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TRICARE
MANAGEMENT ACTIVITY

MB&RS

CHANGE 70
6010.54-M
FEBRUARY 11, 2008

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: **ROUTINE TPM/TRM CHANGE FEBRUARY 2008 (FORMERLY TITLED SEPTEMBER 2007)**

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): This change revises and reissues several TRICARE Policy Manual changes as described in the summary of changes.

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

This change is made in conjunction with Aug 2002 TRM, Change No. 70.

Reta Michak
Chief, Office of Medical Benefits and Reimbursement Systems

ATTACHMENT(S): 70 PAGE(S)
DISTRIBUTION: 6010.54-M

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

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SUMMARY OF CHANGES

CHAPTER 4

1. Section 5.2 (Post-mastectomy Reconstructive Breast Surgery), Section 5.5 (Silicone or Saline Breast Implant Removal) and Section 5.6 (Breast Reconstruction as a Result of a Congenital Anomaly). These changes clarify current TRICARE policy that breast MRI used to detect implant rupture is covered in cases where the breast implants were or would have been a covered TRICARE benefit.

2. Section 8.2 (Lung Volume Reduction Surgery (LVRS)). This section clarifies that LVRS surgery must be performed at facilities that are certified by the Joint Commission under the LVRS Disease Specific Care Certification Program (program standards and requirements as printed in the Joint Commission's October 25, 2004 Disease Specific Care Certification Program packet) as now required by Medicare.

CHAPTER 6

3. Section 1.1 (General). This change clarifies human papillomavirus DNA testing.

CHAPTER 7

4. Section 2.1 (Clinical Preventive Services-TRICARE Standard) and Policy Manual Chapter 7, Section 2.2 (Clinical Preventive Services-TRICARE Prime). This change updated the criteria for qualification of the prostate-specific antigen (PSA) test for prostate cancer.

5. Section 2.2 (Clinical Preventive Services-TRICARE Prime) and Policy Manual Chapter 7, Section 2.5 (Well-Child Care). This change revised the reference to the pediatric vision care benefit to include "routine eye examinations" instead of "comprehensive eye examinations."

6. Section 6.1 (Ophthalmological Services). This change makes an editorial change to eliminate redundancy in reference to eye exams and clarifies that Standard Active Duty Family Members (ADFMs) are eligible for routine eye exams consistent with Chapter 7, Section 2.1 (Clinical Preventive Services-TRICARE Standard).

7. Section 7.1 (Speech Services). This change clarifies that myofunctional therapy is not covered . Myofunctional therapy is not covered because it is not a treatment used to diagnose or treat an illness or injury.

SUMMARY OF CHANGES (Continued)

CHAPTER 10

8. Section 4.1 (Continued Health Care Benefit Program--CHCBP). The policy clarification that is made in this change indicates that any other source authorized by state or local law to provide adoption placement will also be recognized by the Secretary of Defense and the adopted party may therefore enroll in CHCBP.

9. Section 7.1 (Transitional Survivor Status and Survivor Status). Current policy allows eligible surviving family members whose sponsor died while on active duty for a period of more than 30 days to continue their TRICARE eligibility and their status is reflected as either Transitional Survivor or Survivor. The policy clarification made here indicates that those who die while on delayed-effective-date active duty orders also continue their TRICARE eligibility and their status is thus reflected as either Transitional Survivor or Survivor.

CHAPTER 11

10. Section 3.2 (State Licensure and Certification). This change inserts language to clarify current policy and to indicate that individuals placed on probation or whose license has otherwise been restricted are not considered to be practicing at the full clinical practice level.

11. Section 3.10 (Mental Health Counselor). This change clarifies requirements in those jurisdictions that do not offer licensure as a mental health counselor.

12. Section 7.1 (Certification of Organ Transplant Centers). This change removes all references to Medicare-approved pancreas and pancreas-kidney transplant centers because Medicare does not certify pancreas transplant centers. This is a clerical change that will not result in additional health care or administrative costs.

CHAPTER 4
SECTION 5.2

POSTMASTECTOMY RECONSTRUCTIVE BREAST SURGERY

ISSUE DATE: October 7, 1982
AUTHORITY: 32 CFR 199.4(e)(8)(i)(D)

I. CPT[1] PROCEDURE CODES

19160 - 19240, 19340 - 19499 (For post-mastectomy reconstruction surgery)
19316, 19318, 19324 - 19325 (For contralateral symmetry surgery)

II. DESCRIPTION

Breast reconstruction consists of both mound reconstruction, nipple-areola reconstruction and areolar/nipple tattooing.

III. POLICY

A. Payment may be made for post-mastectomy reconstruction of the breast following a covered mastectomy.

B. Payment may be made for contralateral symmetry surgery (i.e., reduction mammoplasty, augmentation mammoplasty, or mastopexy performed on the other breast to bring it into symmetry with the post-mastectomy reconstructed breast).

NOTE: Services related to the reduction of the contralateral breast in post-mastectomy reconstructive breast surgery are not subject to the regulatory exclusion for mammoplasties performed primarily for reasons of cosmesis.

C. Treatment of complications following reconstruction (including implant removal) regardless of when the reconstruction was performed, and complications that may result following symmetry surgery, removal and reinsertion of implants are covered.

D. External surgical garments (specifically designed as an integral part of an external prosthesis) are considered medical supply items and are covered in lieu of reconstructive breast surgery.

NOTE: Benefits are subject to two initial mastectomy bras and two replacement mastectomy bras per calendar year.

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E. Breast prosthesis is limited to the first initial device per missing body part. Requests for replacements are subject to medical review to determine reason for replacement.

F. U.S. Food and Drug Administration (FDA) approved implant material and customized external breast prostheses are covered.

G. Breast Magnetic Resonance Imaging (MRI) to detect implant rupture is covered. The implantation of the breast implants must have been covered by TRICARE.

- END -

CHAPTER 4
SECTION 5.5

SILICONE OR SALINE BREAST IMPLANT REMOVAL

ISSUE DATE: June 30, 1993
AUTHORITY: 32 CFR 199.4(a)(1), (e)(8)(iv), and (e)(9)

I. CPT[1] PROCEDURE CODES

19328, 19330

II. DESCRIPTION

The removal of silicone or saline mammary implant material.

III. POLICY

A. Removal of silicone or saline breast implants is covered if the initial silicone or saline breast implantation was or would have been a covered benefit.

B. Signs or symptoms of complications must be present and documented. Current medical literature supports removal of silicone or saline breast implants for the following indications:

1. Signs and symptoms that may signal implant rupture; and

2. Capsular contracture.

C. If the initial silicone or saline breast implant surgery was for an indication not covered or coverable by TRICARE, implant removal may be covered only if it is necessary treatment of a complication which represents a separate medical condition.

D. Breast Magnetic Resonance Imaging (MRI) to detect implant rupture is covered. The implantation of the breast implants must have been covered by TRICARE.

IV. EXCLUSIONS

A. Removal of silicone or saline breast implants for the presence of autoimmune or connective tissue disorders.

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B. In the case of implants not originally covered or coverable, implant damage, hardening, leakage, and autoimmune disorder do not qualify as separate medical conditions. They are considered unfortunate sequelae resulting from the initial non-covered surgery, and, therefore, are excluded.

- END -

CHAPTER 4
SECTION 5.6

BREAST RECONSTRUCTION AS A RESULT OF A CONGENITAL ANOMALY

ISSUE DATE: April 16, 1986
AUTHORITY: 32 CFR 199.4(c)(2) and (e)(8)

I. CPT[1] PROCEDURE CODES

19361-19369, 19499

II. DESCRIPTION

A congenital anomaly is a significant deviation from the normal form, existing at, and usually before, birth. It also refers to certain malformations or diseases which may be either hereditary or due to some influence occurring during gestation.

III. POLICY

A. Breast reconstructive surgery, to include surgery performed to establish symmetry, is covered to correct breast deformities related to a verified congenital anomaly. The following are examples of congenital anomalies that require breast reconstruction:

1. Amastia (absence of the breast); athelia (absence of nipple); polymastia (supernumerary breasts); polythelia (supernumerary nipples); tubular breast deformity.

2. Congenital hypoplasia of one breast and gigantomastia of the contralateral breast with ptosis.

3. Paucity of breast tissue due to chest wall deformities.

NOTE: The intent of the law is to allow coverage for reconstructive surgery to correct a congenital anomaly. A congenital anomaly may be present at birth, but only manifest later; e.g., at puberty. In these cases, documentation (i.e., photographs and physical examination, etc.) to verify the anomaly may be required.

B. Augmentation and/or reduction of the collateral breast to correct congenital asymmetry when related to a congenital anomaly is covered.

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C. Breast Magnetic Resonance Imaging (MRI) to detect implant rupture is covered. The implantation of the breast implants must have been covered by TRICARE.

IV. EXCLUSION

Reconstructive breast surgery for incomplete or underdevelopment of breast not related to a verified congenital anomaly may not be cost-shared.

- END -

D. Patients should have none of the following exclusion criteria:

1. Previous LVRS.

2. Pleural or interstitial disease which precludes surgery.

3. Giant bulla (greater than 1/3 the volume of the lung in which the bulla is located).

4. Clinically significant bronchiectasis.

5. Pulmonary nodule requiring surgery.

6. Previous lobectomy.

7. Uncontrolled hypertension (systolic greater than 200 mm Hg or diastolic greater than 100 mm Hg).

8. Oxygen requirement greater than 6 liters per minute during resting to keep oxygen saturation greater than or equal to 90%.

9. History of recurrent infections with clinically significant production of sputum.

10. Unplanned weight loss greater than 10% within 3 months prior to consideration for surgery.

11. Pulmonary hypertension, defined as mean pulmonary artery pressure of 33 mm Hg or greater on right-heart catheterization or peak systolic pulmonary artery pressure of 44 mm Hg or greater.

12. Resting bradycardia (less than 50 beats per minute), frequent multifocal Premature Ventricular Contractions (PVCs) of complex ventricular arrhythmia or Sustained Supraventricular Tachycardia (SVT).

13. Evidence of systemic disease or neoplasia that is expected to compromise survival.

E. LVRS must be preceded and followed by a program of diagnostic and therapeutic services consistent with those provided in the National Emphysema Treatment Trial (NETT) and designed to maximize the patient's potential to successfully undergo and recover from surgery. The program must include a 6 to 10 week series of at least 16, and no more than 20 preoperative sessions, each lasting a minimum of two hours. It must also include at least 6 and no more than 10, postoperative sessions, each lasting a minimum of two hours, within 8 to 9 weeks of the LVRS.

F. LVRS must be performed at facilities that are:

1. Certified by the Joint Commission under the LVRS Disease Specific Care Certification Program (program standards and requirements as printed in the Joint Commission's October 25, 2004, Disease Specific Care Certification Program packet); or

2. Approved by Medicare or TRICARE as lung or heart-lung transplantation facilities.

3. In addition, LVRS performed between January 1, 2004, and May 17, 2007, may be covered in facilities that were approved by the National Heart Lung and Blood Institute to participate in the NETT.

V. EXCLUSION

Thorascopic laser bullectomy.

VI. EFFECTIVE DATE March 22, 2004.

- END -

F. TRICARE considers three-dimensional (3D) rendering (CPT[3] procedure codes 76376 and 76377) medically necessary under certain circumstances (see Chapter 5, Section 2.1).

G. Helical (spiral) CT scans, with or without contrast enhancement, are covered when medically necessary, appropriate and the standard of care.

H. Chest x-rays (CPT[3] procedure codes 71010-71035) are covered.

I. Diagnostic mammography (CPT[3] procedure codes 76090-76092/HCPCS codes G0204-G0207) to further define breast abnormalities or other problems is covered.

J. Portable X-ray services are covered. The suppliers must meet the conditions of coverage of the Medicare program, set forth in the Medicare regulations, or the Medicaid program in that state in which the covered service is provided. In addition to the specific radiology services, reasonable transportation and set-up charges are covered and separately reimbursable.

K. Bone density studies (CPT[3] procedure codes 76070-76078) are covered for the following:

1. The diagnosis and monitoring of osteoporosis.

2. The diagnosis and monitoring of osteopenia.

3. Patients must present with signs and symptoms of bone disease or be considered at high-risk for developing osteoporosis. High-risk factors which have been identified as the standard of care by the American College of Obstetricians and Gynecologists (ACOG) include:

a. Women who are estrogen-deficient and at clinical risk for osteoporosis. Naturally or surgically post-menopausal women who have not been on **long-term** Hormone Replacement Therapy (HRT). However, **current** use of HRT does not preclude estrogen deficiency.

b. Individuals who have vertebral abnormalities.

c. Individuals receiving long-term glucocorticoid (steroid) therapy.

d. Individuals with primary hyperparathyroidism.

e. Individuals with positive family history of osteoporosis.

f. Any other high-risk factor identified by ACOG as the standard of care.

