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TRICARE
MANAGEMENT ACTIVITY

MB&RB

CHANGE 97
6010.54-M
JUNE 11, 2009

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 CHANGES - JANUARY 2009

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): See pages 3 and 4.

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

This change is made in conjunction with Aug 2002 TOM, Change No. 80 and Aug
2002 TRM, Change No. 94.

Reta Michak
Acting Chief, Medical Benefits and
Reimbursement Branch

ATTACHMENT(S): 39 PAGE(S)
DISTRIBUTION: 6010.54-M

REMOVE PAGE(S)

INSERT PAGE(S)

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CHAPTER 4

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Section 5.1, pages 1 and 2

Section 7.1, page 3

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CHAPTER 7

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SUMMARY OF CHANGES

CHAPTER 1

1. Section 1.1. Clarified that service animals are excluded from coverage under the Basic and ECHO programs.

CHAPTER 4

2. Section 5.1. Removed the exclusion of endoscopic thoracic sympathectomy when performed for the treatment of hyperhidrosis.
3. Section 7.1. Removed vestibuloplasty from the exclusion list.
4. Section 9.1. Ventricular assist devices -- paragraphs were reformatted for clarity.
5. Section 13.1. Clarified vestibuloplasty may be allowed as adjunctive dental care for repair of cleft lip/cleft palate, but not when preparing the mouth for dentures.
6. Section 23.1. Reinserted paragraph III.K. that was inadvertently deleted, allowing benefits for Deoxyribonucleic Acid-Human Leucocyte Antigen (DNA-HLA) tissue typing in determining histocompatibility. Removed the exclusion paragraph IV.K., transplant for desmoplastic small round-cell tumor.

CHAPTER 7

7. Section 3.7. Added clarification that outpatient care is covered in both individual and group settings in an authorized hospital or a SUDRF.
8. Section 7.1. Provided the correct regulatory cross-reference for physician supervision for speech therapists. Clarified that speech therapists are not authorized to bill using Evaluation and Management (E&M) codes listed in the Physicians Current Procedural Terminology.

CHAPTER 8

9. Table of Contents. Added Section 18.1.
10. Section 13.1. Clarification of coverage for vestibuloplasty added under adjunctive dental care.
11. Section 18.1. The section for Continuous Passive Motion Devices is inserted back into the manual to show continuous coverage from 1988 until present.

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SUMMARY OF CHANGES (Continued)

CHAPTER 9

12. Section 13.1. Service animals added as an exclusion.

CHAPTER 11

13. Table of Contents. Added the acronym CNM after Section 3.11 subject title.

14. Section 3.11. The American College of Nurse Midwives has been changed to American Midwifery Certification Board (AMCB).

CHAPTER 12

15. Section 8.1. TOP prime active duty family members, clarified to read TOP enrolled active duty family members.

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16. Added Continuous Passive Motion (CPM) Devices; Section 18.1.

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CHAPTER 1, SECTION 1.1

EXCLUSIONS

61. Housekeeping, homemaker, or attendant services, sitter or companion (for exceptions, see [32 CFR 199.4\(e\)\(19\)](#) regarding hospice care) (see the TRICARE Reimbursement Manual, [Chapter 11, Sections 1 and 4.](#)).

62. All services and supplies (including inpatient institutional costs) related to a noncovered condition or treatment, or provided by an unauthorized provider.

63. Personal, comfort, or convenience items, such as beauty and barber services, radio, television, and telephone (for exceptions, see [32 CFR 199.4\(e\)\(19\)](#) regarding hospice care).

NOTE: Admission kits are covered.

64. Services and supplies related to “stop smoking” regimens.

65. Megavitamin psychiatric therapy, orthomolecular psychiatric therapy.

66. All transportation except by ambulance, as specifically provided under [32 CFR 199.4\(d\)](#) and [\(e\)\(5\)](#).

NOTE: Transportation of an ECHO beneficiary to or from a facility or institution to receive authorized ECHO services or items may be cost-shared under [32 CFR 199.5\(c\)\(6\)](#). Transportation of an accompanying medical attendant to ensure the safe transport of the ECHO beneficiary may also be cost-shared (see [Chapter 9, Section 11.1](#)).

67. All travel even though prescribed by a physician and even if its purpose is to obtain medical care, except as specified in [32 CFR 199.4\(a\)\(6\)](#).

NOTE: For the exception for certain Prime travel expenses and non-medical attendants, see [32 CFR 199.17\(p\)\(4\)\(vi\)](#) and the TRICARE Reimbursement Manual, [Chapter 1, Section 30](#).

68. Services and supplies provided by other than a hospital, unless the institution has been approved specifically by TRICARE. Nursing homes, intermediate care facilities, halfway houses, homes for the aged, or institutions of similar purpose are excluded from consideration as approved facilities.

69. Service animals (seeing eye dogs, hearing/handicap assistance dogs, seizure and other detection animals, service monkeys, etc.) are excluded from coverage under the Basic or ECHO programs.

- END -

INTEGUMENTARY SYSTEM

ISSUE DATE: August 26, 1985

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

I. CPT¹ PROCEDURE CODES

10021, 10022, 10040 - 11977, 11981 - 11983, 12001 - 15366, 15570 - 15776, 15840 - 15845, 15851 - 19499, 97601, and 97602

II. DESCRIPTION

Integumentary system pertains to the skin, subcutaneous tissue and areolar tissue.

