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TRICARE
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6010.54-M
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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: CORRECTION

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): Aug 2002 TPM, Change No. 75 was published in
error. This change will revert the language back to what it was prior to the
publication of Change 75.

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

David E. Bennett
Acting Chief, Office of Medical Benefits
and Reimbursement Systems

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

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DIGESTIVE SYSTEM

ISSUE DATE: August 26, 1985

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

I. CPT¹ PROCEDURE CODES

40490 - 40831, 40899 - 43644, 43651 - 43761, 43800, 43810, 43820, 43842, 43846 43848, 43880, 43999, 44005 - 47362, 47371, 47379, 47381, 47399 - 49999, 91123, 96570, 96571

II. DESCRIPTION

The digestive system involves the organs associated with the ingestion, digestion, and absorption of nutrients, and the elimination of solid waste.

III. POLICY

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

IV. EXCLUSIONS

- A. Vestibuloplasty except for adjunctive care (CPT¹ procedure code range 40840-40845).
- B. Percutaneous interstitial thermal ablation in the treatment of hepatic cancer is unproven.
- C. For bariatric procedures, see [Section 13.2](#).

- END -

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CLINICAL PREVENTIVE SERVICES - TRICARE STANDARD

ISSUE DATE: April 19, 1983

AUTHORITY: [32 CFR 199.4\(e\)\(3\)\(ii\)](#) and [\(g\)\(37\)](#)

I. CPT¹ PROCEDURE CODES

45300 - 45339, 45355 - 45385, 76092, **77058**, 77059, 80061, 82270, 82274, 84153, 86580, 86585, 86762, 87340, 88141 - 88155, 88160 - 88162, 88164 - 88167, 88174, 88175, 90281 - 90396, 99172, 99173, 99201 - 99215, 99381 - 99387, 99391 - 99397

II. HCPCS PROCEDURE CODES

Level II Codes G0104, G0105, G0107, G0121, G0202, G0206

III. BACKGROUND

The National Defense Authorization Act for Fiscal Year (NDAA FY) 1996 (P.L. 104-106, Section 701) signed into effect on February 10, 1996, expands well-baby visits and immunizations to family members under the age of six and establishes immunizations and comprehensive preventive benefits for family members age six and above to include health promotion and disease preventive visits provided in connection with immunizations, Papanicolaou (Pap) smears, and mammograms. The NDAA FY 1997 (P.L. 104-201, Section 701) signed into effect on September 23, 1996, further expands health care preventive services for colon and prostate cancer examinations. Periodic health examinations that include risk assessment, physical examination, laboratory tests, x-rays, and risk specific counseling will allow for the prevention, early detection and treatment of diseases before they manifest themselves as major health problems. Prior to these Acts, preventive services were quite limited. In addition to Pap smears, mammograms, and well-baby care up to the age of two, the only related services authorized under Extra and Standard plans in the absence of symptoms were immunizations for family members accompanying an active duty member on overseas duty. The expanded preventive services will generally be reflective of those currently being offered to Prime enrollees under the Uniform Health Maintenance Organization (HMO) Benefit (see [32 CFR 199.18\(b\)\(2\)](#)), except for the application of appropriate cost-sharing and deductibles under Extra and Standard plans.

While immunizations are provided as a specific exception to the general preventive care exclusion under the Regulation ([32 CFR 199.4\(g\)\(37\)](#)) and can be provided independently of

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other preventive services for those age six and older, the other expanded services (i.e., preventive services reflective of those currently being offered to Prime enrollees under Uniform HMO Benefit) must be provided in connection with immunizations, Pap smears, mammograms, and other cancer screening authorized by 10 U.S.C. 1079. For example, if a eligible female goes in for a routine Pap smear, she is also eligible to receive a wide variety of other preventive services such as tuberculosis screening, rubella antibody screening, blood pressure screening, cholesterol screening test and preventive counseling services, to name a few. However, the same coverage will not be extended if she simply makes an appointment for a routine health promotion visit, where one or more of the associated preventive services (i.e., Pap smear, mammogram, immunization and/or other cancer screening authorized by 10 U.S.C. 1079) are not performed.