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V. EXCLUSIONS

A. Bone density studies for the routine screening of osteoporosis.

B. Ultrafast CT (electron beam computed tomography (HCPCS code S8092)) to predict asymptomatic heart disease is preventive.

C. MRIs (CPT[4] procedure codes 76058 and 77059) to screen for breast cancer in asymptomatic women considered to be at low or average risk of developing breast cancer; for diagnosis of suspicious lesions to avoid biopsy, to evaluate response to neoadjuvant chemotherapy, to differentiate cysts from solid lesions.

D. MRIs (CPT[4] procedure codes 76058 and 77059) to assess implant integrity or confirm implant rupture, if implants were not originally covered or coverable.

E. 3D rendering (CPT[4] procedure codes 76376 and 76377) for monitoring coronary artery stenosis activity in patients with angiographically confirmed CAD is unproven.

F. 3D rendering (CPT[4] procedure codes 76376 and 76377) for evaluating graft patency in individuals who have undergone revascularization procedures is unproven.

G. 3D rendering (CPT[4] procedure codes 76376 and 76377) for use as a screening test for CAD in healthy individuals or in asymptomatic patients who have one or more traditional risk factors for CAD is unproven.

H. Computed tomography angiography (CPT[4] procedure codes 76376 and 76377) for acute ischemic stroke is unproven.

I. Computed tomography angiography (CPT[4] procedure codes 76376 and 76377) for intracerebral aneurysm and subarachnoid hemorrhage is unproven.

J. Computed tomography, heart, without contrast, including image post processing and quantitative evaluation of coronary calcium (CPT[4] procedure code 0144T) is unproven.

K. Computed tomography, heart, without contrast material followed by contrast, material(s) and further sections, including cardiac gating and 3D image post processing; cardiac structure and morphology (CPT[4] procedure code 0145T) is unproven.

L. Computed tomographic angiography of coronary arteries (including native and anomalous coronary arteries, coronary bypass grafts) without quantitative evaluation of coronary calcium (CPT[4] procedure code 0146T). Computed tomographic angiography of coronary arteries (including native and anomalous coronary arteries, coronary bypass grafts) with quantitative evaluative of coronary calcium (CPT[4] procedure code 0147T) is unproven.

M. Cardiac structure and morphology and computed tomographic angiography of coronary arteries (including native and anomalous coronary arteries, coronary bypass grafts)

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without quantitative evaluation of coronary calcium (CPT[5] procedure code 0148T). Cardiac structure and morphology and computed tomographic angiography of coronary arteries (including native and anomalous coronary arteries, coronary bypass grafts) with quantitative evaluative of coronary calcium (CPT[5] procedure code 0149T) is unproven.

N. Cardiac structure and morphology in congenital heart disease (CPT[5] procedure code 0150T). Computed tomography, heart, without contrast material followed by contrast material(s) and further sections, including cardiac gating and 3D image post processing, function evaluation (left and right ventricular function, ejection fraction and segmental wall motion (CPT[5] procedure code 0152T)) is unproven.

VI. EFFECTIVE DATES

A. The effective date for MRIs with contrast media is dependent on the FDA approval of the contrast media and a determination by the contractor of whether the labeled or unlabeled use of the contrast media is medically necessary and a proven indication.

B. March 31, 2006, for breast MRI.

- END -

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CHAPTER 6
SECTION 1.1

GENERAL

ISSUE DATE:
AUTHORITY: 32 CFR 199.4(a)(1)(i), (b)(2)(ix), (b)(3)(vi), (c)(2)(x) and (g)(60)

I. CPT[1] PROCEDURE CODES

80048 - 87622, 87650 - 87999, 88104 - 89264, 89330 - 89399

II. DESCRIPTION

A. Pathology is the medical science and specialty practice that deals with all aspects of disease, but with special reference to the essential nature, the causes, and development of abnormal conditions, as well as the structural and functional changes that result from disease processes.

B. The surgical pathology services include accession, examination, and reporting for a specimen which is defined as tissue that is submitted for individual and separate attention, requiring individual examination and pathologic diagnosis. These codes require gross and microscopic examination.

III. POLICY

A. Pathology and laboratory services are covered except as indicated.

B. Surgical pathology procedures, billed by a pathologist, are covered services.

C. If the operating surgeon bills for surgical pathology procedures, they will be denied as incidental, since the definitive (microscopic) examination will be performed later, after fixation of the specimen, by the pathologist who will bill separately.

D. Dermatologists are qualified to perform surgical pathology services. Therefore, if a dermatologist bills for both the surgical procedure (e.g. CPT[1] procedure code 11100, skin biopsy) as well as the surgical pathology, both procedures are covered in full.

E. Human papillomavirus testing (CPT[1] procedure codes 87620 - 87622) is covered for the assessment of women with Atypical Squamous Cells of Undetermined Significance (ASCUS) cells detected upon initial pap smear.

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F. For Transfusion Services refer to Chapter 6, Section 2.1.

IV. EXCLUSIONS

A. Autopsy and postmortem (CPT[2] procedure codes 88000-88099).

B. Sperm penetration assay (hamster oocyte penetration test or the zona-free hamster egg test) is excluded for IVF (CPT[2] procedure code 89329).

C. In-vitro chemoresistance and chemosensitivity assays (stem cell assay, differential staining cytoxicity assay and thymidine incorporation assay) are unproven.

D. Hair analysis to identify mineral deficiencies from the chemical composition of hair is unproven. Hair analysis testing (CPT[2] procedure code 96902) may be reimbursed when necessary to determine lead poisoning.

E. Insemination of oocytes (CPT[2] procedure code 89268).

F. Extended culture of oocyte(s) embryo(s) 4-7 days (CPT[2] procedure code 89272).

G. Assisted oocyte fertilization, microtechnique; less than or equal to 10 oocytes (CPT[2] procedure code 89280).

H. Assisted oocyte fertilization, microtechnique; greater than 10 oocytes (CPT[2] procedure code 89281).

I. Biopsy oocyte polar body or embryo blastomere (CPT[2] procedure code 89290).

J. Biopsy oocyte polar body or embryo blastomere; greater than 4 embryos (CPT[2] procedure code 89291).

K. Cryopreservation reproductive tissue, testicular (CPT[2] procedure code 89335).

L. Storage (per year) embryo(s) (CPT[2] procedure code 89342).

M. Storage (per year) sperm/semen (CPT[2] procedure code 89343).

N. Storage (per year) reproductive tissue, testicular/ovarian (CPT[2] procedure code 89344).

O. Storage (per year) oocyte (CPT[2] procedure code 89346).

P. Thawing of cryopreserved, embryo(s) (CPT[2] procedure code 89352).

Q. Thawing of cryopreserved, sperm/semen, each aliquot (CPT[2] procedure code 89353).

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(d) Reimbursement of Resource Sharing claims for the office visit associated with the screening Pap test should follow the same guidelines as civilian providers. Cytopathology laboratory charges billed by a Resource Sharing provider will not be reimbursed, unless the Resource Sharing Agreement states otherwise.

(e) Extra and Standard plans may cost-share services that are rendered during the same office visit of a screening Pap test as long as the services are considered medically necessary and are documented as such, and would not otherwise be considered integral to the office visit.

(f) A 30 day administrative tolerance will be allowed for interval requirements between screening Pap tests.

(g) The effective date for cancer screening for Pap smears is November 5, 1990.

c. Colorectal Cancer.

(1) Physical examination. Digital rectal examination should be performed on individuals 40 years of age and older. The effective date for coverage of a digital rectal exam is October 6, 1997.

(2) Fecal Occult Blood Testing. Once every 12 months (either guaiac-based testing or immunochemical-based testing) for beneficiaries who have attained age 50 (i.e. at least 11 months have passed following the month in which the last covered screening fecal-occult blood test was done). The effective date for coverage of guaiac-based testing is October 6, 1997. The effective date for coverage of immunochemical-based testing is August 20, 2003.

(3) Proctosigmoidoscopy or sigmoidoscopy. Once every three to five years beginning at age 50. The effective date for coverage of proctosigmoidoscopy or sigmoidoscopy is October 6, 1997.

(4) Colonoscopy. Once every 10 years beginning at age 50 for individuals at average risk for colon cancer. The effective date for coverage of colonoscopy for individuals at average risk is March 15, 2006.

(a) The following age ranges and frequencies are recommended for individuals at **increased** risk for colon cancer:

1 Hereditary non-polyposis colorectal cancer syndrome. Colonoscopy should be performed every two years beginning at age 25, or five years younger than the earliest age of diagnosis of colorectal cancer, whichever is earlier. Annual screening after age 40.

2 Familial risk of sporadic colorectal cancer. Familial risk means the individual has a first degree relative with sporadic colorectal cancer or adenomas before the age of 60 or multiple first degree relatives with colorectal cancer or adenomas. Colonoscopy should be performed every three to five years beginning 10 years earlier than the youngest affected relative.

(b) The effective date for coverage of colonoscopy for individuals at **increased** risk is October 6, 1997.

(5) The effective date for colorectal cancer screening is October 6, 1997. The effective date for immunochemical-based fecal occult blood testing is August 20, 2003.

d. Prostate Cancer.

(1) Physical examination. Digital rectal examination will be offered annually for all men beginning at age 50 who have at least a 10 year life expectancy. It should also be offered to begin for men age 45 and over with a family history of prostate cancer in at least one other first degree relative (father, brother, or son) diagnosed with prostate cancer at an early age (younger then age 65) and to all African American men aged 45 and over regardless of family history. Testing should be offered to start at age 40 for men with a family history of prostate cancer in two or more other family members.

(2) Prostate-Specific Antigen.

(a) Annual testing for the following categories of males:

1 All men aged 50 years and older.

2 Men aged 45 years and over with a family history of prostate cancer in at least one (1) other family member.

3 All African American men aged 45 and over regardless of family history.

4 Men aged 40 and over with a family history of prostate cancer in two or more other family members.

(b) Screening will continue to be offered as long as the individual has a 10 year life expectancy.

(3) The effective date for prostate cancer screening is October 6, 1997.

2. Infectious Diseases.

a. Hepatitis B screening. The effective date for screening pregnant women for HBsAG during the prenatal period was March 1, 1992.

b. Human immunodeficiency virus (HIV) testing.

(1) Effective July 7, 1995, TRICARE may share the cost of routine HIV screening tests for pregnant women, and

(2) Extra and Standard plans may share the cost of HIV testing when medically necessary; i.e., when performed on individuals with verified exposure to HIV or who exhibit symptoms of HIV infection (persistent generalized lymphadenopathy). Claims

for HIV testing must include documentation by the attending physician verifying medical necessity. Claims that meet the criteria for coverage are to be reimbursed following the reimbursement methodology applicable to the provider's geographic location.

(3) HIV testing is covered when done in conjunction with routine pre-operative services by an independent laboratory or clinic. If the HIV testing is done while the patient is in an inpatient setting, the testing should be included in the DRG.

c. Prophylaxis. The following preventive therapy may be provided to those who are at risk for developing active disease:

(1) Tetanus immune globulin (human) and tetanus toxoid administered following an injury.

(2) Services provided following an animal bite:

(a) Extra and Standard plans may share the cost of the administration of anti-rabies serum or human rabies immune globulin and rabies vaccine.

NOTE: Pre-exposure prophylaxis for persons with a high risk of exposure to rabies is not covered.

(b) Extra and Standard plans may also cost-share the laboratory examination of the brain of an animal suspected of having rabies if performed by a laboratory which is an authorized provider and if the laboratory customarily charges for such examinations. In order for the examination charges to be paid, the animal must have bitten a beneficiary, the charges for the examination must be submitted under the beneficiary's name, and the beneficiary must be responsible for the cost-share on the claim.

NOTE: Charges by any source for boarding, observing, or destroying animals, or for the collection of brain specimens are not covered.

(3) Rh immune globulin when administered to an Rh negative woman during pregnancy and following the birth of an Rh positive child or following a spontaneous or induced abortion.

(4) For treatment provided to individuals with verified exposure to a potentially life-threatening medical condition (i.e., hepatitis A, hepatitis B, meningococcal meningitis, etc.), claims must include documentation by the attending physician verifying exposure.

(5) Isoniazid therapy for individuals at high risk for tuberculosis to include those:

(a) With a positive Mantoux test without active disease;

(b) Who have had close contact with an infectious case of TB in the past 3 months regardless of their skin test reaction; or

(c) Who are members of populations in which the prevalence of TB is greater than 10% regardless of their skin test reaction - including injection drug users, homeless individuals, migrant workers, and those born in Asia, Africa, or Latin America.

NOTE: In general, isoniazid prophylaxis should be continued for at least 6 months up to a maximum of 12 months.

(6) Immunizations.