III. POLICY

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

B. Topical Treatment of Skin Ulcers Caused by Venous Insufficiency. Topical application of Alpigraf by a physician for the treatment of skin ulcers caused by venous insufficiency is a covered benefit. Effective May 26, 1998.

C. Topical Treatment of Diabetic Foot Ulcers. Application of tissue cultured skin grafts for diabetic foot ulcers is a covered benefit. Effective May 8, 2000.

D. Topical Treatment of Diabetic Foot Ulcers. Application of Becaplermine Gel (Regranex) is a covered treatment of lower extremity diabetic neuropathic foot ulcers that extend into the subcutaneous tissue or beyond. Effective December 16, 1997.

IV. EXCLUSIONS

A. Removal of corns or calluses or trimming of toenails and other routine podiatry services, except those required as a result of diagnosed systemic medical disease affecting the lower limbs, such as severe diabetes.

B. Services performed for cosmetic purposes.

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CHAPTER 4, SECTION 5.1

INTEGUMENTARY SYSTEM

C. Subcutaneous hormone (estradiol and/or testosterone) pellet implantation (CPT² procedure code 11980) is unproven. Estradiol pellets are not FDA approved for general use in humans.

D. Xenograft skin for temporary wound closure, trunk, arms, legs, (CPT² procedure codes 15400 and 15401) is unproven.

E. Xenograft skin for temporary wound closure, face, scalp, eyelids, mouth, neck ears, orbits, genitalia, hands, feet and/or multiple digits (CPT² procedure codes 15420 and 15421) is unproven.

F. Acellular xenograft implant (CPT² procedure codes 15430 and 15431) is unproven.

- END -

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CHAPTER 4, SECTION 7.1

ORAL SURGERY

B. Extraction of unerupted or partially erupted, malposed or impacted teeth, with or without the attached follicular or development tissues, are not covered oral surgery procedures except when the care is indicated in preparation for, or as a result of, dental trauma caused by the medically necessary treatment of an injury or illness.

C. Surgical preparation of the mouth for dentures.

D. Mandibular staple implants are not covered because their primary purpose is to prepare the mouth for dentures.

- END -

CARDIOVASCULAR SYSTEM

ISSUE DATE: August 26, 1985

AUTHORITY: 32 CFR 199.4(c)(2) and (c)(3)

I. CPT¹ PROCEDURE CODES

33010 - 33130, 33140, 33141, 33200 - 37183, 37195 - 37785, 92950 - 93272, 93303 - 93581, 93600 - 93745, 93770, 93797 - 93799

II. DESCRIPTION

The cardiovascular system involves the heart and blood vessels, by which blood is pumped and circulated through the body.

III. POLICY

A. Medically necessary services and supplies required in the diagnosis and treatment of illness or injury involving the cardiovascular system are covered.

B. Ventricular Assist Devices (VADs).

1. VADs (external and implantable) are covered if the device is FDA approved and used in accordance with FDA approved indications.

2. VADs as destination therapy (CPT¹ 33979) are covered if they have received approval from the FDA for that purpose and are used according to the FDA-approved labeling instructions. Benefits are authorized when the procedure is performed at a TRICARE-certified heart transplantation center, a TRICARE-certified pediatric consortium heart transplantation center, or a Medicare facility which is approved for VAD implantation as destination therapy, for patients who meet all of the following conditions:

a. The patient has chronic end-stage heart failure (New York Heart Association Class IV end-stage left ventricular failure for at least 90 days with a life expectancy of less than two years).

b. The patient is not a candidate for heart transplantation.

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CARDIOVASCULAR SYSTEM

- c. The patient's Class IV heart failure symptoms have failed to respond to optimal medical management, including a dietary salt restriction, diuretics, digitalis, beta-blockers, and ACE inhibitors (if tolerated) for at least 60 of the last 90 days.
- d. The patient has Left Ventricular Ejection Fraction (LVEF) less than 25%.
- e. The patient has demonstrated functional limitation with a peak oxygen consumption of less than 12 ml/kg/min; or the patient has a continued need for intravenous inotropic therapy owing to symptomatic hypotension, decreasing renal function, or worsening pulmonary congestion.
- f. The patient has the appropriate body size (by device per FDA labeling) to support the VAD implantation.

C. Gamma and beta intracoronary radiotherapy (brachytherapy) is covered for the treatment of in-stent restenosis in native coronary arteries.

D. Transmyocardial Revascularization (TMR) (CPT² procedures codes 33140 and 33141).

1. Coverage is available for patients with stable class III or IV angina which has been found refractory to standard medical therapy, including drug therapy at the maximum tolerated or maximum safe dosages. In addition, the angina symptoms must be caused by areas of the heart not amenable to surgical therapies such as percutaneous transluminal coronary angioplasty, stenting, coronary atherectomy or coronary bypass.

2. Coverage is limited to those uses of the laser used in performing the procedure which have been approved by the FDA for the purpose for which they are being used.