Preventive physical examinations (for example, oral cavity examinations for pharyngeal cancer, palpation for thyroid nodules, skin cancer screening, and examinations for testicular cancer) are paid under the same comprehensive health promotion and disease prevention examination office visit code (CPT² procedure codes 99381-99387 and 99391-99397) as the associated Pap smear, mammogram, immunization or other cancer screening examination authorized by 10 U.S.C. 1079. In other words, these additional physical examinations are being performed during the same office visit as required to perform the associated Pap smear, mammogram, immunization or other cancer screening authorized by 10 U.S.C. 1079.

IV. POLICY

Preventive care is not directly related to specific illness, injury, a definitive set of symptoms, or obstetrical care, but rather is performed as a periodic health screening, health assessment, or periodic health maintenance. The following services may be provided during acute and chronic care visits or during preventive care visits for asymptomatic individuals to maintain and promote good health:

A. Health Promotion and Disease Prevention Examinations. The following prevention services are specific exceptions to the general preventive care exclusion under the Regulation. 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:

1. Cancer Screening Examinations and Services.

a. Breast Cancer:

(1) Physical Examination. For women under age 40, physicians may elect to perform clinical breast examination for those who are at high risk, especially those whose first-degree relatives have had breast cancer diagnosed before menopause. For women age 40 and older, annual clinical examinations should be performed.

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(2) X-ray mammography. Mammography is recommended as a routine screening procedure (i.e., performed in the absence of any signs or symptoms of breast disease) when ordered by a physician, or upon self-referral as outlined below for:

(a) An asymptomatic woman over the age of 39, for one screening mammography every 12 months.

(b) An asymptomatic woman 35 years of age for a baseline mammogram and one screening mammogram every 12 months thereafter if the woman is considered to be at high risk of developing breast cancer. Acceptable indicators for high risk are:

- 1 A personal history of breast cancer;
- 2 A personal history of biopsy-proven benign breast disease;
- 3 A mother, sister, or daughter who has had breast cancer;
- 4 Not given birth prior to age 30; or

5 Other acceptable high risk factors as may be recommended by major authorities (e.g., the American Academy of Family Physicians, American Cancer Society, American College of Obstetricians and Gynecologists, American College of Physicians, and U.S. Preventive Services Task Force (USPSTF)).

NOTE: Screening mammography procedures should be billed using CPT³ procedure code 76092 except when performed in connection with other preventive services, in which case a comprehensive health promotion and disease prevention examination office visit code (CPT³ procedure codes 99381-99387 and 99391-99397) should be used.

(c) A 30 day administrative tolerance will be allowed for internal requirements between mammograms; e.g., if an asymptomatic woman 39 years of age or older received a screening mammography on September 15, coverage for another screening mammography would be allowed on or after August 17, of the following year.

(d) The effective date for cancer screening mammography is November 5, 1990.

(3) Breast Magnetic Resonance Imaging (MRI) (CPT³ procedure codes 77058 and 77059). Breast MRI is recommended as an annual screening procedure for asymptomatic women age 35 or older considered to be at high risk of developing breast cancer per the guidelines published by the American Cancer Society (ACS) as follows:

(a) Women with a BRCA1 or BRCA2 gene mutation.

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(b) Women with a first degree relative (parent, child, sibling) with a BRCA1 or BRCA2 mutation, even if untested.

(c) Lifetime risk approximately 20-25% or greater as defined by BRCAPRO or other models that are largely dependent on family history.

(d) History of chest radiation between the ages of 10 and 30.

(e) History of LiFraumeni, Cowden, or Bannayan-Riley-Ruvalcaba syndromes or first degree relative with the syndrome.

(f) The effective date for breast cancer screening MRI is March 1, 2007.

b. Cancer of Female Reproductive Organs.

(1) Physical examination. Pelvic examination should be performed in conjunction with Pap smear testing for cervical neoplasms and premalignant lesions.