(a) Coverage is extended for the age appropriate dose of vaccines that meet the following requirements:

1 The vaccine has been recommended and adopted by the Advisory Committee on Immunization Practices (ACIP); and

2 The ACIP adopted recommendations have been accepted by the Director of the Centers for Disease Control and Prevention (CDC) and the Secretary of Health and Human Services (HHS) and published in a CDC *Morbidity and Mortality Weekly Report* (MMWR).

3 Refer to the CDC's homepage (http://www.cdc.gov) for a current schedule of CDC recommended vaccines. The effective date of coverage for the Human Papilloma Virus (HPV) vaccine is October 13, 2006. The effective date of coverage for the zoster vaccine is October 19, 2007.

(b) Coverage is extended for immunizations required by dependents of active duty military personnel who are traveling outside the United States as a result of an active duty member's duty assignment, and such travel is being performed under orders issued by a Uniformed Service.

3. Genetic Testing.

a. Genetic testing and counseling is covered during pregnancy under any of the following circumstances:

(1) The pregnant woman is 35 years of age or older;

(2) One of the parents of the fetus has had a previous child born with a congenital abnormality;

(3) One of the parents of the fetus has a history (personal or family) of congenital abnormality; or

(4) The pregnant woman contracted rubella during the first trimester of the pregnancy.

(5) There is a history of three or more spontaneous abortions in the current marriage or in previous mating of either spouse; or

(6) The fetus is at an increased risk for a hereditary error of metabolism detectable in vitro; or

(7) The fetus is at an increased risk for neural tube defect (family history or elevated maternal serum alpha-fetoprotein level); or

(8) There is a history of sex-linked conditions (i.e., Duchenne muscular dystrophy, hemophilia, x-linked mental retardation, etc.).

NOTE: Extra and Standard plans may not cost-share routine or demand genetic testing or genetic tests performed to establish the paternity or sex of an unborn child.

4. School Physicals.

a. Physical examinations are covered for beneficiaries ages five through 11 that are required in connection with school enrollment. The effective date for coverage of school enrollment physicals is October 30, 2000.

b. Cost-sharing and deductibles are to be applied as prescribed under the beneficiary's respective coverage plan (i.e., in accordance with the cost-sharing and deductible guidelines and either TRICARE Standard or Extra coverage plans).

c. Standard office visit evaluation and management CPT codes (i.e., CPT[5] procedure code ranges 99201-99205 and 99211-99214) may be used in billing for school physicals; however, payment may not exceed what would have otherwise been reimbursed under the comprehensive Preventive Medicine Service codes for beneficiaries ages five through 11 (CPT[5] procedure codes 99383 and 99393).

5. Other.

a. Physical examinations and immunizations provided to the spouse and children of active duty service members in conjunction with official travel outside the United States. Claims must include a copy of the travel orders or other official documentation verifying the official travel requirement.

b. Routine chest x-rays and electrocardiograms required for admission when a patient is scheduled to receive general anesthesia on an inpatient or outpatient basis.

NOTE: Extra and Standard plans may not cost-share routine chest x-rays or electrocardiograms for admissions not involving services that require general anesthesia.

B. Health Promotion and Disease Prevention Services Covered in Connection with Immunizations, Pap Smears, Mammograms, or Examinations for Colon and Prostate Cancer. The following health prevention services are only covered in connection with immunizations, Pap smears, mammograms, or screening examinations for colon and prostate cancer; i.e., preventive services provided during the same comprehensive

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preventative office visit as the associated immunization, Pap smear, mammogram, or colon and prostate examination or preventive services provided as a result of a referral made during that same office visit. The contractor shall apply all appropriate claims processing and rebundling edits before determining if the following preventive services are individually reimbursable. The contractor need not establish additional edits to identify claims within the age, sex, race, or clinical history parameters included below, or research claims history to ensure that an association exists between the following preventive services and an immunization, Pap smear, mammogram, or colon and prostate cancer examination:

1. Cancer Screening Examinations.

a. Testicular Cancer. Physical examination annually for males age 13-39 with history of cryptorchidism, orchipexy, or testicular atrophy.

b. Skin Cancer. Physical skin examination should be performed for individuals with family or personal history of skin cancer, increased occupational or recreational exposure to sunlight, or clinical evidence of precursor lesions.

c. Oral Cavity and Pharyngeal Cancer. A complete oral cavity examination should be part of routine preventive care for adults at high risk due to exposure to tobacco or excessive amounts of alcohol. Oral examination should also be part of a recommended annual dental check-up.

d. Thyroid Cancer. Palpation for thyroid nodules should be performed in adults with a history of upper body irradiation.

2. Infectious Diseases.

a. Tuberculosis screening. Screening annually, regardless of age, all individuals at high risk for tuberculosis (as defined by CDC) using Mantoux tests.

b. Rubella antibodies. Females, once during age 12-18, unless documented history of adequate rubella vaccination with at least one dose of rubella vaccine on or after the first birthday.

3. Cardiovascular Disease.

a. Cholesterol. Non-fasting total blood cholesterol at least once every five years, beginning age 18.

b. Blood pressure screening. Blood pressure screening at least every two years after age six.

4. Body Measurements. Height and weight should be measured periodically. The optimal frequency is a matter of clinical discretion. Those individuals who are 20% or more above desirable weight should receive appropriate nutritional and exercise counseling.

5. Vision Screening. Vision screening continues to be excluded from coverage under the Extra and Standard plans except for the one routine eye examination per calendar year

per person for family members of active duty members and vision screening allowed under the well-child benefit.

6. Audiology Screening. Preventive hearing examinations are only allowed under the well-child care benefit.

7. Counseling Services.

a. Patient and parent education counseling for:

(1) Dietary assessment and nutrition;

(2) Physical activity and exercise;

(3) Cancer surveillance;

(4) Safe sexual practices;

(5) Tobacco, alcohol and substance abuse;

(6) Promoting dental health;

(7) Accident and injury prevention; and

(8) Stress, bereavement and suicide risk assessment.

b. These are expected components of good clinical practice that are integrated into the appropriate office visit at no additional charge.

V. EFFECTIVE DATE

Unless otherwise stated, the effective date of health promotion and disease prevention services covered in connection with immunizations, Pap smears, mammograms, or examinations for colon and prostate cancer is October 6, 1997.

- END -

SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT CPT[1] CODE
Cancer of Female Reproductive Organs:	**Physical Examination:** Pelvic examination should be performed in conjunction with Pap smear testing for cervical neoplasms and premalignant lesions.	See appropriate level evaluation and management codes.
	Papanicolaou smears: Annually starting at age 18 (or younger, if sexually active) until three consecutive satisfactory normal annual examinations. Frequency may then be less often at the discretion of the patient and clinician but not less frequently than every three years.	88141-88155, 88164-88167, 88174, 88175, 99201-99215, or 99301-99313.
Testicular Cancer:	**Physical Examination:** Clinical testicular exam annually for males age 13-39 with a history of cryptorchidism, orchiopexy, or testicular atrophy.	See appropriate level evaluation and management codes.
Prostate Cancer:	**Physical Examination:** Digital rectal examination should be offered annually for all men aged 50 years and over; men aged 45 and over with a family history of prostate cancer in at least one other family member; all African American men aged 45 and over regardless of family history; and men aged 40 and over with a family history of prostate cancer in two or more other family members.	See appropriate level evaluation and management codes.
	Prostate Specific Antigen: Annually for the following categories of males: all men aged 50 years and older; men aged 45 years and over with a family history of prostate cancer in at least one other family member; all African American men aged 45 and over regardless of family history; and men aged 40 and over with a family history of prostate cancer in two or more other family members.	84153
Colorectal Cancer:	**Physical Examination:** Digital rectal examination should be included in the periodic health examination of individuals 40 years of age and older.	See appropriate level evaluation and management codes.
	Fecal occult blood testing: Once every 12 months (either guaiac-based testing or immunochemical-based testing) for beneficiaries who have attained age 50 (i.e., at least 11 months have passed following the month in which the last covered screening fecal-occult blood test was done). The effective date for coverage of immunochemical-based testing is August 20, 2003.	82270, 82274, and HCPCS code G0107.

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SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT CPT[1] CODE
Colorectal Cancer (Continued):	**Proctosigmoidoscopy or Sigmoidoscopy**: Once every three to five years beginning at age 50.	45300-45321, 45327, 45330-45339.
	Colonoscopy for Individuals at Average Risk for Colon Cancer: Once every 10 years for individuals age 50 or above. The effective date for coverage of colonoscopy for individuals at average risk is March 15, 2006. **Colonoscopy for Individuals at Increased Risk for Colon Cancer:** Performed every two years beginning at age 25, or five years younger than the earliest age of diagnosis of colorectal cancer, whichever is earlier and then annually after age 40 for individuals with hereditary non-polyposis colorectal cancer syndrome. Individuals with familial risk of sporadic colorectal cancer (i.e., individuals with first degree relatives with sporadic colorectal cancer or adenomas before the age 60 or multiple first degree relatives with colorectal cancer or adenomas) may receive a colonoscopy every three to five years beginning at age 10 years earlier than the youngest affected relative.	45355, 45378-45385, and HCPCS codes G0105 and G0121.
Skin Cancer:	**Physical Examination**: Skin examination should be performed for individuals with a family or personal history of skin cancer, increased occupational or recreational exposure to sunlight, or clinical evidence of precursor lesions.	See appropriate level evaluation and management codes.
Oral Cavity and Pharyngeal Cancer:	**Physical Examination**: A complete oral cavity examination should be part of routine preventive care for adults at high risk due to exposure to tobacco or excessive amounts of alcohol. Oral examination should also be part of a recommended annual dental check-up.	See appropriate level evaluation and management codes.
Thyroid Cancer:	**Physical Examination**: Palpation for thyroid nodules should be performed in adults with a history of upper body irradiation.	See appropriate level evaluation and management codes.
Infectious Diseases:	**Tuberculosis screening**: Screen annually, regardless of age, all individuals at high risk for tuberculosis (as defined by CDC) using Mantoux tests.	86580 and 86585
	Rubella antibodies: females, once, age 12-18, unless documented history of adequate rubella vaccination with at least one dose of rubella vaccine on or after the first birthday.	86762

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SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT CPT[1] CODE
Infectious Diseases (Continued):	**Hepatitis B screening**: Screen pregnant women for HBsAG during prenatal period.	87340
Cardiovascular Diseases:	**Cholesterol**: Non-fasting total blood cholesterol: At least once every five years, beginning age 18.	80061
	Blood pressure screening: For children: annually between three and six years of age, and every two years thereafter. For adults: a minimum frequency of every two years.	See appropriate level evaluation and management codes.
	Abdominal Aortic Aneurysm (AAA): One time AAA screening by ultrasonography for men, age 65-75, who have ever smoked.	76999
Other:	**Body Measurement:** For children: Height and weight should be measured regularly throughout infancy and childhood. Head circumference should be measured through age 24 months. For adults: Height and weight should be measured periodically. The optimal frequency is a matter of clinical discretion. Those individuals who are 20% or more above desirable weight should receive appropriate nutritional and exercise counseling.	See appropriate level evaluation and management codes.
	Vision Care: Pediatric vision screening at birth and approximately six months of age to include determination of vision on visual acuity, ocular alignment and red reflex, along with external examination of ocular abnormalities. Routine eye examination once every two years for all TRICARE Prime enrollees age three and older. Diabetic patients, at any age, should have routine eye examinations at least yearly.	92002, 92004, 92012, 92014, 92015, 99172, and 99173.
	NOTE: Routine eye examinations are meant to be more than the standard visual acuity screening test conducted by the member's primary care physician through the use of a standard Snellen wall chart. Self-referral will be allowed for routine eye examinations since PCMs are incapable of providing this service; i.e., a prime beneficiary will be allowed to set up his or her own appointment for a routine eye examination with any network optometrist and/or ophthalmologist.	

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SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT CPT[1] CODE
Other (Continued):	**Hearing screening:** For children: all high risk neonates (as defined by the Joint Committee on Infant Hearing) audiology screening before leaving the hospital. If not tested at birth, high-risk children should be screened before three months of age. Evaluate hearing of all children as part of routine examinations and refer those with possible hearing impairment as appropriate.	92551, 92587, and 92588
	Pediatric Blood Lead: Assessment of risk for lead exposure by structured questionnaire based on Centers for Disease Control and Prevention (CDC) Preventing Lead Poisoning in Young Children (October 1991) during each well child visit from age six months through 6 years. Screening by blood lead level determination for all children at high risk for lead exposure per CDC guidelines.	83655
COUNSELING SERVICES:		
These are expected components of good clinical practice that are integrated into the appropriate office visit at no additional charge.	**Patient & parent education counseling:** Dietary Assessment & Nutrition; Physical Activity & Exercise; Cancer Surveillance; Safe Sexual Practices; Tobacco, Alcohol and Substance Abuse; Accident & Injury Prevention; Promoting Dental Health; Stress, Bereavement, & Suicide Risk Assessment.	These are expected components of good clinical practice that are integrated into the appropriate office visit at no additional charge.
IMMUNIZATIONS:		
	Age appropriate dose of vaccines that have been recommended and adopted by the Advisory Committee on Immunization Practices (ACIP) and accepted by the Director of the CDC and the Secretary of Health and Human Services (HHS) and published in a CDC *Morbidity and Mortality Weekly Report* (MMWR). Refer to the CDC's home page (http://www.cdc.gov) for current schedule of CDC recommended vaccines. The effective date of coverage for the Human Papilloma Virus (HPV) vaccine is October 13, 2006. The effective date of coverage for the zoster vaccine is October 19, 2007.	