E. TMR as an adjunct to Coronary Artery Bypass Graft (CABG) is covered for patients with documented areas of the myocardium that are not amenable to surgical revascularization due to unsuitable anatomy.

F. FDA approved IDE clinical trials. See [Chapter 8, Section 5.1, paragraph D.](#) and [F.](#) for policy.

G. Endovenous radiofrequency ablation/obliteration (CPT² procedure codes 36475 and 36476) for the treatment of saphenous venous reflux with symptomatic varicose veins is covered when:

1. One of the following indications is present:

a. Persistent symptoms interfering with activities of daily living in spite of conservative/non-surgical management. Symptoms include aching, cramping, burning, itching and/or swelling during activity or after prolonged standing.

b. Significant recurrent attacks of superficial phlebitis.

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- c. Hemorrhage from a ruptured varix.
- d. Ulceration from venous stasis where incompetent varices are a contributing factor.
- e. Symptomatic incompetence of the great or small saphenous veins (symptoms as in [paragraph III.G.1.a.](#)).

2. A trial of conservative, non-operative treatment has failed. This would include mild exercise, avoidance of prolonged immobility, periodic elevation of legs, and compressive stockings.

3. The patient's anatomy is amenable to endovenous ablation.

H. Ambulatory Blood Pressure Monitoring (ABPM) is only covered for beneficiaries with suspected white coat hypertension and is NOT covered for any other uses. The information obtained by ABPM is necessary in order to determine the appropriate medical management of the beneficiary. Suspected white coat hypertension is considered to exist when the following is documented:

- 1. There is no evidence of end-organ damage;
- 2. Office blood pressure greater than 140/90 mm Hg on at least three separate clinic/office visits with two separate measurements made at each visit; and
- 3. At least two blood pressure measurements taken outside the office which are less than 140/90 mm Hg.

l. Pulmonary vein isolation/ablation (CPT³ procedure code 93651) is covered for beneficiaries who meet the guidelines published in the Heart Rhythm Society (HRS)/European Heart Rhythm Association (EHRA)/European Cardiac Arrhythmia Society (ECAS) 2007 Consensus Statement as follows:

- 1. Symptomatic Atrial Fibrillation (AF) refractory or intolerant to at least one Class 1 or 3 antiarrhythmic medication.
- 2. In rare clinical situations, as first line therapy.
- 3. Selected symptomatic patients with heart failure and/or reduced ejection fraction.
- 4. The presence of a Left Atrial (LA) thrombus is a contraindication.

IV. EXCLUSIONS

A. Thermogram; cephalic (CPT³ procedure code 93760); peripheral (CPT³ procedure code 93762) are unproven.

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CARDIOVASCULAR SYSTEM

- B. Percutaneous Myocardial Laser Revascularization (PMR) is unproven.
- C. Cardiomyoplasty (Cardiac Wrap) for treatment of heart failure is unproven.
- D. Minimally Invasive CABG surgery to include Minimally Invasive Direct Coronary Artery Bypass (MIDCAB) and Port Access Coronary Artery Bypass (PACAB) are unproven.
- E. Percutaneous Transluminal Angioplasty (PTA) in the treatment of obstructive lesions of the carotid, vertebral and cerebral arteries is unproven.
- F. Signal-Average Electrocardiography (CPT⁴ procedure code 93278) is unproven.
- G. Primary percutaneous transluminal mechanical thrombectomy (CPT⁴ procedure code 37184) with or without second and all subsequent vessel(s) with the same vascular family (CPT⁴ procedure code 37185) is unproven.
- H. Secondary percutaneous transluminal thrombectomy (CPT⁴ procedure code 37186) is unproven.
- I. Percutaneous transluminal mechanical thrombectomy vein(s) including intraprocedural pharmacological thrombolytic injections and fluroscopic guidance (CPT⁴ procedure code 37187) is unproven.
- J. Percutaneous transluminal mechanical thrombectomy, vein(s) including intraprocedural pharmacological thrombolytic injections and fluroscopic guidance, repeat treatment on subsequent day during course of thrombolytic therapy (CPT⁴ procedure code 37188) is unproven.

V. EFFECTIVE DATES

- A. March 1, 2001, for gamma and beta intracoronary radiotherapy (brachytherapy).
- B. January 1, 2002, for TMR.
- C. October 1, 2003, for ventricular assist devices as destination therapy.
- D. December 1, 2003, for endovenous radiofrequency ablation/obliteration.
- E. January 1, 2005, for ABPM.
- F. January 1, 2007, for pulmonary vein isolation/ablation.

- 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 (CPT¹ procedure code range 40840-40845) EXCEPT for adjunctive dental care ([Chapter 8, Section 13.1](#)).

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

- END -

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CHAPTER 4, SECTION 23.1
HIGH DOSE CHEMOTHERAPY AND STEM CELL TRANSPLANTATION

1. Patients with undifferentiated leukemia, Chronic Myelogenous Leukemia (CML), aplastic anemia, Acute Lymphocytic Leukemia (ALL) or Acute Myelogenous Leukemia (AML), when histocompatible related or unrelated donors are not available, a 3 antigen mismatch is allowed for related donors.

2. For patients under 18 years of age with a relapsed leukemia, when histocompatible related or unrelated donors are not available, parental CD34++ stem cell transplantation with 2-3 antigen mismatch is allowed.