(2) Pap smears. Cancer screening Pap tests should be performed for women who are at risk for sexually transmissible diseases, women who have or have had multiple sexual partners (or if their partner has or has had multiple sexual partners), women who smoke cigarettes, and women 18 years of age and older when provided under the terms and conditions contained in the guidelines adopted by the Executive Director, TRICARE Management Activity (TMA). The frequency of the Pap tests will be at the discretion of the patient and clinician but not less frequent than every three years.

(c) Reimbursement for screening Pap smears shall not exceed the reimbursement for the intermediate office level visit except when performed in connection with other preventive services, in which case reimbursement will be allowed for the appropriate comprehensive health promotion and disease prevention examination office visit (CPT⁴ procedure codes 99381-99387 and 99391-99397).

(b) Claims for screening Pap smears which are coded at a level greater than the intermediate level office visit and for which no additional preventive services have been provided will be reimbursed at the allowable charge for either CPT⁴ procedure code 99203 or 99213 using the EOB message: "Charge reimbursed at the intermediate office visit level." Separate charges for the preparation, handling, and collection of the screening cervical Pap test are considered to be an integral part of the routine office examination visit and will not be allowed.

(c) Reimbursement for the cytopathology laboratory procedure associated with screening Pap tests should be billed using CPT⁴ procedure codes 88141-88155, 88164-88167, 88174, and 88175. Reimbursement of these procedures is limited to the total CHAMPUS Maximum Allowable Charge (CMAC) and will only be paid once regardless of whether the attending physician or the laboratory bills for the services.

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(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., CPT⁵ 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 (CPT⁵ 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

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CHAPTER 7, SECTION 2.2

CLINICAL PREVENTIVE SERVICES - TRICARE PRIME

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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CLINICAL PREVENTIVE SERVICES - TRICARE PRIME

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 <i>Morbidity and Mortality Weekly Report</i> (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 -

SPECIAL OTORHINOLARYNGOLOGIC SERVICES

ISSUE DATE: April 19, 1983

AUTHORITY: 32 CFR 199.4(c)(3)(iv), (g)(45), (g)(47), and 32 CFR 199.5(c)

I. CPT¹ PROCEDURE CODES

92502 - 92512, 92516, 92520, 92526, 92551 - 92597, 92601 - 92617, 92626, 92627, 92630, 92633, 92700

II. DESCRIPTION

Otolaryngology is that branch of medicine concerned with the screening, diagnosis and management of medical and surgical disorders of the ear, the upper respiratory and upper alimentary systems and related structures and the head and neck.

Audiology is the discipline involved in the prevention, identification and the evaluation of hearing disorders, the selection and evaluation of hearing aids, and the re-habilitation of individuals with hearing impairment. Audiological services, including function tests, performed to provide medical diagnosis and treatment of the auditory system.

III. POLICY

A. Otorhinolaryngology services, including audiological services are covered for the diagnosis and treatment of a covered medical condition.

B. For services prior to September 1, 2005, hearing aid services and supplies may be cost-shared only for active duty beneficiaries through the basic program.

C. For services on or after September 1, 2005, hearing aid services and supplies may be cost-shared only for Active Duty Family Members (ADFMs) with a profound hearing loss through the TRICARE Basic Program. See Chapter 7, Section 8.2.

D. Diagnostic analysis of cochlear implant with programming is covered for patients under seven years of age (CPT¹ procedure codes 92601, 92602), and age seven years or older with programming (CPT¹ procedure codes 92603, 92604). See Chapter 4, Section 22.2.

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SPECIAL OTORHINOLARYNGOLOGIC SERVICES

E. Evaluation for prescription of non-speech-generating augmentative and alternative communication device, including programming and modification, may be cost-shared only for eligible beneficiaries through the **Extended Care Health Option (ECHO)** on the basis of a speech disability or of multiple disabilities, one of which involves a speech disability (CPT² procedure codes 92605 - 92609).