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- END -

CHAPTER 7
SECTION 2.5

WELL-CHILD CARE

ISSUE DATE: April 19, 1983
AUTHORITY: 32 CFR 199.4(c)(2)(xiii) and (c)(3)(xi)

I. CPT[1] PROCEDURE CODES

54150, 54160, 81000 - 81015, 81099, 83655, 84030, 84035, 85014, 85018, 86580, 86585, 90465 - 90468, 90471 - 90474, 90476 - 90748, 92002, 92004, 92012, 92014, 92015, 92551, 92585 - 92588, 99172, 99173, 99381 - 99383, 99391 - 99393, 99431, 99433, 99499.

II. DESCRIPTION

Well-child care includes routine newborn care, health supervision examinations, routine immunizations, periodic health screening, and developmental assessment in accordance with the American Academy of Pediatrics (AAP) guidelines.

III. POLICY

Well-child care is covered for beneficiaries from birth to age six when services are provided by the attending pediatrician, family physician, opthalmologist or optometrist, certified Nurse Practitioner (NP), or certified Physician Assistant (PA). Well-child services are considered preventive and are subject to the same cost sharing/copayment and authorization requirements prescribed under the TRICARE Prime and Standard Clincial Preventive Services benefits.

IV. POLICY CONSIDERATIONS

A. Visits for diagnosis or treatment of an illness or injury are not included in the well-child benefit. Benefits should be extended on the basis of the medical necessity for the services.

B. For children whose health screening and immunizations may not be current, payment may be made for well-child visits and immunizations up to midnight of the day prior to the day the child turns six years old, and thereafter under the TRICARE Preventive Services (see Sections 2.1 and 2.2).

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C. Immunizations are covered for age appropriate dose of vaccines that have been recommended and adopted by the Advisory Committee on Immunization Practices (ACIP) and accepted by the Director of the Centers for Disease Control and Prevention (CDC) and the Secretary of Health and Human Services (HHS) and published in a CDC *Morbidity and Mortality Weekly Report* (MMWR). Refer to the CDC's home page (http://www.cdc.gov) for access to the MMWRs and a current schedule of CDC recommended vaccines. Immunizations required by dependents of active duty military personnel who are traveling outside the United States as a result of an active duty member's duty assignment, and such travel is being performed under orders issued by a Uniformed Service, are covered.

NOTE: The procedure codes in this policy are not necessarily an all-inclusive list of vaccines currently recommended by the CDC's ACIP.

D. Well-child care for newborns includes the routine care of the newborn in the hospital, newborn circumcision, and newborn screening as recommended by the AAP. Covered newborn screenings include, but are not limited to, testing for hypothyroidism, phenylketonuria (PKU) hemoglobinopathies (refer to paragraph IV.G.2. for further details), and galactosemia. Only routine well-child care for newborns is covered as part of the mother's maternity episode, i.e., a separate cost-share is not required for the infant. If a circumcision is performed after the child has been discharged from the hospital, the service is cost-shared as an outpatient service (unless it qualifies for the special cost-sharing for ambulatory surgery). Separate professional claims must be submitted for the newborn and the mother.

E. A program of well-child care conducted according to the most current Guidelines for Health Supervision, AAP, is covered. Significant deviation from the guidelines requires justification. In any case, no more than nine well-baby visits in two years are covered.

F. Each office visit for well-child care includes the following services:

1. History and physical examination and mental health assessment.

2. Developmental and behavioral appraisal.

a. Height and weight should be measured regularly throughout infancy and childhood.

b. Head circumference should be measured for children through 24 months of age.

c. Sensory screening: vision, hearing (by history).

(1) Eye and vision screening by primary care provider during routine examination at birth, and approximately six months of age.

(2) All high risk neonates (as defined by the Joint Committee on Infant Hearing) should undergo audiology screening before leaving the hospital. If not tested at birth, high-risk children should be tested before three months of age using Evoked Otoacoustic Emission (EOE) and/or Auditory Brainstem Response (ABR) testing.

(3) All children should undergo hearing screening (by history) at each well-child visit, and children with possible hearing impairments should be referred for appropriate testing.

d. Dental screenings.

e. Discussion with parents, anticipatory guidance.

G. The following specific services are covered in a program of well-child care:

1. Immunizations are covered for age appropriate dose of vaccines that have been recommended and adopted by the ACIP and accepted by the Director of the CDC and the Secretary of HHS and published in a CDC MMWR. Immunizations required by dependents of active duty military personnel who are traveling outside the United States as a result of an active duty member's duty assignment, and such travel is being performed under orders issued by a Uniformed Service.

2. Heredity and metabolic screening:

a. Two screening tests for PKU, one prior to discharge from the hospital nursery and the other within one to two weeks after hospital discharge.

b. All neonates should be screened for congenital hypothyroidism prior to discharge from the hospital nursery but not later than day six of life.

c. Screening for hemoglobinophies should be done for those in high-risk ethnic groups.

3. Tuberculin test: at 12 months of age and once during second year of age.

4. Hemoglobin or hematocrit testing: once during first year of age, once during second year of age.

5. Urinalysis: once during first year of age, once during second year of age.

6. Annual blood pressure screening for children between three and six years of age.

7. Blood lead test: (CPT[2] procedure code 83655): Assessment of risk for lead exposure by structured questionnaire based on CDC's Preventing Lead Poisoning in Young (October 1991) during each well-child visit from age six months to under six years of age.

8. Health guidance and counseling, including breast feeding and nutrition counseling.

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9. One routine eye examination by an ophthalmologist or optometrist every two years beginning at age three. The routine eye exams offered between the ages of three and six should include screening for amblyopia and strabismus.

10. Additional services or visits required because of specific findings or because the particular circumstances of the individual case are covered if medically necessary and otherwise authorized for benefits.

H. Well-child services are considered preventive and are subject to the same cost-sharing/copayment and authorization requirements as prescribed under TRICARE Preventive Services (refer to Sections 2.1 and 2.2).

- END -

CHAPTER 7
SECTION 3.12

PSYCHOLOGICAL TESTING

ISSUE DATE: March 13, 1992
AUTHORITY: 32 CFR 199.4(c)(3)(ix)

I. CPT[1] PROCEDURE CODES

96101-96103, 96118-96120

II. DESCRIPTION

Psychological testing, with written report, per hour (assessment)

III. POLICY

A. Psychological testing and assessment is a covered benefit when medically or psychologically necessary and is provided in conjunction with otherwise covered psychotherapy. Testing and assessment is generally limited to six (6) hours in a fiscal year.

B. Psychological testing and assessment in the excess of six hours in a fiscal year may be considered for coverage upon review for medical necessity.

NOTE: Psychological tests are considered diagnostic services and are not counted against the 2 psychotherapy visits per week. Copay for retirees and their dependents would be $12.00 per visit.

IV. EXCLUSIONS

A. Payment is specifically excluded for the Reitan-Indiana battery when administered to a patient under age five and for self-administered tests to patients under age 13.

B. Psychological testing and assessment as part of an assessment for academic placement. This exclusion encompasses all psychological testing related to educational programs, issues or deficiencies. Testing to determine whether a beneficiary has a learning disability if the primary or sole basis for the testing is to assess for a learning disability.

C. Psychological testing related to child custody disputes or job placement.

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D. Psychological testing done for general screening (in the absence of specific symptoms of a covered mental disorder) to determine if individuals being tested are suffering from a mental disorder.

E. Teacher and parental referrals for psychological testing.

F. Testing related to diagnosed specific learning disorders or learning disabilities is excluded (encompasses reading disorder (also called dyslexia), mathematics disorder, disorder of written expression and learning disorder not otherwise specified).

G. Testing for a patient in a residential treatment center or partial hospitalization program is included in the per diem rate and can not be separately reimbursed. Also, payment billed by an individual professional provider not employed by or under contract with the residential treatment center or partial hospitalization program is included in the per diem rate.

- END -

CHAPTER 7
SECTION 6.1

OPHTHALMOLOGICAL SERVICES

ISSUE DATE: November 3, 1992
AUTHORITY: 32 CFR 199.4(c)(2)(xvi), (e)(6), (g)(46) and (g)(50)

I. CPT[1] PROCEDURE CODE RANGES

92002 - 92060, 92070 - 92335, 92390 - 92499

II. DESCRIPTION

Ophthalmological services may include an examination and other specialized services. The purpose of an examination is to diagnose or treat a medical condition of the eye, eyelid, lacrimal system, or orbit. A "routine eye examination" is an evaluation of the eyes, including but not limited to refractive services, that is not related to a medical or surgical condition or to the medical or surgical treatment of a covered illness or injury.

III. POLICY

A. For all beneficiaries, opthalmological services (including refractive services) provided in connection with the medical or surgical treatment of a covered illness or injury are covered.

B. Section 632 of P.L. 98-525 signed into effect on October 19, 1994, authorizes payment under TRICARE for one routine eye examination per year for dependents of active duty members.

1. Routine eye examinations as defined in 32 CFR 199.2 includes coverage of those services rendered in order to determine the refractive state of the eyes. The CPT[2] procedure codes for payment of routine eye examinations are as follows:

92002 - EYE EXAM, NEW PATIENT
92004 - EYE EXAM, NEW PATIENT
92012 - EYE EXAM, ESTABLISHED PATIENT
92014 - EYE EXAM & TREATMENT
92015 - REFRACTION
99172 - OCULAR FUNCTION SCREEN
99173 - VISUAL ACUITY SCREEN

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2. TRICARE Prime and Standard Active Duty Family Members (ADFMs) are entitled to one annual routine eye examination. Prime ADFMs may receive their annual routine eye exam from any network provider without referral, authorization, or preauthorization from the Primary Care Manager (PCM), or any other authority; i.e., a Prime ADFM will be allowed to set up his or her own appointment for a routine eye examination with any network optometrist or ophthalmologist. Standard ADFMs may self-refer to any TRICARE authorized provider regardless of whether or not they are a network provider; i.e., a Standard ADFM may set up his or her own appointment with either a network or non-network TRICARE authorized optometrist or ophthalmologist.

C. For Prime enrollees, see Chapter 7, Section 2.2 for additional information on routine eye examinations.

IV. EXCLUSIONS

A. Routine eye examinations are NOT covered for Standard retirees or their dependents that are not enrolled in Prime except for eye exams allowed under the well-child benefit in Chapter 7, Section 2.5.

B. Orthoptics, also known as vision training, vision therapy, eye exercises, eye therapy, is excluded by 32 CFR 199.4(g)(46) (CPT[2] procedure code 92065).

C. Heidelberg Retina Tomograph (HRT) is unproven.

- END -

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CHAPTER 7
SECTION 7.1

SPEECH SERVICES

ISSUE DATE: April 19, 1983
AUTHORITY: 32 CFR 199.4(g)(45), 32 CFR 199.5(c), and Public Law 107-107

I. CPT[1] PROCEDURE CODE RANGE

92506 - 92508

II. DESCRIPTION

Medical services that provide evaluation, treatment, habilitation, and rehabilitation of speech, language, and voice dysfunctions resulting from congenital anomalies, disease, injury, hearing loss, communication or pervasive developmental disorders or a therapeutic process.

III. POLICY

A. Speech services provided or prescribed and supervised by a physician may be cost-shared.

B. Speech therapy to improve, restore, or maintain function, or to minimize or prevent deterioration of function of a patient when prescribed by a physician is covered in accordance with the rehabilitative therapy provisions found in Chapter 7, Section 18.1.

IV. EXCLUSIONS

A. Services provided to address speech, language, or communication disorders resulting from occupational or educational deficits.

B. For beneficiaries under the age of 3, services and items provided in accordance with the beneficiary's Individualized Family Service Plan as required by Part C of the Individuals with Disabilities Education Act, and which are otherwise allowable under the TRICARE Basic Program or the Extended Care Health Option (ECHO) but determined not to be medically or psychologically necessary, are excluded.

C. For beneficiaries ages 3 to 21 who are receiving special education services from a public educational agency, cost-sharing of outpatient speech services that are required by the

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Individuals with Disabilities Education Act and which are indicated in the beneficiary's Individualized Education Program (IEP), may not be cost-shared except when the intensity or timeliness of speech services as proposed by the educational agency are not appropriate medical care.