I. Bone marrow, peripheral blood stem cell and umbilical blood stem cell transplantation is a process which includes mobilization, harvesting, and transplant of bone marrow, peripheral blood stem cell, or umbilical cord blood stem cells and the administration of high dose chemotherapy or radiotherapy prior to the actual transplant. When bone marrow, peripheral blood stem cell or umbilical cord blood stem cell transplantation is covered, all necessary steps are included in coverage. When bone marrow, peripheral stem cell, or umbilical cord blood stem cell transplantation is noncovered, none of the steps are covered. The prophylactic harvesting, cryopreservation and storage of bone marrow, peripheral blood stem cells, or umbilical cord blood stem cells when proposed for possible future use is not covered. In the event that the patient expires prior to the stem cell reinfusion being completed, benefits for the harvesting may be allowed.

J. Benefits are allowed for Hepatitis B and pneumococcal vaccines for patients undergoing transplantation.

K. **Benefits may be allowed for Deoxyribonucleic Acid-Human leucocyte Antigen (DNA-HLA) tissue typing in determining histocompatibility.**

L. Charges for stem cell and umbilical cord blood preparation and storage shall be billed through the transplantation facility in the name of the TRICARE patient.

M. Charges for the umbilical cord blood bank may be allowed only for patients who have undergone a covered transplant.

N. Claims for services and supplies related to the HDC and transplant for beneficiaries under the age of 18 will be reimbursed based on billed charges. Claims for HDC and transplant for adult patients, 18 years and older, will be reimbursed under the Diagnostic Related Group (DRG) payment system. Outpatient institutional facility charges will be paid as billed. Professional services are reimbursed under the CHAMPUS Maximum Allowable Charge (CMAC) Methodology.

O. Transportation of the patient by air ambulance may be cost-shared when determined to be medically necessary. Benefits for advanced life support air ambulance (to include attendant) may be preauthorized by the appropriate preauthorizing authority on an individual case basis in conjunction with the preauthorization for the services themselves.

P. In those cases where the beneficiary fails to obtain preauthorization, benefits may be extended if the services or supplies otherwise would qualify for benefits but for the failure to obtain preauthorization. If preauthorization is not received, the appropriate preauthorizing authority is responsible for determining if the patient meets the coverage criteria. Charges for

transplant and transplant-related services provided to TRICARE Prime enrollees who failed to obtain PCM referral and contractor authorization for HDC with ABMT or PSCT will be reimbursed only under Point of Service rules.

IV. EXCLUSIONS

Benefits will not be paid for:

A. HDC with ABMT or Autologous PSCT, Allogeneic BMT or Allogeneic PSCT, with or without HDC, or Allogeneic Umbilical Cord Blood transplantation, with or without HDC, if the patient has a concurrent condition (other existing illness) that would jeopardize the achievement of successful transplantation.

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

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

D. Administration of an unproven immunosuppressant drug that is not FDA approved.

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

F. Transportation of a donor.

G. Allogeneic bone marrow transplantation for treatment of low grade non-Hodgkin's lymphoma is not a benefit.

H. Autologous umbilical cord blood transplantation therapy as this procedure is considered unproven.

I. Allogeneic bone marrow transplantation for neuroblastoma as this procedure is considered unproven.

J. Allogeneic donor bone marrow transplantation (infusion) performed with or after organ transplants for the purpose of increasing tolerance of the organ transplant is considered unproven.

K. HDC with ABMT or PSCT is not covered for treatment of breast cancer.

L. HDC with allogeneic BMT is not a benefit for treatment of Waldenstrom's macroglobulinemia.

M. HDC with stem cell rescue is not a benefit for the treatment of epithelial ovarian cancer.

N. HDC with allogeneic stem cell transplantation is not covered for the treatment of cold agglutinin disease.

○ Donor lymphocyte infusion if not specifically listed as covered in [paragraph III.D.](#) under POLICY above.

○ Immunoablative therapy with bone marrow or peripheral stem cell transplantation is not covered for the treatment of multiple sclerosis

V. EFFECTIVE DATES

A. May 1, 1987, for HDC with ABMT or PSCT for Hodgkin's disease, non-Hodgkin's lymphoma and neuroblastoma.

B. November 1, 1987, for HDC with ABMT or PSCT for acute lymphocytic and nonlymphocytic leukemias.

C. November 1, 1983, for HDC with allogeneic bone marrow transplants using related donors.

D. July 1, 1989, for HDC with allogeneic bone marrow transplants using unrelated donors.

E. July 11, 1996, for HDC with ABMT or PSCT for multiple myeloma.

F. January 1, 1994, for HDC with ABMT and PSCT for Wilms' tumor.

G. January 1, 1995, for allogeneic umbilical cord blood transplants.

H. January 1, 1994, for HDC with ABMT or PSCT for chronic myelogenous leukemia.

I. January 1, 1996, for HDC with ABMT or PSCT for Waldenstrom's macroglobulinemia.

J. January 1, 1996, for allogeneic bone marrow transplants using related 3 antigen mismatch donors for patients with undifferentiated leukemia, Chronic Myelogenous Leukemia (CML), aplastic anemia, Acute Lymphocytic Leukemia (ALL) or Acute Myelogenous Leukemia (AML).

