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TRICARE
MANAGEMENT ACTIVITY

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

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

CHANGE TITLE: CONSOLIDATED CHANGE ADDRESSING GASTRIC
STIMULATION AND RADIOLOGIC GUIDANCE

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): This change provides the updated language for the
TRICARE Policy Manual to address Gastric Electrical Stimulation Devices and
Radiologic Guidance Services, as well as coverage of Tick Borne Encephalitis
immunizations.

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

Reta Michak
Chief, Office of Medical Benefits
and Reimbursement Branch

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REMOVE PAGE(S)

INSERT PAGE(S)

CHAPTER 2

Table of Contents, page i

★ ★ ★ ★ ★ ★

Table of Contents, page i

Section 8.2 page 1

CHAPTER 4

Section 13.1, page 1

Section 13.1, pages 1 and 2

CHAPTER 5

Table of Contents, page i

★ ★ ★ ★ ★ ★

Table of Contents, page i

Section 2.2 pages 1 and 2

CHAPTER 7

Section 2.1, pages 1 - 4, and 9 - 11

Section 2.1, pages 1 - 4, and 9 - 11

Section 2.2, pages 1 through 7

Section 2.2, pages 1 through 7

Section 8.1, page 1 and 2

Section 8.1, pages 1 and 2

CHAPTER 8

Section 13.2, pages 1 and 2

Section 13.2, pages 1 and 2

CHAPTER 9

Section 15.1, pages 23 through 25

Section 15.1, pages 23 through 25

Addendum A, page 1

Addendum A, page 1

CHAPTER 11

Section 3.2, pages 1 and 2

Section 3.2, pages 1 and 2

CHAPTER 12

Section 1.1, pages 7 and 8

Section 1.1, pages 7 and 8

Section 2.2, page 1

Section 2.2, page 1

INDEX

pages 1, 2, 21, and 22

pages 1, 2, 21, and 22

EVALUATION AND MANAGEMENT

SECTION	SUBJECT
1.1	Office Visits
1.2	Office Visits With Surgery
2.1	Home Services
3.1	Hospital Care
3.2	Inpatient Concurrent Care
3.3	Outpatient Observation Stays
4.1	Nursing Facility Visits
6.1	Emergency Department (ED) Services
6.2	Neonatal And Pediatric Critical Care Services
8.1	Consultations
8.2	Anticoagulant Management
9.1	Patient Transport
10.1	Physician Standby Charges

ANTICOAGULANT MANAGEMENT

ISSUE DATE: August 25, 2008

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

I. CPT¹ PROCEDURE CODES

99363 - 99364

II. DESCRIPTION

Anticoagulant services are intended to describe the outpatient management of Warfarin therapy, including ordering, review, and interpretation of International Normalized Ratio (INR) testing, communication with patient, and dosage adjustments as appropriate.

III. POLICY

Outpatient anticoagulation management (CPT¹ procedure codes 99363 and 99364) for patients receiving long-term anticoagulant therapy (e.g., Warfarin) in the office or outpatient setting may be considered for cost-sharing.

- END -

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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, 43647, 43648, 43651 - 43761, 43800, 43810, 43820, 43842, 43846, 43848, 43880 - 43882, 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

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

B. Gastric electrical stimulation (CPT¹ procedure codes 43647, 43648, 43881, and 43882) for treatment of symptoms of nausea and vomiting from chronic gastroparesis that is refractory to medical management may be considered for coverage as a Humanitarian Use Device (HUD).

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. The Stretta System (Curon Medical, Sunnyvale, CA) and Bard Endoscopic Suturing System for the treatment of refractory gastroesophageal reflux disease (GERD) is unproven (CPT¹ procedure codes 43201 and 43257).