D. Myofunctional or tongue thrust therapy.

E. Maintenance therapy that does not require a skilled level after a therapy program has been designed (see Chapter 7, Section 18.1).

F. Videofluroscopy evaluation in speech pathology.

- END -

NOTE: This policy does not exclude multidisciplinary services, such as physical therapy, occupational therapy, or speech therapy after traumatic brain injury, stroke and children with an autistic disorder.

13. Vertebral Axial Decompression (VAX-D) for relieving low back pain associated with herniated disc or degenerative disc disease of the lumbar vertebrae is unproven.

14. For beneficiaries under the age of three, services and items provided in accordance with the beneficiary's Individualized Family Service Plan (IFSP) as required by Part C of the Individuals with Disabilities Education Act (IDEA), and which are otherwise allowable under the TRICARE Basic Program or the Extended Care Health Option (ECHO) but determined not to be medically or psychologically necessary, are excluded.

15. For beneficiaries aged three to 21, who are receiving special education services from a public education agency, cost-sharing of outpatient physical therapy services that are required by the IDEA and which are indicated in the beneficiary's Individualized Education Program (IEP), may not be cost-shared except when the intensity or timeliness of physical therapy services as proposed by the educational agency are not sufficient to meet the medical needs of the beneficiary.

- END -

CHAPTER 7
SECTION 18.3

OCCUPATIONAL THERAPY

ISSUE DATE: July 3, 1997
AUTHORITY: 32 CFR 199.4(c)(3)(x)

I. CPT[1] PROCEDURE CODES

97003 - 97004, 97150, 97532, 97533, 97535, 97799

II. DESCRIPTION

Occupational therapy is the prescribed use of specific purposeful activity or interventions designed to promote health, prevent injury or disability, and which develop, improve, sustain, or restore functions which have been lost or reduced as a result of injury, illness, cognitive impairment, psychosocial dysfunction, mental illness, or developmental, learning or physical disability(ies), to the highest possible level for independent functioning.

III. POLICY

A. Occupational therapy prescribed and supervised by a physician is covered.

B. Occupational therapy to improve, restore, or maintain function, or to minimize or prevent deterioration of function of a patient when prescribed by a physician is covered in accordance with the rehabilitative therapy provisions found in Chapter 7, Section 18.1.

IV. EXCLUSIONS

A. The following occupational therapy services are not covered:

1. Vocational assessment and training.

2. General exercise programs.

3. Separate charges for instruction of the patient and family in therapy procedures.

4. Repetitive exercise to improve gait, maintain strength and endurance, and assisted walking such as that provided in support of feeble or unstable patients.

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B. Maintenance therapy that does not require a skilled level after a therapy program has been designed (see Chapter 7, Section 18.1).

1. Range of motion and passive exercises which are not related to restoration of a specific loss of function.

2. CPT[2] procedure code 97532 or 97533 is not a covered benefit when used as a restorative approach. That is, cognitive function improves as a result of neuronal growth, which is enhanced through the repetitive exercise of neuronal circuits and that recovery of functions is determined by biological events.

3. CPT[2] procedure codes 97532 and 97533 for sensory integration training is excluded.

NOTE: This policy does not exclude multidisciplinary services, such as physical therapy, occupational therapy, or speech therapy after traumatic brain injury, stroke and children with an autistic disorder.

C. Occupational therapists are not authorized to bill using Evaluation and Management (E&M) codes listed in the Physicians' Current Procedural Terminology (CPT).

D. For beneficiaries under the age of three, services and items provided in accordance with the beneficiary's Individualized Family Service Plan (IFSP) as required by Part C of the Individuals with Disabilities Education Act (IDEA), and which are otherwise allowable under the TRICARE Basic Program or the Extended Care Health Option (ECHO) but determined not to be medically or psychologically necessary, are excluded.

E. For beneficiaries aged three to 21, who are receiving special education services from a public education agency, cost-sharing of outpatient occupational therapy services that are required by the IDEA and which are indicated in the beneficiary's Individualized Education Program (IEP), may not be cost-shared except when the intensity or timeliness of occupational therapy services as proposed by the educational agency are not sufficient to meet the medical needs of the beneficiary.

V. EFFECTIVE DATE October 28, 1997.

- END -

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CHAPTER 8

OTHER SERVICES

SECTION	SUBJECT
1.1	Ambulance Service
2.1	Durable Medical Equipment: Basic Program
2.2	Infantile Apnea Cardiorespiratory Monitor
2.3	External And Implantable Infusion Pump
2.4	Cold Therapy Devices For Home Use
2.5	Home Prothrombin Time (PT) International Normalized Ratio (INR) Monitor
2.6	Breast Pumps
2.7	Pulsed Irrigation Evacuation (PIE)
3.1	Orthotics
4.1	Prosthetic Devices And Supplies
5.1	Medical Devices
5.2	Neuromuscular Electrical Stimulation (NMES) Devices
6.1	Medical Supplies And Dressings (Consumables)
7.1	Nutritional Therapy
7.2	Liquid Protein Diets
8.1	Diabetes Outpatient Self-Management Training Services
8.2	Therapeutic Shoes For Diabetics
9.1	Pharmacy Benefits Program
10.1	Oxygen And Oxygen Supplies
11.1	Podiatry
12.1	Wigs Or Hairpiece
13.1	Adjunctive Dental Care
13.2	Dental Anesthesia And Institutional Benefit
14.1	Physician-Assisted Suicide
15.1	Custodial Care Transitional Policy (CCTP)
16.1	Mucus Clearance Devices
17.1	Lymphedema

CHAPTER 8
SECTION 2.3

EXTERNAL AND IMPLANTABLE INFUSION PUMP

Issue Date: February 26, 1986
Authority: 32 CFR 199.4(d)(1)

I. CPT[1] PROCEDURE CODES

36260 - 36262, 36530 - 36535, 62350 - 62368, 96530

II. HCPCS PROCEDURE CODES

Level II Codes E0780, E0784, Q0081, Q0084-Q0085

III. DESCRIPTION

A. An External Infusion Pump (EIP) is a device designed to deliver measured amounts of a drug through injection over a period of time into a patient in a controlled manner.

B. An Implantable Infusion Pump (IIP) system delivers therapeutic plasma levels of active drug to a target organ or body compartment for prolonged periods of time. The bulk flow of drug is generated either by fluorocarbon propellant (nonprogrammable IIP) or direct electromechanical action powered by a battery (programmable IIP). The pump is surgically implanted in a subcutaneous pocket and connects to a dedicated catheter that has been placed in the appropriate compartment. Constant or variable-rate infusions are possible over long periods of time (several weeks to years) with minimal human intervention (refilling or reprogramming) while retaining the capability for external control of rate and volume of primary and supplemental drug delivery. In addition to the pump itself, dependent on the type of pump used, the components of the system may include any of the following: reservoir, optional access port, connectors, various size catheters, micropore filter, hand-held programmer, and a variety of accessories.

IV. POLICY

A. External Infusion Pump (EIP)

1. Claims may be reimbursed for medically necessary U.S. Food and Drug Administration (FDA)-approved EIPs when used according to label specifications in delivering continuous or intermittent drug therapy on an inpatient or outpatient basis.

[1] CPT codes, descriptions and other data only are copyright 2005 American Medical Association. All rights reserved. Applicable FARS/DFARS Restrictions Apply to Government use.

2. Supplies for the effective use of the EIP. must be FDA approved. Such supplies include those drugs and biologicals prescribed for usage directly into the EIP in order to achieve the therapeutic benefit of the EIP, or to assure the proper functioning of the equipment.

3. EIPs and otherwise covered medical supplies required in the administration of the drug therapy performed in the home are covered.

4. Other medical conditions requiring the use of an infusion of medicine from a FDA-approved EIP may be cost shared when medical review determines the treatment to be medically necessary and generally accepted medical practice.

Examples of covered medical conditions requiring the use of FDA-approved EIPs.

a. Cancer chemotherapy agents.

b. Morphine when used in the treatment of intractable pain.

c. Desferoxamine.

d. Insulin: only when the diagnosis is insulin dependent Type 1 diabetes mellitus and there is documentation by the physician of poor diabetic control.

e. Antibiotic therapy.

f. Heparin therapy in treatment of thromboemobolic disease.

5. EIPs are cost shared as Durable Medical Equipment (DME). (See the TRICARE Reimbursement Manual (TRM), Chapter 1, Section 11 for more information on reimbursement of DME.)

B. Implantable Infusion Pump (IIP)

Claims may be reimbursed for services and supplies related to the use of medically necessary, FDA-approved IIPs when used according to pump label specifications. This may include but is not limited to implantation, refilling, servicing, maintenance, and removal of the pump and/or accessories. Uses may include but are not limited to the following (please note "EXCEPTIONS" and "EFFECTIVE DATES" listed below):

1. Treatment of primary liver cancer or metastatic colorectal liver cancer where the metastases are limited to the liver with continuous hepatic artery infusions of chemotherapeutic agents (e.g., floxuridine, doxorubicin hydrochloride, cisplatin, methotrexate, with bacteriostatic water or physiologic saline and/or heparin);

2. Treatment of osteomyelitis with administration of antibiotics (e.g., clindamycin);

3. Treatment of chronic intractable pain of malignant or nonmalignant origin by administration of opioid drugs (e.g., morphine) intrathecally or epidurally in patients who have a life expectancy of at least 3 months and who have not responded to less invasive

medical therapy. Documentation of the following must be provided in order for TRICARE to consider a claim for payment:

a. Inadequate response to noninvasive methods of pain management such as systemic opioids, including attempts to eliminate physical and behavioral abnormalities which may cause an exaggerated reaction to pain, and

b. A preliminary trial of intraspinal opioid with a temporary intrathecal/ epidural catheter to evaluate pain relief, side effects, and patient acceptance.

4. Treatment of chronic intractable spasticity with administration of anti-spasmodic drugs (e.g., baclofen) in patients who have proven unresponsive to less invasive medical therapy. The following must be provided in order to consider a claim for payment:

a. Documentation of inadequate control of spasticity or intolerable side effects resulting from at least a 6-week trial of noninvasive methods of spasm control with drugs such as oral antispasmodics alone or combined with anticonvulsants (depending on the disease progression and the patient' symptoms), and

b. Documentation of a favorable response to a trial intrathecal dose of the antispasmodic drug prior to pump implantation;

5. Second level review is required for all other IIP uses. Reimbursement may be considered for other uses of IIPs (not specifically excluded in "EXCEPTIONS" below) with documentation of the following:

a. The medical necessity of the drug;

b. The medical necessity and appropriateness of an IIP to deliver the drug; and

c. The IIP use adheres to the FDA-approved labeling for the pump and the drug.

V. POLICY CONSIDERATIONS

A. FDA-approved IIPs are labeled for specific drugs and routes of administration, e.g., intravenous fluorouracil (5-FU), intra-arterial floxuridine, epidural morphine sulfate, intrathecal morphine sulfate, and intrathecal baclofen. Payments of claims may be considered for IIPs used according to label specifications.

B. Reimbursement will follow the appropriate methodology for the place where the services are delivered, i.e., services provided in a hospital will be reimbursed according to the appropriate inpatient reimbursement methodology; reimbursement for physician's office services will follow appropriate outpatient reimbursement procedures. When the implantation is performed on an inpatient basis, charges for the pump and the related equipment, supplies, and drugs will be included in the hospital charges. If services performed in the physician's office are primarily for maintenance and refilling of the infusion system, reimbursement is limited to the charges for the maintenance and refilling services; no allowance may be made for an office visit.

C. In addition to IIPs, implanted access ports and pulsatile pumps forming a self-sealing patent access portal for the administration of intravenous medications (e.g., Port-a cath, Medi-port and Infusiport systems) may be cost-shared. These systems are distinguished from IIPs by the method of controlling the drug delivery rate. Access ports deliver drugs by passive diffusion. Pulsatile pumps deliver drugs when the patient manually compresses the device. Drug delivery rates in IIPs are controlled by vapor pressure or by direct electromechanical action.

VI. EXCLUSIONS

A. TRICARE currently classifies the use of implantable infusion pumps in the treatment of thromboembolic disease and diabetes as unproven. TRICARE may not, therefore, reimburse charges for the use of IIPs for these indications.

B. IIP labels include specific contraindications. Claims for IIPs and related services and supplies for pumps not used in accordance with FDA-approved label specifications may not be reimbursed.