- END -

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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 FY 2007), 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 FY 2007 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

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CHAPTER 8, SECTION 13.2

DENTAL ANESTHESIA AND INSTITUTIONAL BENEFIT

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 -

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CHAPTER 9, SECTION 15.1

ECHO HOME HEALTH CARE (EHHC)

NOTE: Although CMS periodically publishes updates to the SNF rates during any given fiscal year, those will not be used to calculate the EHHC cap. Only the SNF reimbursement rates in effect on October 1 of each year will be used to calculate the EHHC cap for the fiscal year beginning on that date.

(2) From the “Table 6. RUG-53 Case-Mix Adjusted Federal Rates for Urban SNFs by Labor and Non-Labor Component”, determine the highest cost RUG-III category;

(3) Multiply the labor component obtained in [paragraph VI.H.2.a.\(2\)](#) by the “Table 8. FY 2007 Wage Index for Urban Areas Based on CBSA Labor Market Areas” value corresponding to the beneficiary’s location;

(4) Sum the non-labor component from [paragraph VI.H.2.a.\(2\)](#) and the adjusted labor component from [paragraph VI.H.2.a.\(3\)](#); the result is the beneficiary’s EHHC per diem in that location;

(5) Multiply the per diem obtained in [paragraph VI.H.2.a.\(4\)](#) by 365 (366 in leap year); the result is the beneficiary’s fiscal year cap for EHHC in that location.

(6) For beneficiary’s residing in areas not listed in Table 8, use “Table 7. RUG-53 Case-Mix Adjusted Federal Rates for Rural SNFs by Labor and Non-Labor Component” and “Table 9. FY 2007 Wage Index Based on CBSA Labor Market Areas for Rural Areas” and adjust similarly to [paragraph VI.H.2.a.\(3\)](#) through (5) to determine the EHHC cap for beneficiaries residing in rural areas.

NOTE: See [Chapter 9, Addendum A](#) for an example of the EHHC cap based on the FY 2007 rates published in the **Federal Register** on [July 31, 2006 \(71 FR 43158\)](#).

NOTE: ~~The previous reference to and use of the Benefits Improvement and Protection Act (BIPA) adjustment in this issuance is deleted as of January 1, 2006.~~

b. Beneficiaries who seek EHHC at any time during the fiscal year will have their cap calculated as above and prorated by month for the remaining portion of that fiscal year.

c. The maximum amount reimbursed in any month for EHHC services is the amount authorized in accordance with the approved plan of care and based on the actual number of hours of home health care provided and billed at the allowable charge or the negotiated rate. In no case will the amount reimbursed for any month of EHHC exceed one-twelfth (1/12) of the annual fiscal year cap established under [paragraph VI.H.2.a.](#) and as adjusted for the actual number of days in the month during which the services were provided.

d. Beneficiaries who move will have their cap recalculated to reflect the wage index for their new location. The maximum amount reimbursed in the remaining months of that fiscal year for EHHC services will reflect the re-calculated EHHC cap.

e. The cost for EHHC services does not accrue to the \$2,500 maximum monthly Government cost-share indicated in [Chapter 9, Section 16.1](#).

3. The sponsor's cost-share for EHHC services will be as indicated in [Chapter 9, Section 16.1](#).

l. Transition to EHHC.

1. Following modification of the MCS contracts that incorporates the ECHO, the MCSCs will identify all active duty family members who are currently using, or have used any benefit of the PFPWD within the 12-month period immediately preceding the contract modification. The MCSCs will also identify those active duty family members who are in SNFs.

2. Not less than 60 days prior to the scheduled implementation of the ECHO, the MCSCs will send the government furnished notification and information brochures to all beneficiaries identified in [paragraph VI.I.1](#). The notification announces the conversion of the PFPWD to the ECHO and the brochure highlights the benefit structure, the requirements, and the primary points of contact to access the ECHO.

3. Beneficiaries in SNFs will be afforded the opportunity to relocate to a more natural setting, such as in the sponsor's home, or other primary residence as defined herein.

4. MCSCs will assist EHHC-eligible beneficiaries with initiating the ECHO registration process and developing and approving the plan of care.

5. Those homebound beneficiaries whose need for skilled services can be appropriately met by the HHA-PPS (TRM, [Chapter 12](#)) will be required to access that program for such services.