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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 4, SECTION 13.1

DIGESTIVE SYSTEM

D. For bariatric procedures, see [Section 13.2](#).

- END -

RADIOLOGY

SECTION	SUBJECT
1.1	Diagnostic Radiology (Diagnostic Imaging)
2.1	Diagnostic Ultrasound
2.2	Radiologic Guidance
3.1	Radiation Oncology
4.1	Nuclear Medicine
5.1	Thermography

RADIOLOGIC GUIDANCE

ISSUE DATE: January 1, 2007

AUTHORITY: 21 CFR 199.4(b)(c), (e)(14), and 32 CFR 199.6(a)(2)

I. CPT¹ PROCEDURE CODES

Fluoroscopic Guidance: 77001 - 77003

Computed Tomography Guidance: 77011 - 77014

Magnetic Resonance Guidance: 77021 and 77022

Radiologic Other: 77031 and 77032

II. DESCRIPTION

A. Use of a fluoroscopy to examine deep structures by means of x-ray; it consists of a fluorescent screen covered with crystals of calcium tungstate on which are projected the shadows of x-rays passing through the body placed between the screen and the source of radiation.

B. Fluoroscopic guidance (CPT¹ procedure code 77001) for central venous placement, replacement or removal may be considered for cost-sharing. Fluoroscopic guidance (CPT¹ procedure code 77002) for needle placement (e.g., biopsy, aspiration, injection, localization device) may be considered for cost-sharing. Fluoroscopic guidance (CPT¹ procedure code 77003) and localization of needle or catheter tip for spine or paraspinal diagnostic or therapeutic injection procedures may be considered for cost-sharing.

C. Computed tomography guidance (CPT¹ procedure code 77011) for stereotactic localization, for guidance of needle placement (CPT¹ procedure code 77012); for guidance and monitoring of parenchymal tissue ablation (CPT¹ procedure code 77013); for guidance for placement of radiation therapy field (CPT¹ procedure code 77014) may be considered for cost-sharing.

D. Magnetic resonance guidance for needle placement (CPT¹ procedure code 77021); for guidance and monitoring of parenchymal tissue ablation (CPT¹ procedure code 77022) may be considered for cost-sharing.

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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 5, SECTION 2.2

RADIOLOGIC GUIDANCE

E. Stereotactic localization guidance for breast biopsy or needle placement (CPT² procedure code 77031) may be considered for cost-sharing.

F. Mammographic guidance for needle placement for wire localization or for injection, breast may be considered for cost-sharing (CPT² procedure code 77032).

- 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, [77052](#), [77057](#) - 77059, 80061, 82270, 82274, 84153, 86580, 86762, 87340, 88141 - 88155, 88160 - 88162, 88164 - 88167, 88174, 88175, 90281 - 90396, 99172, 99173, 99201 - 99215, 99381 - 99387, 99391 - 99397

II. HCPCS AND TEMPORARY PROCEDURE CODES

A. Level II Codes G0008 - G0010, G0104, G0105, G0121, G0202

B. Level III Codes 0066T, 0067T - Specific criteria must be met for coverage of these codes. See [paragraph IV.A.1.c\(5\)](#) for coverage criteria.

III. BACKGROUND

A. 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.

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B. 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 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.

C. 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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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 7, SECTION 2.1

CLINICAL PREVENTIVE SERVICES - TRICARE STANDARD

(2) X-ray mammography. Mammography (CPT³ procedure codes 77052 and 77057) 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 77057 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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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 7, SECTION 2.1

CLINICAL PREVENTIVE SERVICES - TRICARE STANDARD

(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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(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., 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.

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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 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. **A lipid panel** at least once every five years, beginning age 18.

TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 7, SECTION 2.1

CLINICAL PREVENTIVE SERVICES - TRICARE STANDARD

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 -

CLINICAL PREVENTIVE SERVICES - TRICARE PRIME

ISSUE DATE: May 15, 1996

AUTHORITY: [32 CFR 199.17](#)

I. POLICY

A. TRICARE Prime enrollees may receive Prime Clinical Preventive Services from any network provider without referral, authorization, or preauthorization from the Primary Care Manager (PCM), or any other authority. If a Prime Clinical Preventive Service is not available from a network provider (e.g., a network provider is not available within prescribed access parameters), an enrollee may receive the service from a non-network provider with a referral from the PCM and authorization from the contractor. If an enrollee uses a non-network provider without first obtaining a referral from the PCM and authorization from the Health Care Finder (HCF) payment is made under the Point of Service (POS) option only for services that are otherwise covered under TRICARE Standard. Payment will not be made under the POS option for clinical preventive services that are not otherwise covered under TRICARE Standard.