VII. EFFECTIVE DATES

A. Chemotherapy for malignancies: March 14, 1988

B. Antibiotics for osteomyelitis: February 2, 1989

C. Opioids for chronic intractable pain of malignant origin: July 25, 1991

D. Opioids for chronic intractable pain of nonmalignant origin: October 28, 1991

E. Antispasmodics for chronic intractable spasticity: August 12, 1992

- END -

CHAPTER 8
SECTION 13.2

DENTAL ANESTHESIA AND INSTITUTIONAL BENEFIT

ISSUE DATE: May 23, 2007
AUTHORITY: 32 CFR 199.4(e)(10)

I. BACKGROUND

Section 702 of the John Warner National Defense Authorization Act for Fiscal Year 2007, (NDAA-07), Public Law 109-364, amended paragraph (1) of section 1079(a) of title 10, United States Code and provided that "in connection with dental treatment for patients with developmental, mental, or physical disabilities or for pediatric patients age five or under, only institutional and anesthesia services may be provided". The NDAA-07 was signed into law on October 17, 2006

II. POLICY

A. Medically necessary institutional and general anesthesia services may be covered in conjunction with non-covered or non-adjunctive dental treatment for patients with developmental, mental, or physical disabilities or for pediatric patients age five or under. Also, see Section 13.1, paragraph B., on additional hospital services benefit.

B. Patients with diagnosed developmental, mental, or physical disabilities are those patients with conditions that prohibit dental treatment in a safe and effective manner. Therefore, it is medically or psychologically necessary for these patients to require general anesthesia for dental treatment.

C. The general anesthesia cannot be performed by the attending dentist, but rather must be administered by a separate anesthesiology provider.

D. Coverage of institutional services will include institutional benefits associated with both hospital and in-out surgery settings.

E. Preauthorization is required for above outpatient care or inpatient stays to be covered in the same manner as required for adjunctive dental care as provided in Section 13.1. No preauthorization will be required for care obtained during the period from October 17, 2006 to the implementation date of this policy.

F. When the Managed Care Support Contractor (MCSC) receives a claim for reimbursement for general anesthesia services in conjunction with dental care that is covered under this section, the MCSC shall check with the appropriate TRICARE dental contractor to determine if the general anesthesia charges have already been covered for claims involving

services during the period October 17, 2006 to the implementation date of this policy. If the general anesthesia services were provided in an institutional or in-out surgery setting, then the MCSC shall advise the sponsor of the right to file a claim for the difference in the amount authorized under TRICARE and the appropriate TRICARE dental plan, as well as the difference in the amount of the anesthesia cost-share under the TRICARE dental plan, and the cost-share the beneficiary has under the TRICARE plan in which they were participating at the time, TRICARE Prime, Standard, or Extra.

III. EXCLUSION

The professional services related to non-adjunctive dental care are not covered with the exception of coverage for general anesthesia services.

IV. EFFECTIVE Date

October 17, 2006.

- END -

E. In overseas areas where there are no managed care support contracts, the Director, TRICARE Area Office or designees are responsible for performing the ECHO registration process as outlined above.

F. The TRICARE Global Remote Overseas (TGRO) health care contractor is not responsible for administering any portion of the ECHO.

G. TRICARE does not charge a fee for registering in the ECHO, however, the sponsor/beneficiary may incur costs associated with the determination of eligibility for the ECHO. For example, the sponsor of a beneficiary who uses TRICARE Standard or Extra to receive diagnostic services that result in a diagnosis that is an ECHO qualifying condition, is liable for all relevant cost-shares associated with receipt of those diagnostic services through TRICARE Standard or Extra. Those cost-shares are not reimbursable under the ECHO. Additionally, TRICARE does not provide separate or additional reimbursement to providers for completion of forms, such as the DD 2792, **Exceptional Family Member Medical Summary**, or for reproducing, copying or transmitting records necessary to register in the ECHO. TRICARE will deny claims for such services.

III. EFFECTIVE DATE September 1, 2005.

- END -

CHAPTER 10
SECTION 4.1

CONTINUED HEALTH CARE BENEFIT PROGRAM (CHCBP)

ISSUE DATE: September 8, 1994
AUTHORITY: Section 4408 of P. L. 102-484, 32 CFR 199.20

I. ISSUE

Establishing eligibility for enrollment in the Continued Health Care Benefit Program (CHCBP) for members of the Uniformed Services who are discharged or released from active duty (or full-time National Guard duty), whether voluntarily or involuntarily as long as not under adverse conditions as characterized by the Secretary concerned, and their family members; emancipated children of a member or former member; and certain unremarried former spouses of a member or former member.

II. BACKGROUND

Implementation of the CHCBP was directed by Congress in section 4408 of the National Defense Authorization Act for Fiscal Year 1993, Public Law 102-484, which amended Title 10, United States Code, by adding Section 1078a. This law directed the implementation of a program of temporary continued health benefits coverage comparable to the health benefits provided for former civilian employees of the Federal government. The CHCBP is a premium based transitional health care coverage program that will be available to qualified beneficiaries. Medical benefits under this program are intended to model the TRICARE Standard Plan, and to provide basic program benefits which TRICARE would provide. The CHCBP is not a part of the TRICARE program; however, it functions under most of the rules and procedures of the TRICARE program.

III. POLICY

A. Eligibility. Enrollment in the CHCBP is open to the following individuals regardless of their place of residence (e.g., overseas or in the United States):

1. Members of the Uniformed Services who:

a. Are discharged or released from active duty (or full-time National Guard duty), whether voluntarily or involuntarily, under other than adverse conditions as characterized by the Secretary concerned;

b. Immediately preceding that discharge or release, were entitled to medical and dental care under a military health care plan--including transitional health care under the

Transitional Assistance Management Program (TAMP) (except in the case of a member discharged or released from full-time National Guard duty);

c. After that discharge or release and any period of transitional health care provided under TAMP would not otherwise be eligible for any benefits under TRICARE; and

2. A person who:

a. Ceases to meet requirements for being considered an unmarried dependent child of a member or former member of the Uniformed Services;

b. On the day before ceasing to meet those requirements, was covered under TRICARE or TAMP as a family member of the member or former member; and

c. Would not otherwise be eligible for any benefits under TRICARE.

3. A person who:

a. Is an unremarried former spouse of a member or former member of the Uniformed Services (for purposes of this program, there is no minimum time requirement regarding the length of time the former spouse was married to the member or former member);

b. On the day before the date of the final decree of divorce, dissolution, or annulment was covered under a health benefits plan under TRICARE or TAMP as a family member of the member or former member; and,

c. Is not eligible for TRICARE as a former spouse of a member or former member.

4. An unmarried person who:

a. Is placed in the legal custody of a member or former member as a result of a court order or by an adoption agency recognized by the Secretary of Defense or by any other source authorized by state or local law to provide adoption placement for a period of at least 12 consecutive months; and

b. Meets paragraph III.A.4.b.(1), (2), or (3) below:

(1) Has not attained the age of 21;

(2) Has not attained the age of 23 and is enrolled in a full time course of study at an institution of higher learning; or

(3) Is incapable of self-support because of a mental or physical incapacity. This incapacity must have occurred while the person was considered a family member of the member or former member under paragraph III.A.4.b.(1) or (2) above; and

c. Is dependent on the member or former member for over one-half of the person's support; and

d. Resides with the member or former member unless separated by the necessity of military service or to receive institutional care as a result of disability or incapacitation; and

e. Is not a family member of a member or a former member under any other subparagraph.

B. Notification of Eligibility.

1. The Department of Defense will notify persons eligible to receive health benefits under the CHCBP.

2. In the case of a member who becomes (or will become) eligible for continued coverage, the member shall be notified of their rights for CHCBP coverage as part of pre-separation counseling.

3. In the case of a child of a member or former member who becomes eligible for continued coverage:

a. The member or former member may submit to the CHCBP contractor a notice of the child's change in status (including the child's name, address, and such other information needed); and

b. The CHCBP contractor, within 14 days after receiving such information, will inform the child of the child's rights under the CHCBP.

4. In the case of a former spouse of a member or former member who becomes eligible for continued coverage, the CHCBP contractor will notify the former spouse of eligibility for CHCBP when the contractor becomes aware of the change in marital status.

5. In the case of a family member who is placed in the legal custody of a member or former member:

a. The member or former member may submit to the CHCBP contractor a notice of the family member's status (including the family member's name, address, date placed in legal custody, and such other information needed); and

b. The CHCBP contractor, within 14 days after receiving such information, will inform the member or former member of the family member's rights under the CHCBP.

C. Election of Coverage.

1. In order to obtain continued coverage, written election by an eligible beneficiary must be submitted to the CHCBP contractor before the end of the 60-day period beginning on the later of:

a. Date of discharge or release from active duty or full-time National Guard duty;

b. The date on which the period of transitional health care applicable to the member under TAMP ends;

c. The day after the one-year period of TRICARE coverage for former spouses ends;

d. The day after the date the beneficiary loses eligibility for care under the Military Health System.

e. The date the beneficiary receives notification of eligibility. This date will correspond to the date of brochures, newsletters, etc., of which the beneficiaries are expected to be aware.

f. The date the family member is placed in the legal custody of a member or former member.

2. A member of the Uniformed Services who is eligible for enrollment may elect self-only or family coverage. Family members who may be included in such family coverage are the spouse and children of the member.

D. Enrollment.

1. General. In order to enroll in the CHCBP, an eligible individual must submit a CHCBP enrollment application to the CHCBP contractor. The name and address of the CHCBP contractor will be extensively publicized and is available through TRICARE Service Centers, DoD transition offices, military medical treatment facilities (MTFs), other DoD entities and Uniformed Services which provide information regarding TRICARE.

2. Application. Applicants for enrollment in CHCBP are required to use DD Form 2837, Continued Health Care Benefit Program (CHCBP) Application. DD Form 2837 is available electronically on the web at http://www.dior.whs.mil/icdhome/forms.htm, through the TRICARE web site, and through the CHCBP contractor's web site. It is also available in hardcopy from the CHCBP contractor or any of the TRICARE Service Centers. The individual must submit with the application supporting documentation as requested by the CHCBP contractor to validate the individual's eligibility for enrollment in CHCBP.

The application must also include payment for the premium for the first quarter (three months) coverage under the CHCBP. Payment must be by check or money order made out to "The Treasury of the United States" or by credit card. The exact amount of the premium is shown on the enrollment application form and is also available from the CHCBP contractor or wherever the applicant obtains information regarding the CHCBP.

3. Enrollment Determinations.

a. Verification of Enrollment. Once eligibility for the CHCBP has been verified by the CHCBP contractor, the CHCBP contractor will make the appropriate entries in DEERS

and will notify the applicant of the enrollment approval (or denial) and provide the enrollee with a CHCBP identification card.

b. Family members not identified on DEERS. When a contractor receives a CHCBP claim which includes a family member not identified on DEERS as enrolled, but the sponsor indicates CHCBP coverage, the contractor is to take the following action: If the claim includes a copy of an appropriately marked CHCBP ID card for the beneficiary, the claim is to be processed. If the claim is for a beneficiary who is less than 60 days old, the claim is to be processed, even if no copy of an CHCBP ID card is attached. In all other cases, the claim is to be denied.

c. Disputes Regarding Enrollment. Determination of a person's eligibility as a CHCBP beneficiary is the responsibility of the CHCBP contractor. Disputed questions of fact concerning a beneficiary's eligibility will not be considered an appealable issue, but must be resolved with the appropriate Uniformed Service.

4. Disenrollment in Other Programs. In order to be eligible to enroll in the CHCBP, the beneficiary will be disenrolled from any other managed care programs established or operated under the auspices of the DoD. This will require no action on the beneficiary's part.

E. Period of Coverage.

1. Limits on Coverage Periods. Coverage under the CHCBP varies depending on the category of beneficiary as described below.

a. Members discharged or released from active duty or full-time National Guard duty.

(1) For any member discharged or released from active duty or full-time National Guard duty, whether voluntarily or involuntarily, coverage under the CHCBP is limited to eighteen (18) months from the date the member was first eligible for the CHCBP. That first date of eligibility is either the date the member first ceases to be entitled to care under a military health care plan as an active duty member or the date the member first ceases to be eligible for care under the TAMP, whichever is later.

(2) If a separated active duty member who was enrolled in CHCBP returns to active duty, enrollment in CHCBP will end. At that time, the CHCBP contractor will refund any portion of the member's previously paid premium for any days after CHCBP enrollment ends. If the member subsequently separates from active duty again and reenrolls in CHCBP, the member's period of coverage in CHCBP shall be a full 18 months beginning the date of the most recent separation.

NOTE: If the member elects family coverage, eligibility periods for the family are identical to those for the member.

b. Unmarried dependent child. For an unmarried dependent child of a member or former member, coverage under the CHCBP is limited to 36 months from the date on which the person first ceases to meet the requirements for being considered an unmarried dependent child. However, if the person ceases to meet the requirements for being

considered an unmarried dependent child during a period of continued coverage of the member for self and family members, the person's coverage under the CHCBP ends 36 months after the date the child became ineligible for medical and dental care under a military health care plan or the date the child first ceases to be eligible for care under TAMP, whichever is later.

c. Unremarried former spouse.