NOTE: Although it is the intent that eligible beneficiaries complete the registration process and all applicable requirements of this issuance by the date of implementation of the ECHO, it is recognized that certain requirements may not be completed at that time. Therefore, to avoid delaying necessary services, those otherwise ECHO-eligible beneficiaries will be granted provisional eligibility status for a period of not more than 90 days following the date of implementation during which EHHC benefits will be authorized and payable. Beneficiaries failing to complete the ECHO registration process and the requirements of this issuance by the end of that 90 day period will be determined ineligible, at which point authorization and Government liability for all ECHO/EHHC benefits will terminate. The Department will not recoup claims paid for ECHO benefits provided during the provisional period.

6. Following implementation of the ECHO, the MCSCs will make available the Government furnished information brochures to beneficiaries seeking information about or access to the ECHO.

VII. EXCLUSIONS

A. Basic program and the ECHO Respite Care benefit (see [Chapter 9, Section 12.1](#)).

B. EHHC services will not be provided outside the beneficiary's primary residence.

TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 9, SECTION 15.1

ECHO HOME HEALTH CARE (EHHC)

C. EHHC respite care services are not available for the purpose of covering primary caregiver(s) absences due to deployment, employment, seeking employment, or to pursue education.

D. EHHC services and supplies can be provided only to the eligible beneficiary, that is, such services will not be provided to or on behalf of other members of the beneficiary's family nor other individuals who reside in or are visiting in the beneficiary's primary residence.

E. EHHC services and supplies are excluded from those who are being provided continuing coverage of home health care as participants of the former Individual Case Management Program for Persons with Extraordinary Conditions (ICMP-PEC) or previous case management demonstrations.

VIII. EFFECTIVE DATE September 1, 2005.

- END -

ECHO HOME HEALTH CARE (EHHC) BENEFIT

The following example illustrates the process of calculating the maximum fiscal year benefit for ECHO Home Health Care (EHHC) as described in [Chapter 9, Section 15.1, paragraph VI.H.](#)

This example is based on the Fiscal Year 2007 rates for the Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities-[Update-Notice](#), published by the Centers for Medicare and Medicaid Services (CMS) in the [Federal Register](#) on [July 31, 2006](#) (71 FR 43158).

STEP	DESCRIPTION	URBAN ¹	RURAL ²
1	Tables 6 and 7 Highest RUG-III Category	RUX	RUX
2	Tables 6 and 7 Labor Component of RUX	442.22	462.04
3	Tables 8 and 9 Wage Index	1.5819	1.1709
4	Adjusted Labor Component (Step 2 x Step 3)	699.55	541.00
5	Tables 6 and 7 Non-Labor Component	140.88	147.20
6	Total RUX Daily Rate (Step 4 + Step 5)	840.43	688.20
7	Total Fiscal Year EHHC Benefit (Step 6 x 365) ³	306,756.95	251,193.00

NOTE: The "BIPA" adjustment shown as "Step 8" in the February 14, 2005, edition of this issuance is deleted from the EHHC Benefit calculation as of January 1, 2006.

¹ Beneficiary resides in **Oakland, CA.**

² Beneficiary resides in rural **Connecticut.**

³ 366 in Leap Year.

- END -

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.

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CHAPTER 11, SECTION 3.2

STATE LICENSURE AND CERTIFICATION

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 -

2. If ADFMs are allowed to relocate under the sponsor's PCS orders, in accordance with JFTR U5222, or Noncombatant Evacuation Orders without the sponsor to an OCONUS location supported by TOP Prime or TGRO, then the ADFMs will be eligible for enrollment in the overseas program consistent with their orders.

3. If ADFMs are currently enrolled in TOP Prime or TGRO and the family has a newborn or adopts a child, then the new family member will be eligible to enroll in the appropriate overseas program.

4. If the ADFM is a transitional survivor, that individual may remain enrolled in TOP Prime for the duration specified for transitional survivor benefits.

B. Those ADFMs who choose to reside overseas but are not Command Sponsored as defined in the JFTR, and who do not meet any of the exceptions listed above, will remain eligible for TRICARE Standard, TRICARE Plus, or space-available care when and where it is available.