K. October 1, 1996, for HDC with ABMT or PSCT for AL Amyloidosis.

L. January 1, 1995, for allogeneic bone marrow transplant for hypereosinophilic syndrome.

M. May 1, 1997, for HDC with ABMT or PSCT for trilateral retinoblastoma/pineoblastoma.

N. January 1, 1997, for HDC with ABMT or PSCT for follicular lymphoma.

○ January 1, 1997, for HDC with ABMT or PSCT for non-Hodgkin's lymphoma in first complete remission.

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- P. November 28, 1997, for HDC with ABMT or PSCT for Hodgkin's disease in second or third remission.
- Q. January 1, 1996, for HDC with allogeneic BMT for multiple myeloma.
- R. July 1, 1999, for HDC with ABMT or PSCT for germ cell tumors in a second or subsequent relapse.
- S. January 1, 1998, for HDC with ABMT or PSCT for osteosarcoma (osteogenic sarcoma).
- T. June 1, 1995, for allogeneic BMT for Chediak-Higashi syndrome.
- U. January 1, 1998, for allogeneic peripheral stem cell transplantation.
- V. June 1, 2003, for Langerhans Cell Histiocytosis, refractory to conventional treatment.
- W. January 24, 2002, for allogeneic stem cell transplant for Hodgkin's disease.
- X. May 19, 2005, for tandem autologous peripheral stem cell transplant for high-risk neuroblastoma.
- Y. January 1, 2006, for HDC with ABMT or PSCT for desmoplastic small round cell tumor.

- END -

(2) Coverage during a single benefit period is limited to 21 days unless the limit is waived in accordance with the criteria in [paragraph III.E](#).

2. Outpatient care is subject to the following:

a. Outpatient care (substance use disorder) must be provided by an approved substance use disorder rehabilitation facility, whether freestanding or hospital-based. Certified addiction rehabilitation counselors or certified alcohol counselors employed by **an authorized hospital or a** Substance Use Disorder Rehabilitation Facility (SUDRF) may provide the care.

b. The SUDRF must bill for the services using the appropriate Healthcare Common Procedure Coding System (HCPCS) code. Payment is the lesser of the billed amount or the CHAMPUS Maximum Allowable Charge (CMAC).

c. Coverage is up to 60 visits in a benefit period unless the limit is waived in accordance with the criteria in [paragraph III.E](#).

d. Outpatient care is covered in both individual and group settings, **in an authorized hospital or a** SUDRF. For patients with a primary diagnosis of mental disorder (DSM IV) that coexists with an alcohol and other drug abuse disorder see [Chapter 7, Section 3.13](#).

3. Family Therapy.

a. Family therapy provided on an outpatient basis by an approved substance use disorder rehabilitation facility, whether freestanding or hospital-based, is covered beginning with the completion of the patient's rehabilitative care as outlined in [paragraph III.C.1](#). The family therapy is covered for up to 15 visits in a benefit period unless the limit is waived in accordance with the criteria in [paragraph III.E](#). Services provided on an outpatient basis will be reimbursed under the appropriate allowable charge for the procedure code(s) billed.

b. Family therapy must be provided by a qualified mental health provider (psychiatrists or other physicians, clinical psychologists, certified psychiatric nurse specialists or clinical social workers; and certified marriage and family therapists, pastoral, and mental health counselors, under a physician's supervision).

D. Coverage limitations.

1. Detoxification. Admissions to all facilities (includes DRG and non-DRG facilities) for detoxification are covered if preauthorized as medically/psychologically necessary. Days of detoxification must be counted toward the statutory day limit, limiting care for adults (age 19 and over) to 30 days in a fiscal year or 30 days in an admission and to 45 days for children (age 18 and under).

2. Rehabilitation. Rehabilitation stays are subject to a limit of three benefit periods in a lifetime unless this limit is waived. Preadmission and continued stay authorization is required for substance use disorder detoxification and rehabilitation. Rehabilitation stays are covered if preauthorized as medically/psychologically necessary. Days of rehabilitation

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CHAPTER 7, SECTION 3.7

SUBSTANCE USE DISORDERS

must be counted toward the statutory day limit, restricting care for adults (age 19 and over) to 30 days in a fiscal year or 30 days in an admission and to 45 days for children (aged 18 and under). The concept of an emergency admission does not apply to rehabilitative care.

NOTE: The beneficiary may have either 21 days of rehabilitation in a residential (inpatient) basis or 21 days of rehabilitation in a partial hospital setting or a combination of both, as long as the 21-day limit for the total rehabilitation period is not exceeded.

E. Waiver of benefit limits. The specific benefit limits set forth in this section may be waived by the contractor in special cases based on a determination that all of the following criteria are met:

1. Active treatment has taken place during the period of the benefit limit and substantial progress has been made according to the plan of treatment.
2. Further progress has been delayed due to the complexity of the illness.
3. Specific evidence has been presented to explain the factors that interfered with further treatment progress during the period of the benefit limit.
4. The waiver request includes specific time frames and a specific plan of treatment which will complete the course of treatment.