(1) For an unremarried former spouse of a member or former member, coverage under the CHCBP is limited to 36 months after the later of:

(a) The date on which the final decree of divorce, dissolution, or annulment occurs; or

(b) The date which is one year after the date of the divorce, dissolution, or annulment, if the former spouse is eligible for one-year transitional coverage under TRICARE.

(c) The date the member became ineligible for medical and dental care under a military health care plan as an active duty member or the date the member first ceases to be eligible for care under TAMP, whichever is later, if the former spouse first meets the requirements for being considered an unremarried former spouse during a period of continued coverage of that member for self and family members.

(2) The limitations described in (1) above do not apply and the length of coverage can be for an unlimited period of time, if the former spouse:

(a) Has not remarried before the age of 55; and

(b) Was enrolled in the CHCBP or Prime as the family member of an involuntarily separated member during the 18-month period before the date of the divorce, dissolution, or annulment; and

(c) Is receiving any portion of the retired or retainer pay of the member or former member or an annuity based on the retired or retainer pay of the member; <u>or</u>

(d) Has a court order for payment of any portion of the retired or retainer pay; <u>or</u>

(e) Has a written agreement (whether voluntary or pursuant to a court order) which provides for an election by the member or former member to provide an annuity to the former spouse.

(3) If an unremarried former spouse who is enrolled in the CHCBP subsequently remarries, enrollment in CHCBP will end as of the date of the marriage. The CHCBP contractor will refund any portion of the former spouse's previously paid premium for any days after CHCBP enrollment ends. Regardless of the period of coverage used by the former spouse, remarriage results in loss of <u>all</u> further eligibility for CHCBP coverage unless

future eligibility can be subsequently established based on the criteria in paragraph III.A. above.

d. Family member placed in the legal custody of a member or former member. For a family member who is placed in the legal custody of a member or former member, coverage under the CHCBP is limited to 36 months from the date on which the person was formally placed in legal custody. If the family member ceases to meet the eligibility criteria in paragraph III.A.4. above prior to the expiration of the 36 months (e.g., is removed from legal custody of the member or former member), eligibility will end as of the date the family member no longer meets the criteria.

2. Beginning of Enrollment. Although beneficiaries have 60 days to enroll in the CHCBP (as described in paragraph III.D. above), the period of coverage must begin on the day after entitlement to a military health care plan (including transitional health care under TAMP) ends but no earlier than October 1, 1994.

F. CHCBP Administration

1. General. Except as provided below, all basic TRICARE benefits and procedures apply to the CHCBP. In addition, any DoD-sponsored preferred provider benefits organization program which provides for reduced cost sharing, etc., such as the TRICARE Extra option, is also available to CHCBP beneficiaries.

2. Exceptions.

a. Eligibility. The CHCBP has unique eligibility requirements as contained in paragraph III.A. above.

b. Nonavailability Statements and Use of MTFs.

(1) Since CHCBP beneficiaries pay premiums for coverage and since they must have lost their eligibility for all other DoD health care benefits in order to be eligible for the CHCBP, there is no requirement that they use any medical facility of the Uniformed Services or that they obtain a nonavailability statement.

(2) CHCBP beneficiaries cannot normally receive treatment in an MTF except due to an emergency situation. When this occurs, payment may be made to the MTF since it meets all of the requirements of an authorized provider.

c. Beneficiary Liability.

(1) For purposes of CHCBP deductible and cost sharing requirements, and catastrophic CAP limits, amounts applicable to the category of beneficiary (active duty or retired) to which the CHCBP enrollee's sponsor last belonged shall continue to apply. Because separating active duty members were not eligible for TRICARE, amounts applicable to family members of active duty members shall apply to this category of enrollee.

(2) Active duty cost-shares shall apply to emancipated children and family members placed in legal custody whose sponsor is an active duty member at the time of

enrollment. If the sponsor retires during the period of enrollment of the emancipated child or family member placed in legal custody, retirees' cost-shares shall apply to the enrollee as of the date of retirement of the sponsor.

(3) Former spouses are responsible for retiree cost-shares just as they are under TRICARE.

(4) Deductible and cost-sharing amounts for the CHCBP must be met independent of TRICARE deductible and cost-sharing amounts. Any deductible and cost-sharing amounts previously paid under TRICARE cannot be carried over to the CHCBP.

d. Special Programs.

(1) Available to CHCBP. TRICARE Extra.

(2) Not Available to CHCBP. The following special TRICARE programs are not available to CHCBP beneficiaries.

(a) Extended Care Health Option (ECHO).

(b) TRICARE Dental Plan.

(c) Supplemental Health Care Program.

(d) TRICARE Enrollment Program (except for TRICARE Extra as noted above).

G. Premiums

1. Rates.

a. General. Premium rates are established by the Assistant Secretary of Defense (Health Affairs) for two rate groups--individual and family. The rates are based on Federal Employee Health Benefit Program employee and agency contributions which would be required for a comparable health benefits plan, plus an administrative fee. The administrative fee, which is not to exceed ten percent of the basic premium amount, is determined based on actual expected administrative costs for administration of the CHCBP. The premium rates may be updated annually and will be published when updated. The rates are also available from the CHCBP contractor.

b. Rate Groups. Members discharged or released from active duty or full-time National Guard duty must select their rate group at the time they enroll--either individual or family. (All other CHCBP enrollees must select the individual option.)

c. Changing Rate Groups. Only those individuals identified in paragraph III.A.1. of this section are eligible to change rate groups.

(1) Family to Individual. After enrollment, the sponsor may change from family to individual at any time by notifying the CHCBP contractor in writing.

(2) Individual to Family. Changes from individual to family may not be made except when one of the following qualifying events has occurred.

(a) The birth of a child;

(b) Marriage of the sponsor;

(c) Legal adoption of a child; or

(d) Placement by a court of a child as a legal ward in the sponsor's home.

(3) If one of the above qualifying events has occurred, the sponsor can change his/her enrollment from individual to family, effective as of the date of the qualifying event, if:

(a) The qualifying event occurred after the beneficiary's enrollment in the CHCBP;

(b) The beneficiary sends a written request to the CHCBP contractor no later than 60 days from the date of the qualifying event (date of birth, date of marriage, etc.);

(c) The written request includes documentation of the qualifying event (a copy of the birth certificate, etc.) and the necessary additional premium. Premiums are to be prorated based on the days of each type of coverage.

2. Payments.

a. Frequency. Premiums are to be paid quarterly to the CHCBP contractor. Payment must be made no later than 30 days after the start of the enrollment quarter.

b. Failure to Make Payments. Failure by enrollees to make a premium payment as required in paragraph III.G.2.a. above will result in denial of continued enrollment in the CHCBP and denial of payment of medical claims for services provided on or after the first day of the quarter for which the premium payment was not paid. Beneficiaries denied continued enrollment due to lack of premium payments will not be allowed to reenroll.

IV. EFFECTIVE DATE October 1, 1994.

FIGURE 10-4.1-1 CHCBP IMPLEMENTING INSTRUCTIONS

Continued Health Care Benefit Program (CHCBP). The CHCBP is a health care program that allows certain groups of Military Health System (MHS) beneficiaries to continue receiving benefits under TRICARE when they lose eligibility for military health care. This temporary health program is supported by premium revenue collected from the enrollees of the program. Effective with the start work date of this contract, the contractor shall provide all services necessary to support the Continued Health Care Benefit Program (CHCBP) as outlined in 32 CFR 199.20. Other references describing the CHCBP that are to be used by the contractor in fulfilling its responsibilities are applicable sections of the TRICARE Policy Manual and TRICARE Operations Manuals and the Federal Registers dated September 30, 1994 (pg. 49817ff), February 11, 1997 (pg. 6225ff), and February 24, 1997 (pg. 8312). The contractor shall perform these functions for CHCBP beneficiaries on a worldwide basis, irrespective of the geographic area in which the beneficiary resides or the area in which health care services are received.

The legislative basis for the program is Section 4408 of the National Defense Authorization Act of 1993 (Public Law 102-484) which revised section 1078 of Title 10 of the U.S. Code. Beneficiaries eligible to purchase the continued health program are described in Title 10, U.S. Code, section 1078a.

As CHCBP is not part of the TRICARE Program, the contractor shall follow the following requirements for those areas in which the CHCBP instructions and processing requirements are different than TRICARE.

1. Validate Eligibility for CHCBP.

Upon receiving a completed enrollment application from a prospective enrollee, the contractor shall validate eligibility on the Defense Enrollment and Eligibility Reporting System (DEERS) and request such other information as may be necessary to validate eligibility for participating in CHCBP. The supporting documentation that the contractor shall request from the applicant differs depending on the category of individual who is applying for enrollment as shown below:

a. Individual sponsor and his/her family: a copy of the DD Form 214, "Certificate of Release or Discharge from Active Duty," or a copy of the sponsor's active duty orders

b. Unremarried former spouse and stepchildren of the sponsor: a copy of the final divorce decree

c. Child who loses military coverage due to marriage: a copy of marriage certificate

d. Child who loses military health coverage on his/her 21st birthday if not a full-time student or on his/her 23rd birthday if a full-time student: a copy of the front and back of military ID card

e. Child who loses military coverage due to college graduation: a copy of college transcript

f. Child who ceases to be a full-time student: a letter from the college stating the student's status

g. Child placed in sponsor's legal custody: a copy of the court order

CHAPTER 10
SECTION 7.1

TRANSITIONAL SURVIVOR STATUS AND SURVIVOR STATUS

ISSUE DATE: September 28, 2006
AUTHORITY: 32 CFR 199.3, Public Law 109-163

I. DESCRIPTION

A. Eligible surviving family members whose sponsor died while on active duty for a period of more than 30 days (to include those who die while on delayed-effective-date active duty orders) may continue their TRICARE eligibility and their status is reflected as either Transitional Survivor or Survivor.

B. Transitional Survivor and Survivor are terms used to reflect the status of certain otherwise eligible TRICARE beneficiaries. The status determines the appropriate payment rate and benefit level used in claims processing. Transitional Survivor status reflects Active Duty Family Member (ADFM) payment rates and provisions. Survivor status reflects retiree payment rates.

C. TRICARE Eligibility rules have priority over the rules that apply to those in Transitional Survivor or Survivor status.

II. BACKGROUND

A. Family members of Active Duty Service Members (ADSMs) who died while on active duty have always been eligible for TRICARE; however, their payment rates/cost-sharing provisions have changed over time. Initially, their cost-sharing provisions were at the retiree payment rate for all care received.

B. Section 707(c) of the National Defense Authorization Act for Fiscal Year 1995 (NDAA FY 1995), Public Law 103-337 provided for two changes.

1. For dependents of active duty members who died while on active duty between January 1, 1993 and October 1, 1993, only care for pre-existing conditions was cost-shared at the active duty dependent payment rate.

2. Effective October 1, 1993, active duty dependent payment rate was limited to a one-year period.

C. Section 704 of the Floyd D. Spence NDAA FY 2001 created a three year period, beginning with the date of death, for health care to be cost shared at the active duty

dependent payment rate. After three years, survivors remained eligible for TRICARE, but at the retiree payment rate. This provision was effective October 30, 2000.

III. POLICY

A. Effective with respect to deaths occurring on or after October 7, 2001, Section 715 of the NDAA FY 2006, Public Law 109-163, extended the time frame that certain eligible dependents (children and unmarried persons) remain in Transitional Survivor status. See paragraph III.B.

B. Time Frames for Transitional Survivor Status.

1. Spouse. Transitional Survivor status is retained for three years from the date of death of the sponsor. After three years, the surviving spouse converts to Survivor status and TRICARE benefits may continue at retiree payment rates and rules.

2. Children and Unmarried Persons (those defined in 10 U.S.C. 1072(2)(D) or (I)) whose sponsor died on or after October 7, 2001. Transitional survivor status ends at age 21 or 23 if enrolled in a full-time course of study in a secondary school or in a full-time course of study in an institution of higher education (subject to the eligibility limitations as described in the NOTE below).

3. Incapacitated Children and Incapacitated Unmarried Persons (those defined in 10 U.S.C. 1072(2)(D) or (I)) whose sponsor died on or after October 7, 2001. Transitional Survivor status (subject to the eligibility limitations as described in the NOTE below) is the greater of:

a. Three years from the sponsor's date of death, **OR**

b. The date on which such dependent attains 21 years of age, **OR**

c. The date on which the dependent attains 23 years of age if enrolled in a full-time course of study in a secondary school or in a full-time course of study in an institution of higher education.

NOTE: A status of Transitional Survivor or Survivor status does not impact eligibility rules. Loss of eligibility as a result of any condition which routinely results in loss of TRICARE eligibility such as reaching age limits, marriage, remarriage, etc. also results in loss of Transitional Survivor/Survivor status. Individuals are considered to be eligible for TRICARE if they are shown as eligible on the Defense Enrollment Eligibility Reporting System (DEERS). The DEERS record will indicate the dates of eligibility and the status.

