** or Health Care Provider recognizes that continuity of patient care is of the utmost importance to the MTF, and will endeavor to furnish support staff who are available for the duration of the Agreement.

MTF COMMANDER _____

Commander

Provider

Date: _____

Date: _____

ENCLOSURE 3

APPENDIX B

SAMPLE

CLAIMS SUBMISSION REQUIREMENTS

To facilitate the processing of Partnership Claims, the following guidelines must be followed.

1. Each claim must be identified by a large, bold "Partnership" stamp that does not obscure the claim information. If claims are not identified in this manner, they will be processed as TRICARE claims since it is impossible for the TMA claims processor to otherwise distinguish them.
2. All Partnership claims are to be submitted on either a CMS 1500 (08/05) or DD 2642 claims form. No beneficiary-submitted claims will be processed.
3. The claim form must clearly indicate that it is from a participating provider by checking the "Yes" block next to "participating" on the appropriate TRICARE-approved claim form.
4. Only TRICARE-approved procedure codes are to be used to bill for all services provided.
5. Only procedures/services that are within the scope of the approved Agreement are to be billed.
6. The procedures/services billed to TRICARE are only those provided to TRICARE-eligible beneficiaries.
7. All partnership procedures/services are to be performed within the Military Treatment Facility (MTF), and the appropriate block on the TRICARE claim form must indicate that the procedures/services were provided in the MTF.
8. If a beneficiary has other health insurance (OHI), the claims for Partnership procedures/services must first be filed with the other coverage before being submitted to TRICARE. Documentation of the action taken by the OHI plan must accompany the partnership claim submitted to TRICARE.
9. The beneficiary must not be billed for any deductibles or cost-shares.
10. Only the fees specified in the Partnership Agreement are to be billed to TRICARE.

TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 12, SECTION 11.1

MANAGED CARE SUPPORT CONTRACTOR (MCSC) RESPONSIBILITIES FOR CLAIMS PROCESSING

3. The overseas **claims processing contractor** shall pay all non-emergency and emergency civilian/medical surgical and dental claims for TRICARE Europe and **TLAC ADSM** health care even when not a TRICARE **covered** benefit when the claim is:

a. Submitted by the MTF or other military command personnel, or by a designated POC; and

b. Accompanied by a completed and signed TRICARE claim form; and

c. Accompanied by either a Standard Form 1034, a Standard Form 1035 continuation sheet, a NAVMED 6320/10 (these forms shall be considered an authorization for payment); or an **authorization letter from the TGRO contractor/TPRC (these forms shall be considered an authorization for payment)**; and

NOTE: The SF 1034, SF 1035 continuation sheet or **NAVMED** 6320/10 must be signed by the submitting military command. If a patient signature is not present on the claim form, the military command must submit a letter of explanation with the unsigned claim form prior to payment.

d. DEERS verification indicates the TRICARE Europe and **TLAC ADSM** was on active duty at the time the services were rendered.

4. Upon payment for a TOP enrolled **ADSM** overseas claim, a copy of the EOB and, when applicable, the SF 1034 or SF 1035 or NAVMED 6320/10, shall also be **manually** submitted to the MTF, or MTF command personnel, or a designated POC.

5. Emergency submitted non-remote TRICARE Europe and **TLAC ADSM** claims for health care received overseas/**CONUS** not meeting **Chapter 2, Section 6.1** policy on emergency department services shall be denied explaining the reason of denial and advising resubmission with proper forms by the appropriate MTF, etc.

6. The overseas **claims processing contractor** shall deny non-remote TRICARE Europe and **TLAC ADSM** claims for health care received overseas when any one of the administrative items outlined above in **paragraph VI.3.a. - d.** are missing. Upon denial, the overseas **claims processing contractor** shall instruct the non-remote TRICARE Europe and **TLAC ADSM**/host nation provider to contact the local MTF or other military command personnel, for assistance in proper claim submission and in obtaining missing documentation. Copies of EOBs and claims denied as DEERS ineligible or not submitted by an MTF shall be electronically forwarded to the appropriate overseas **TAO** Director for further action.

7. The overseas **claims processing contractor** shall follow the additional specific processing procedures outlined in this chapter when processing claims for TRICARE Europe **ADSMs** stationed in Germany.

8. The overseas **claims processing contractor** shall pay all TOP non-assigned **ADSM CONUS** claims as outlined in **Chapter 12, Section 10.1.**

9. The TGRO contractors/TPRCs shall submit all remote area claims electronically to the overseas claims processing contractor. The TGRO contractor/TPRC is required to submit all claims in U.S. dollars.

10. The overseas claims processing contractor is required to receive TGRO contractor and TPRC electronic claims submitted in an X12 HIPAA-compliant format. The overseas claims processing contractor is responsible for entering into a trading partner agreement with the TGRO contractor/TPRC. The agreement shall include the companion document for submission of claims in the X12 format. Copies of the companion document and any updates shall be provided to the appropriate TMA COR.

11. Electronic claims not accepted by the overseas claims processing contractor's Electronic Data Information (EDI) system/program shall be rejected. Upon rejection by the overseas claims processing contractor EDI system/program, the overseas claims processing contractor shall advise the TGRO contractor and TPRC of the missing information needed for acceptance of the TGRO contractor and TPRC electronic claim by the overseas claims processing contractor's EDI system.

12. The TGRO contractor and TPRC shall ensure that when submitting electronic claims for outpatient services with dates of service not in the same month, claims crossing months must be submitted on separate lines in the Electronic Medical Claims (EMCs) submission (i.e., data entry at claims input must separate months by claim line item). TGRO contractor and TPRC electronic claims for institutional services (i.e., room and board charges), and professional charges may not be submitted on the same electronic claims submission. Institutional room and board charges which cross months may be submitted on the same claim but must be submitted using the **CMS 1450 UB-04** form. Institutional professional charges, etc., must be submitted using a non-institutional format. Institutional professional charges, etc. which cross months may be submitted on the same claim using separate line items. When in doubt about how to submit claims with multiple services, varying dates of service, etc., the TGRO contractor and TPRC shall contact the overseas claims processing contractor EMC's department for assistance in claims submission prior to the submission of the electronic claim.

13. For all overseas claims, including the TGRO contractor and TPRC claims, the overseas claims processing contractor shall create and submit TEDs following current guidelines in the TSM for TED development and submission. Except for TRICARE Europe non-remote ADSM claims, these claims shall be submitted on vouchers. TLAC ADSM claims shall be submitted on vouchers. Non-remote TRICARE Europe ADSM claims shall be submitted as batches. Claim information will be able to be accessed through the TRICARE Patient Encounter Processing and Reporting (PEPR) Purchased Care Detail Information System (PCDIS).

14. The overseas claims processing contractor shall process claims for TGRO contractor/TPRC claims following the guidelines outlined in this chapter.

15. The overseas claims processing contractor shall establish high dollar thresholds of \$5,000 for non-institutional claims and \$10,000 for institutional TOP claims. Claims exceeding these thresholds should be reviewed for medical necessity.