F. Payment responsibility. Providers may not hold patients liable for payment for services for which payment is disallowed due to the provider's failure to follow established procedures for preadmission and continued stay authorization. With respect to such services, providers may not seek payment from the patient or the patient's family, unless the patient has agreed to personally pay for the services knowing that payment would not be made. Any such effort to seek payment is a basis for termination of the provider's authorized status.

G. Coverage is allowed for Antabuse® in the treatment of alcoholism.

H. Confidentiality. Release of any patient identifying information, including that required to adjudicate a claim, must comply with the provisions of section 544 of the Public Health Service Act, as amended, (42 U.S.C. 290dd-3), which governs the release of medical and other information from the records of patients undergoing treatment of substance use disorder. If the patient refuses to authorize the release of medical records which are, in the opinion of the contractor necessary to determine benefits on a claim for treatment of substance use disorder the claim will be denied.

IV. EXCEPTIONS

A. Aversion therapy. The programmed use of physical measures, such as electric shock, alcohol or other drugs (except Antabuse®) as negative reinforcement is not covered, even if recommended by a physician. All professional and institutional charges associated with a rehabilitation treatment program that uses aversion therapy must also be denied.

SPEECH SERVICES

ISSUE DATE: April 19, 1983

AUTHORITY: [32 CFR 199.5\(c\)](#), [32 CFR 199.6\(c\)](#), and Public Law 107-107

I. CPT¹ PROCEDURE CODE RANGE

92506 - 92508

II. DESCRIPTION

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

III. POLICY

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

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

IV. EXCLUSIONS

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

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

C. For beneficiaries ages 3 to 21 who are receiving special education services from a public educational agency, cost-sharing of outpatient speech services that are required by the Individuals with Disabilities Education Act and which are indicated in the beneficiary's

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Individualized Education Program (IEP), may not be cost-shared except when the intensity or timeliness of speech services as proposed by the educational agency are not appropriate medical care.

D. Myofunctional or tongue thrust therapy.

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

F. Videofluoroscopy evaluation in speech pathology.

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

- END -

OTHER SERVICES

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1.1	Ambulance Service
2.1	Durable Medical Equipment: Basic Program
2.2	Infantile Apnea Cardiorespiratory Monitor
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2.6	Breast Pumps
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6.1	Medical Supplies And Dressings (Consumables)
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8.2	Therapeutic Shoes For Diabetics
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13.1	Adjunctive Dental Care
13.2	Dental Anesthesia And Institutional Benefit
14.1	Physician-Assisted Suicide
15.1	Custodial Care Transitional Policy (CCTP)
16.1	Mucus Clearance Devices
17.1	Lymphedema

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SECTION SUBJECT

I 18.1 Continuous Passive Motion (CPM) Devices

ADJUNCTIVE DENTAL CARE

ISSUE DATE: October 8, 1986

AUTHORITY: [32 CFR 199.4\(e\)\(10\)](#)

I. DESCRIPTION

Adjunctive dental care is that dental care which is medically necessary in the treatment of an otherwise covered medical (not dental) condition, is an integral part of the treatment of such medical condition; or is required in preparation for, or as the result of, dental trauma which may be or is caused by medically necessary treatment of an injury or disease.

II. POLICY

A. Adjunctive dental care requires preauthorization. However, if a beneficiary fails to obtain preauthorization before receiving the services, the contractor shall extend benefits if the services or supplies qualify for benefits. Where adjunctive dental care involves a medical (not dental) emergency (such as facial injuries resulting from an accident), the requirement for preauthorization is waived. Such waiver, is limited to the essential adjunctive dental care related to the medical condition requiring the immediate emergency treatment.

B. Hospital services and supplies will be covered for a patient who requires a hospital setting for noncovered, nonadjunctive dental care when medically necessary to safeguard the life of the patient from the effects of dentistry on an underlying nondental organic condition. Professional services related to the noncovered dental care are not covered; professional services related to the medical condition (excluding the dentist and anesthesiologist) are covered.

C. Benefits may be cost-shared for the treatment of the following conditions:

1. Intraoral Abscesses. An intraoral abscess should be considered a medical condition only when it extends beyond the dental alveolus. These abscesses may require immediate attention in an acute phase which would preclude preauthorization.
2. Extraoral Abscesses. In some cases, it is necessary to incise and treat abscesses extraorally; e.g., when the infection follows the facial planes.
3. Cellulitis and Osteitis. Elimination of a non-local infection which is clearly exacerbating and directly affecting a medical condition currently under treatment.

4. Facial Trauma Requiring Removal of Teeth or Tooth Fragments.

a. Removal of teeth and tooth fragments in order to treat and repair facial trauma resulting from an accidental injury.

b. Removal of an impacted tooth in the line of a fracture may be required in order to treat the fracture.

5. Myofacial Pain Dysfunction Syndrome.

a. Treatment of this syndrome may be considered a medical problem only when it involves immediate relief of pain.

b. Emergency treatment may include initial radiographs, up to four (4) office visits and the construction of an occlusal splint, if necessary to relieve pain and discomfort.

c. Treatment beyond four (4) visits, or any repeat episodes of care within a six (6) month period, must receive individual consideration and be documented by the provider of services.