C. Actions necessary due to Section 715 of the NDAA FY 2006.

1. Status Conversion. Dependent children whose sponsor's death occurred on or after October 7, 2001, and who, upon implementation of this policy are:

a. In Transitional Survivor status shall remain in Transitional Survivor status in accordance with time frames found in paragraph III.B. The Transitional Survivor's Health

Care Plan (e.g., Prime, Standard, etc.) shall continue until such time it is changed by the beneficiary.

b. In Survivor status shall have their Transitional Survivor status reinstated and shall remain in Transitional Survivor status in accordance with paragraph III.B. The Health Care Plan (e.g., Prime, Standard, etc.) that the beneficiary was in as a Survivor shall continue to apply and will be carried over when the status is changed to Transitional Survivor until such time the beneficiary elects to choose another plan.

c. In Survivor status and who have since lost TRICARE eligibility shall have their Transitional Survivor status end date changed to the date they lost eligibility for TRICARE. The Health Care Plan (e.g., Prime, Standard, etc.) that the beneficiary was in as a Survivor shall also be applied to the period of Transitional Survivor status.

2. Refunds - General.

a. The contractor shall process refunds of enrollment fees proactively.

b. The contractor shall reprocess claims either based on proactive contact with the beneficiary, upon the beneficiary's request, or when contacted by a beneficiary's parent or legal guardian.

c. The contractor shall confirm the beneficiary's mailing address before mailing any refunds.

d. A letter will be sent to beneficiaries affected by changes found in Section 715, NDAA FY 2006. The letter will advise them of the extended Transitional Survivor time frames and will direct them to contact the contractor for further information. Once contacted by the beneficiary or beneficiary's parent or legal guardian, the contractor shall assist the beneficiary with actions necessary in order to correctly reprocess claims in accordance with this policy.

3. Refunds - Enrollment Fees.

a. Upon contact by a beneficiary, beneficiary's parent, or legal guardian or when the contractor initiates contact with those due a refund of enrollment fees, the contractor shall issue an enrollment fee refund for all individuals described in paragraphs III.C.1.b. and c.

b. Since the Prime Health Care Delivery Plan (HCDP) that the beneficiary was in during the Survivor status shall be carried over and applied during the Transitional Survivor status, refunds are necessary. Refunds shall be:

(1) The difference between Prime enrollment fee for family versus Prime enrollment fee for individual (if a spouse was enrolled) or,

(2) Refund of all applicable enrollment fees (if a spouse was not enrolled).

c. The contractor shall include a written explanation, with any applicable refund of enrollment fees.

4. Refunds - Claims.

a. The contractor shall reprocess claims and issue refunds to the family for those individuals described in paragraphs III.C.1.b. and c. Since the HCDP (e.g., Prime, Standard, etc.) that the beneficiary was in as a Survivor shall be carried over and applied during the Transitional Survivor status, refunds shall be the difference between any retiree payment rates the beneficiary may have paid and the active duty payment rates that now apply. For example, those Survivors who were in TRICARE Standard and had paid retiree cost-shares for covered care may now be entitled to refunds of the difference between Standard retiree cost-shares and active duty dependent cost-shares.

b. Waiver of timely filing. 32 CFR 199.7(d)(2)(i)(A) permits an exception for the timely filing waiver of claims in the event of retroactive eligibility. Consequently, timely filing waivers apply to those whose status is changed from Survivor to Transitional Survivor.

5. Refunds - PFPWD/ECHO.

a. Upon request, contractors shall reprocess Survivor Basic Program claims that otherwise would have been processed as Program For Persons With Disabilities (PFPWD) claims had Transitional Survivor status been in effect at the time the benefit was received and will issue appropriate refunds.

b. Upon request, contractors shall reprocess denied Survivor Basic Program claims that otherwise would have been processed as PFPWD claims had Transitional Survivor status been in effect at the time the benefit was received and will issue appropriate refunds.

c. The contractor shall assist those Transitional Survivors who are otherwise eligible for the Extended Care Health Option (ECHO) to register in ECHO. Contractors will also reprocess claims for services or items that were previously denied and claims for services or items that were not previously submitted because the beneficiary was not eligible for ECHO due to his/her Survivor status at the time such services or items were received by the beneficiary.

d. For the purpose of paragraphs III.C.5.a., b., and c. contractors shall waive the requirement for prior authorization of a PFPWD benefit and the requirement for the "Public Facility Use Certification." For the purpose of paragraph III.C.5.c., contractors shall waive the ECHO requirement that the beneficiary demonstrate enrollment in the Exceptional Family Member Program (EFMP).

e. Claims processing under paragraphs III.C.5.a., b., and c., shall be done in accordance with the claims adjustment policies in effect at the time the claim was originally processed. In no case will reprocessing result in a greater cost share to the sponsor/beneficiary than what was determined when the claims were originally processed.

D. Prime Enrollment.

1. Transitional Survivors shall retain eligibility to enroll in TRICARE Prime, TRICARE Prime Remote Active Duty Family Member (TPRADFM), and TRICARE Overseas

CHAPTER 11
SECTION 3.2

STATE LICENSURE AND CERTIFICATION

ISSUE DATE: September 20, 1990
AUTHORITY: 32 CFR 199.6(c)(2)(i) and (c)(2)(ii)

I. ISSUE

TRICARE/CHAMPUS requirement for state licensure and certification

II. POLICY

A. State Licensure/Certification. Otherwise covered services shall be cost-shared only if the individual professional provider holds a current, valid license or certification to practice his or her profession in the state where the service is rendered. Licensure/certification in a profession other than that for which the provider is seeking authorization is not acceptable. The licensure/certification must be at the full clinical level of practice. Full clinical practice level is defined as an unrestricted license that is not subject to limitations on the scope of practice ordinarily granted all other applicants for similar specialty in the granting jurisdiction. Individuals placed on probation or whose license has otherwise been restricted are not considered to be practicing at the full clinical practice level and do not meet the requirements to be an authorized provider. The services provided must be within the scope of the license, certification, or other legal authorization. Licensure or certification is required to be an authorized provider when offered in the state where the service is rendered, even if such licensure or certification is not required by the state where the service is rendered. Providers who practice in a state where licensure or certification is optional are required to obtain that licensure or certification to become an authorized provider. A temporary professional state license which allows full and unrestricted scope of practice fully satisfies any Individual Professional Provider certification requirement for the period during which the temporary license is valid. The authorized status of the provider expires when the temporary license expires unless the temporary license is renewed or a regular license is issued to the provider.

B. Certified Membership in National or Professional Association that Sets Standards for the Profession. If the state does not offer licensure or certification, the provider must have membership in or certification by (or be eligible to have membership in or certification by) the appropriate national or professional association that sets standards for the specific profession. Associate, provisional, or student membership is not acceptable. Membership or certification must be at the full clinical level. If the provider does not have membership in or certification by the standard setting national or professional association, acceptable proof of eligibility is a letter or other written documentation from the appropriate association stating that the provider meets the requirements to be a member of or certified by the association.

C. Time Period for Obtaining Licensure or Certification. When a new State law is enacted that requires or provides for a certain category of provider to be in possession of licensure or certification, authorized providers must obtain the license as soon as the State begins issuance. A period of time, not to exceed a maximum of 6 months, will be authorized to obtain the license.

- END -

CHAPTER 11
SECTION 3.10

MENTAL HEALTH COUNSELOR

ISSUE DATE: February 24, 1988
AUTHORITY: 32 CFR 199.6(c)(3)(iv)(C)

I. ISSUE

Mental Health Counselor.

II. POLICY

A. Provider Certification. A mental health counselor may provide covered mental health services upon the referral and under the supervision of a physician. The mental health counselor must meet the following criteria:

1. A master's degree in mental health counseling or allied mental health field from a regionally accredited institution; and

2. Two years of post-master's experience which includes 3,000 hours of clinical work and 100 hours of face-to-face supervision; and

3. Licensure or certification as a mental health counselor.

a. If licensure/certification is offered by the jurisdiction in which the provider is practicing, it is required in all cases, even if the jurisdiction offers it on an optional basis.

b. In jurisdictions that do not offer licensure as a mental health counselor, the provider must be eligible for full clinical membership in the American Mental Health Counselor Association (AMHCA); or, be certified (or eligible for certification) as a Certified Clinical Mental Health Counselor (CCMHC) by the Clinical Academy of the National Board of Certified Counselors (NBCC). Information regarding the AMHCA may be found at www.amhca.org. Information regarding the NBCC may be found at www.nbcc.org.

- END -

2. TRICARE approval will lapse if either the number of heart transplants falls below eight in 12 months or if the one-year actuarial survival rate falls below 60% for a consecutive 24-month period.

G. Lung Transplantation. TRICARE shall provide coverage for lung transplantation procedures performed only by experienced transplant surgeons at centers complying with the provisions outlined in paragraph I.B. and the following criteria or status as a TRICARE-certified lung transplantation center may be granted based upon Medicare certification as a lung transplantation center.

1. The center must have:

a. Experts in the fields of cardiology, cardiovascular surgery, pulmonary disease, anesthesiology, immunology, infectious disease, nursing, social services, and organ procurement to complement the transplant team.

b. Performed lung (single and/or double) transplantation in at least 10 patients within the 12 months prior to application and in at least an additional 10 patients prior thereto.

c. Demonstrated Kaplan-Meier actuarial survival rates of no less than 65% at one-year post-transplantation for patients who have undergone lung transplantation at the center since January 1, 1987.

H. Heart-Lung and Lung Transplantation. TRICARE shall provide coverage for heart-lung transplantation procedures performed only by experienced transplant surgeons at centers complying with the provisions outlined in paragraph I.B. and meeting either the heart or lung transplantation criteria or performed in a Medicare-certified heart, lung or heart-lung transplant center.

I. Small Intestine (SI), Combined Small Intestine-Liver (SI/L), and Multivisceral Transplantation.

1. TRICARE shall provide coverage for SI, SI/L, and multivisceral transplantation procedures performed only by experienced transplant surgeons at centers complying with the provisions outlined in paragraph I.B. and meeting the following criterion or status as a TRICARE-certified transplant center may be granted based upon Medicare certification as a small intestine transplant center:

2. Perform 10 SI, SI/L, or multivisceral transplants with a documented Kaplan-Meier actuarial survival rate of no less than 65% at one-year.

J. Simultaneous Pancreas-Kidney (SPK), Pancreas-Transplant-Alone (PTA), and Pancreas-After-Kidney (PAK) Transplantation. TRICARE shall provide coverage for SPK, PTA, and PAK transplantation procedures performed only by experienced transplant surgeons at Medicare-approved renal transplant centers.

K. Combined Liver-Kidney Transplantation (CLKT). If the facility is certified as a TRICARE (or Medicare) certified liver transplant center, the facility may be considered to be a certified center to perform CLKTs.

L. Kidney Transplantation. Kidney transplants must be performed at a Medicare-approved transplant center.

M. Combined Heart-Kidney Transplantation (CHKT). CHKTs must be performed at a center certified by TRICARE or Medicare for heart transplantation and Medicare-approved for renal transplantation.

N. Organ Transplant Consortia. TRICARE shall approve individual pediatric organ transplant centers which meet the General Certification Requirements outlined in paragraph B., and would otherwise qualify as a TRICARE-certified transplantation center by using the combined experience and survival date of a consortium of which a single transplant team rotates among member hospitals for purposes of meeting the certification requirements outlined in paragraphs E. through M., for heart, heart-lung, lung, liver, liver-kidney, heart-kidney, small intestine, small intestine-liver, and multivisceral when:

1. The consortium hospitals are under common control or have a formal affiliation arrangement with each other under the auspices of an organization such as a university or a legally-constituted medical research institute;

2. The consortium hospitals share resources by using the same personnel or services in their transplant programs. The individual physician members of the transplant team practice in all of the hospitals;

3. The same organ procurement organization, immunology, and tissue typing services are used by all the hospitals; and

4. The hospital submits its individual and combined experience and survival data to the TRICARE authorizing authority; and

5. If one of the hospitals is a pediatric transplant program, in addition to the requirements previously listed the following apply:

a. Although pediatric surgeons and pathologists are not required to practice the adult hospital and vice versa, it can be documented that they otherwise function as members of the transplant team.

b. The facility must have other solid organ transplant program(s) that meet TRICARE criteria for certification based on actuarial survival rates and experience.

c. The surgeon responsible for the transplant is commonly involved in the type of surgery (i.e., related to hepatology, cardiology and pulmonary medicine) with children of the age and size in whom the transplant is being performed; and

d. If the program involves heart transplant, the facility must have an active pediatric cardiovascular medical and surgical program with a minimum of 150 cardiac

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