B. There shall be no co-payments associated with the individually TRICARE reimbursable services listed below. The contractor shall apply all appropriate claims processing and rebundling edits before determining if the below listed CPT procedure code is individually reimbursable. The contractor need not establish additional edits to identify claims within the age, sex, race or clinical history perimeters included below. However, a 30 day administrative tolerance will be allowed for any time interval requirements imposed on screening mammographies and Pap smears; e.g., if an asymptomatic woman 50 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.

SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT PROCEDURE CODE
SCREENING EXAMINATIONS:		
COMPREHENSIVE HEALTH PROMOTION AND DISEASE PREVENTION EXAMINATIONS	For ages 24 months or older: One comprehensive disease prevention clinical evaluation and follow up during age intervals: 2-4; 5-11; 12-17; 18-39; 40-64.	CPT ¹ codes 99382-99386 and 99392-99396.
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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 7, SECTION 2.2

CLINICAL PREVENTIVE SERVICES - TRICARE PRIME

SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT PROCEDURE CODE
TARGETED HEALTH PROMOTION AND DISEASE PREVENTION EXAMINATIONS	The following screening examinations may be performed during either the above periodic comprehensive health promotion examination or as part of other patient encounters. The intent is to maximize preventive care.	
School Physicals:	Physical Examinations: 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.	CPT ¹ codes 99201-99205*, 99211-99214*, 99383, and 99393.
	* Standard office visit evaluation and management CPT ¹ procedure codes (i.e., 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 ¹ procedure codes 99383 and 99393).	
Breast Cancer:	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.	See appropriate level evaluation and management codes.
	Mammography: Annual screening mammograms for women over age 39; For high risk women (family history of breast cancer in a first degree relative), baseline mammogram age 35, then annually.	CPT ¹ codes 77052 and 77057 HCPCS codes G0202, G0204, and G0206.
	Magnetic Resonance Imaging (MRI): Annual screening breast MRI for asymptomatic women age 30 or older considered to be at high risk of developing breast cancer per the guidelines of the American Cancer Society (ACS) as follows: 1) Women with a BRCA1 or BRCA2 gene mutation; 2) Women with a first degree relative (parent, child, sibling) with a BRCA1 or BRCA2 mutation, even if untested; 3) Lifetime risk approximately 20-25% or greater as defined by BRCAPRO or other models that are largely dependent on family history; 4) History of chest radiation between the ages of 10 and 30;	CPT ¹ codes 77058 and 77059.
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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 7, SECTION 2.2

CLINICAL PREVENTIVE SERVICES - TRICARE PRIME

SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT PROCEDURE CODE
Breast Cancer (Continued):	Magnetic Resonance Imaging (MRI) (Continued): 5) History of LiFraumeni, Cowden, or Bannayan-Riley-Ruvalcaba syndromes or first degree relative with the syndrome. The effective date for breast cancer screening MRI is March 1, 2007.	
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 (PAP) 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.	CPT ¹ codes 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.	CPT ¹ code 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.

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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 7, SECTION 2.2

CLINICAL PREVENTIVE SERVICES - TRICARE PRIME

SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT PROCEDURE CODE
Colorectal Cancer (Continued):	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.	CPT ¹ codes 82270 and 82274.
	Proctosigmoidoscopy or Sigmoidoscopy: Once every three to five years beginning at age 50.	CPT ¹ codes 45300-45321, 45327, and 45330-45339. HCPCS code G0104.
	Optical (Conventional) Colonoscopy for Individuals at <u>Average Risk</u> 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. Optical (Conventional) Colonoscopy for Individuals at <u>Increased Risk</u> 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.	CPT ¹ codes 45355 and 45378-45385. HCPCS codes G0105 and G0121.