NOTE: Occlusal equilibration and restorative occlusal rehabilitation are specifically excluded for myofacial pain dysfunction syndrome.

6. Total or Complete Ankyloglossia. This condition is commonly known as tongue-tie. It involves the lingual frenum resulting in fixation of the tip of the tongue to the degree that it interferes with swallowing and speech. Surgery for partial ankyloglossia is considered unnecessary, and of no medical value.

7. Severe Congenital Anomaly. Adjunctive dental and orthodontia is covered when directly related to, and an integral part of, the medical and surgical correction of a severe congenital anomaly.

a. Coverage Guidelines. Depending on the severity or degree of involvement of the congenital anomaly, the patient may require adjunctive dental or orthodontic support from birth until the medical/surgical treatment of the anomaly has been completed; i.e., until the dentoalveolar arch discrepancies and/or maxillomandibular disharmonies are corrected through a combined effort of the surgeon and orthodontist. Treatment may include the fabrication of obturators early in life, and splints at the time of surgical treatment for stabilization of the maxilla and mandible. As the arches develop and teeth erupt, orthodontic treatment may be required to establish a functional relationship of the dental arches. When the deformity is severe and function is greatly impaired, obturators and pharyngeal bulb appliances may be required to assure proper nutrition, deglutition and to avoid aspiration of foreign matter during the intake of food.

(1) Vestibuloplasty (CPT¹ procedure codes 40840-40845) may be considered adjunctive dental when it is determined to be an appropriate and medically necessary surgical procedure for correction of a severe cleft lip/cleft palate.

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NOTE: Vestibuloplasty is EXCLUDED when performed to prepare the mouth for dentures.

(2) Orthodontics should be a covered treatment in any congenital deformity of the head and neck, wherein the orthodontia:

(a) Corrects dentoalveolar arch discrepancies that are part of, or the result of, the congenital anomaly and are severe enough to prevent the usual and normal action of mastication and ingestion of normally solid foods.

(b) Corrects dentoalveolar arch discrepancies, the correction of which is necessary to satisfactorily correct other aspects of the general deformity, or to prevent relapse of such treatment.

(c) Corrects dentoalveolar arch discrepancies that are, in themselves, severe enough to obviously disfigure the face.

(d) The following is a listing of congenital anomalies that affect the face and possibly the dentoalveolar arches, or their relationships to each other:

- 1 Cleft palate isolated.
- 2 Lateral or oblique facial clefting.
- 3 Cleft mandible.
- 4 Klippel-Fiel Syndrome.
- 5 Pierre Robin Syndrome.
- 6 Trisomies 18, 21, 13 - 15.
- 7 Chondroectodermal dysplasia (Ellis-van Creveld Syndrome).
- 8 Bird headed dwarfism (Nanoccephalic or primordial dwarfism).
- 9 Turner's Syndrome (X-0 Syndrome).
- 10 Klinefelter's Syndrome.
- 11 Craniofacial dysostosis (Crouzon's Syndrome).
- 12 Occuloauriculovertebral dysplasia (Goldenhar's Syndrome).
- 13 Occulamandibulofacial Syndrome (Hallerman Striff Syndrome, Ullrich et al Syndrome).
- 14 Treacher Collins Syndrome.

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15 Hemifacial microsomia.

16 Hemifacial hyperplasia.

(e) Coverage of orthodontia for congenital anomalies of the head and/or neck which do not appear in the above listing must be evaluated to assess the significance of their functional impairments related to the dentoalveolar arch discrepancies described in [paragraph II.a.\(2\)\(a\)](#) and [\(b\)](#) above; i.e., the dentoalveolar arch discrepancies of an unlisted congenital anomaly must impose a significant functional impairment in order for coverage of orthodontia under TRICARE.

(f) The severity and functional impairment of a given congenital anomaly must be assessed on a case-by-case basis from a series of medical records over a period of time. The congenital impairment of the head and/or neck must be at a level resulting in an inability of a beneficiary to perform normal bodily functions (e.g., the inability to eat, breath and/or speak normally) in order for coverage to be extended. The functional impairment must be disabling and ongoing.

b. Preauthorization Requirements.

(1) Preauthorization is required for all adjunctive dental and orthodontia directly related to, and an integral part of, the medical and surgical correction of a severe congenital anomaly.

(2) Orthodontia benefits for severe congenital anomalies of the head and neck will be continued as long as the primary physician requires support of his/her treatment or until the best reasonably attainable results have been achieved by the orthodontist. Once active orthodontic treatment has been completed and the patient is placed in the retention phase of treatment, benefit payment ends. If the primary physician or dentist subsequently determines that additional orthodontia work is required, a new preauthorization is required.

8. Iatrogenic Dental Trauma. Dental care which is prophylactic, restorative, prosthodontic (e.g., dentures and bridge work) and/or periodontic qualifies as adjunctive dental care when performed in preparation for, or as a result of, trauma to the teeth and supporting structures caused by medically necessary treatment of an injury or disease. There must be a direct cause-effect relationship between the otherwise covered medical treatment and the ensuing dental trauma, and the ensuing dental trauma must be functionally associated (adjunct) with the treatment of the physician induced trauma. This must be based on sound medical practice and substantiated in the current medical literature. The following are examples of conditions which are eligible for payment under the iatrogenic dental trauma provision. Because these examples are not meant to be all-inclusive, similar conditions or circumstances may be brought to the attention of the Executive Director, TRICARE Management Activity, or designee, for consideration.

c. Radiation Therapy for Oral or Facial Cancer.