C. Retirees and their family members are not eligible for the TOP Prime.

VIII. OTHER TOP BENEFITS

A. The TOP benefit package includes a limited mail service pharmacy program. The TRICARE Mail Order Pharmacy (TMOP) may be used by all TOP beneficiaries provided certain criteria are met, such as a U.S. credentialed provider to write the prescription and a U.S. ZIP coded address to ship to (APO, FPO, or Diplomatic Pouch Mail). Additionally, ADSMs or ADFMs assigned to overseas U.S. Embassies/State Departments may also use the TMOP. TOP beneficiaries who are covered by other health insurance (OHI) with a prescription drug benefit may not use TMOP unless the OHI plan does not cover the medication needed, or the OHI coverage limit has been met. The TMOP cannot ship drugs which must be refrigerated (e.g., insulin) to an overseas address. Drugs purchased by TOP eligible beneficiaries at overseas embassies may not be covered under TRICARE/TOP.

B. The TRICARE retail network pharmacy benefit is available overseas only in Puerto Rico, the U.S. Virgin Islands, and Guam.

IX. ADMINISTRATIVE AND EFFECTIVE DATES

Definitions of administrative and effective dates related to TOP policy or program changes are identical to TRICARE and may be located in this manual in the INTRODUCTION section.

X. TOP BENEFIT POLICY (Chapter 12, [Sections 2.1](#) and [2.2](#))

TOP benefit policy applies to the scope of services and items which may be considered for coverage by TRICARE within the intent of [32 CFR 199.4](#) and [199.5](#) in addition to allowing for the significant cultural differences unique to foreign countries and their health care practices/services when the procedure is determined to be "appropriate medical care" and is "medically or psychologically necessary" and is not unproven as defined in 32 CFR 199, and the TPM does not explicitly exclude or limit coverage of the service or supply. While

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CHAPTER 12, SECTION 1.1

INTRODUCTION

appropriate medical care references the norm for medical practice in the U.S. the TOP gives consideration to the significant culture differences unique to foreign countries.

XI. TOP PROGRAM POLICY (Chapter 12, [Sections 2.3 - 12.2](#))

A. TOP policy applies to beneficiary eligibility, provider eligibility, claims adjudication, claims payment and quality assurance. TOP Program policy implementation instructions are found in the TOM and TSM and shall be used by the overseas claims processing contractor and overseas TAO Directors, to the extent possible, unless otherwise specifically stated in this chapter or in the appropriate overseas claims processing contract.

B. The TOP policy provides the methodology for paying/allowing TOP services and items rendered by host nation authorized providers. These methods allow the overseas claims processing contractor to approve and pay for specific examples of overseas services or items which are not explicitly addressed in the TRICARE manuals.

C. Refer to [Chapter 12, Section 11.1](#) for TOP claims payment and processing procedures.

D. Refer to the TOM, [Appendix A](#) for a list of Acronyms and Definitions used in this chapter.

- END -

CLINICAL PREVENTIVE SERVICES (PRIME/STANDARD)

ISSUE DATE: September 20, 1996

AUTHORITY: [32 CFR 199.17](#)

I. POLICY

A. See Chapter 7, [Sections 2.1](#) and [2.2](#), for **listing of** TRICARE Overseas Program (TOP) (Prime/Standard) clinical preventative services.

B. Generally, for overseas enrolled beneficiaries there is no preauthorization or referral required for the TOP Prime clinical preventative services. However, Active Duty Service Member (ADSM) preauthorization or referral requirements for clinical preventive services may differ in each overseas region. Regional specific requirements may be obtained by contacting the appropriate overseas TRICARE Area Office (TAO) Director.

C. **There shall be no co-payments for care associated with the individually TRICARE/ TOP reimbursable clinical preventive services.** Verification of codes **are** not required for payment of enhanced services under the TOP. The overseas claims processing contractor does not have to establish additional edits to identify claims within the age, sex, race or clinical history parameters included within the table outlined in Chapter 7, [Sections 2.1](#) and [2.2](#).

- END -

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