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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 7, SECTION 2.2

CLINICAL PREVENTIVE SERVICES - TRICARE PRIME

SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT PROCEDURE CODE
Colorectal Cancer (Continued):	Computed Tomographic Colonography (CTC) for Individuals in whom an Optical Colonoscopy is Medically Contraindicated or Incomplete: CTC is covered as a colorectal cancer screening ONLY when an optical colonoscopy is medically contraindicated OR cannot be completed due to a known colonic lesion, structural abnormality, or other technical difficulty is encountered that prevents adequate visualization of the entire colon. The effective date for coverage of CTC for this indication is March 15, 2006. CTC is NOT covered as a colorectal cancer screening for any other indication or reason.	CPT ¹ Level III codes 0066T or 0067T.
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.	CPT ¹ codes 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.	CPT ¹ code 86762.
	Hepatitis B Screening: Screen pregnant women for HBsAG during prenatal period.	CPT ¹ code 87340.
Cardiovascular Diseases:	Cholesterol: A lipid panel at least once every five years, beginning age 18.	CPT ¹ code 80061.

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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 7, SECTION 2.2

CLINICAL PREVENTIVE SERVICES - TRICARE PRIME

SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT PROCEDURE CODE
Cardiovascular Diseases (Continued):	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.	CPT ¹ code 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.	CPT ¹ codes 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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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 7, SECTION 2.2

CLINICAL PREVENTIVE SERVICES - TRICARE PRIME

SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT PROCEDURE 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.	CPT ¹ codes 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.	CPT ¹ code 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, 92640, 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. Prior to September 1, 2005, hearing aid services and supplies may be cost-shared only for **eligible** beneficiaries through the **Program for Persons with Disabilities (PPPWD) on the basis of a hearing disability or of multiple disabilities, one of which involves a hearing disability.**

C. On or after September 1, 2005, hearing aid services and supplies may be cost-shared only for Active Duty Family Members (ADFM) 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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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 7, SECTION 8.1

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. **No referrals are required for the above services.** 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

TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 8, SECTION 13.2

DENTAL ANESTHESIA AND INSTITUTIONAL BENEFIT

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 -

TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

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 2008 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 2008 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 2008 rates published in the **Federal Register** on **August 31, 2007 (72 FR 43412)**.

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](#).

I. 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.

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.

TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 9, SECTION 15.1

ECHO HOME HEALTH CARE (EHHC)

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 2008 rates for the Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for Fiscal Year 2008; **Final Rule** published by the Centers for Medicare and Medicaid Services (CMS) in the **Federal Register** on August 31, 2007 (71 FR 43412).

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	422.24	441.19
3	Tables 8 and 9 Wage Index	1.6122	1.1644
4	Adjusted Labor Component (Step 2 x Step 3)	680.71	513.72
5	Tables 6 and 7 Non-Labor Component	179.66	187.71
6	Total RUX Daily Rate (Step 4 + Step 5)	860.40	701.43
7	Total Fiscal Year EHHC Benefit (Step 6 x 365) ³	314,906.40	256,723.38
¹ Beneficiary resides in Santa Cruz, CA. ² Beneficiary resides in rural Massachusetts. 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. 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.

TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

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 -

1. If the ADSM and his/her Command Sponsored ADFM are enrolled in TOP Prime or TGRO and the sponsor is reassigned on unaccompanied orders to a location that does not permit Command Sponsored family members, the family member(s) can remain enrolled at their current TOP Prime or TGRO site, as long as they remain Command Sponsored. If the family member(s) do not relocate elsewhere during the sponsor's PCS move, then the family may remain enrolled in TOP Prime or TGRO for a period based on the length of the sponsor's unaccompanied orders but not to exceed two years. The normal unaccompanied tour is 24 months or fewer.

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.

C. Tick Borne Encephalitis (TBE) is a health concern unique to certain areas of Europe and Asia. Because of this, the TBE vaccine is specifically authorized as a covered service under TOP in endemic areas of Europe and Asia for at-risk ADFMs, retirees, or retiree family members when the vaccine is received from a TRICARE authorized provider. When covered,

the TBE vaccine shall be cost-shared as a clinical preventive service. See Chapter 7, Sections 2.1 and 2.2.

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 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](#) and [Chapter 12, Section 1.1](#), for TRICARE Overseas Program (TOP) (Prime/Standard) clinical **preventive** services.

B. Generally, for overseas enrolled beneficiaries there is no preauthorization or referral required for the TOP Prime clinical **preventive** 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. Verification of codes **is** not required for payment of enhanced services under the TOP. The overseas claims processing contractor **is** not **required** 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 -

INDEX	CHAPTER	SECTION
A		
Abortions	4	18.3
Accreditation	11	3.3
Adjunctive Dental Care	8	13.1
Aeromedical Evacuation Services	12	10.4
Allergy Testing And Treatment	7	14.1
Ambulance Service	8	1.1
In Overseas Locations For TRICARE Prime-Enrolled Active Duty Family Members (ADFM) And Related Services To Other Beneficiaries	12	10.4
Ambulatory Surgery	11	6.1
Ancillary Inpatient Mental Health Services	7	3.11
Anesthesia	3	1.1
Dental	8	13.2
Anesthesiologist Assistant	11	3.4A
Antepartum Services	4	18.2
Anticoagulant Management	2	8.2
Assistant Surgeons	4	4.1
Attention-Deficit/Hyperactivity Disorder	7	3.9
Audiology Services	7	8.1
Auditory System	4	22.1
Augmentative Communication Devices (ACD)	7	23.1

INDEX	CHAPTER	SECTION
B		
Biofeedback	7	4.1
Birthing Centers		
Accreditation	11	11.1
Certification Process	11	11.2
Birthing Centers	11	2.3
Bone Density Studies	5	1.1
	5	2.1
	5	4.1
Brachytherapy	5	3.1
Breast Pumps	8	2.6
Breast Reconstruction As A Result Of A Congenital Anomaly	4	5.6

INDEX	CHAPTER	SECTION
R		
Radiation Oncology	5	3.1
Radiologic Guidance	5	2.2
Rare Diseases	1	3.1
Reduction Mammoplasty For Macromastia	4	5.4
Regional Director Requirements	1	10.1
Rehabilitation - General	7	18.1
Requirements For Documentation Of Treatment In Medical Records	1	5.1
Residential Treatment Center (RTC)		
Care Limitations	7	3.2
Preauthorization Requirements	7	3.4
Resource Sharing	1	11.1
Respiratory System	4	8.1
Routine Physical Examinations	7	2.6

INDEX	CHAPTER	SECTION
S		
Salivary Estriol Test	4	18.1
Sensory Evoked Potentials (SEP)	7	15.2
Services Rendered By Employees Of Authorized Independent Professional Providers	11	10.1
Sexual Dysfunctions, Paraphilias and Gender Identity Disorders	7	1.1
Silicone Or Saline Breast Implant Removal	4	5.5
Simultaneous Pancreas-Kidney Transplantation (SPK)	4	24.7
Single Photon Emission Computed Tomography (SPECT)	5	4.1
Small Intestine (SI) Transplantation	4	24.4
Small Intestine-Liver (SI/L) Transplantation	4	24.4
Special Authorization Requirements	1	7.1
Special Education	9	9.1
Special Otorhinolaryngologic Services	7	8.1
Speech Services	7	7.1
State Licensure And Certification	11	3.2
Stereotactic Radiofrequency Pallidotomy With Microelectrode Mapping For Treatment Of Parkinson's Disease	4	20.2
Thalamotomy	4	20.3
Substance Use Disorders Rehabilitation Facilities (SUDRFs)	7	3.7
Certification Process	11	8.1
Preauthorization Requirements	7	3.5
Surgery For Morbid Obesity	4	13.2
Survivor Status	10	7.1