(1) It is generally recognized that certain dental care may be required in preparation for or as a result of in-line radiation therapy for oral or facial cancer.

(2) Treatment may include dental prophylactic, restorative, periodontic and/or orthodontic procedures. Without this necessary care, patients who undergo radiation therapy about the head may be at risk for development of osteonecrosis because their dental needs were not met either prior to, or in conjunction with, radiation therapy. Since the problem here deals with cancer, it may not be possible to wait for prior authorization before beginning radiation therapy. Out of necessity, dental care may have to be initiated before benefit authorization is granted by the dental contractor. Extraction of affected teeth due to poor dental health (e.g., multiple dental caries and/or periodontal disease) may necessitate the coverage of dentures or bridge work.

b. Gingival Hyperplasia.

(1) Gingival hyperplasia, or overgrowth of the gingival tissues, occurs frequently in patients who have undergone prolonged Dilantin therapy for epilepsy or seizure disorders. The incidence of this problem can be reduced by good oral hygiene and prophylactic gum care. Severe cases of gingival overgrowth may require surgical intervention to reduce the excessive fibrous tissue growth. The problem is more prevalent among young children, as the older population is not prone to the condition. Also, there is an important difference in the character of tissue between gingival hyperplasia and periodontal disease. Because of this, care needs to be taken in differentiating true gingival hyperplasia from periodontally diseased tissue.

(2) Treatment usually entails excision of the hyperplastic tissue; however, in some severe cases, free soft tissue grafts may be required.

c. Preauthorization Requirements. The preauthorization criteria for dental care required in preparation for, or as a result of, trauma to the teeth and supporting structures caused by medically necessary treatment of an injury or disease are the same as those described in [paragraph II.b.\(1\)](#) and [\(2\)](#) above.

9. Dental metal amalgam/alloy hypersensitivity. The removal of dental metal amalgam/alloy source may be cost-shared for procedures rendered after April 18, 1983, under the following conditions:

a. Independent diagnosis by a physician allergist based upon generally accepted test(s) for any dental metal amalgam/alloy hypersensitivity, and

b. Contemporary clinical record documentation which reasonably rules out sources of metal exposure other than the dental amalgam/alloy.

III. POLICY CONSIDERATIONS

A. Dental care which is routine, preventive, restorative, prosthodontic (adding or modifying of bridge work and dentures), periodontic or emergency does not qualify as adjunctive dental care except when performed in preparation for, or as a result of, dental trauma caused by medically necessary treatment of an injury or disease.

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B. Orthodontia is only covered when it is an integral part of the medical or surgical correction of a severe congenital anomaly or when required in preparation for, or as a result of, physician induced dental trauma.

C. Clinical oral examinations, radiographs and laboratory tests and examinations may be payable only when necessary in conjunction with the diagnosis and treatment of covered adjunctive dental or oral surgery procedures.

D. The Frankel Dental Appliance is categorized as orthodontia and must be denied unless adjunctive to the surgical correction of a cleft palate.

E. The treatment of generally poor dental health (dental caries) due to certain systemic causes (e.g., congenital syphilis, malabsorption syndromes, rickets, etc.) is excluded from coverage.

F. American Dental Association (ADA) claim forms and procedure codes may be used in the processing and payment of adjunctive dental claims.

- END -

CONTINUOUS PASSIVE MOTION (CPM) DEVICES

ISSUE DATE: January 26, 1987

AUTHORITY: [32 CFR 199.4\(d\)\(3\)\(ii\)](#)

I. HCPCS PROCEDURE CODES

Level II Code E0935 and E0936

II. POLICY

Continuous Passive Motion (CPM) devices are covered as Durable Medical Equipment (DME) for patients receiving therapy for joints that are replaced, traumatized, infected, operated upon, and when used following extensive burns involving one or more kinetic areas.

III. POLICY CONSIDERATIONS

A. Use of CPM in the patient's home must begin within two days following surgery, assuming the patient was discharged within that time frame. For other conditions identified under [paragraph II.](#), CPM must begin within two days of stabilization of the patient's condition that led to the need for CPM. If CPM was being used in the hospital immediately prior to discharge either following surgery or for other conditions identified above, continuity may be maintained at home not to exceed a combined total of three continuous weeks (hospital and home).

B. Use of CPM following removal of an orthopedic cast or splint is approved if the cast or splint was applied following surgery. As in [paragraph III.A.](#), CPM must begin within two days of removal of the cast or splint and reimbursement will not exceed three continuous weeks.

C. Evidence has shown that maximum benefits from CPM are derived within the limits stated in [paragraph III.A.](#) and [B.](#)

IV. EFFECTIVE DATES

A. January 26, 1987, as therapy following total knee replacement.

B. October 6, 1988, as therapy following any joint replacement.

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C. September 11, 1989, as therapy for joints that are traumatized, infected, operated upon, and when used following extensive burns, involving one or more kinetic areas.

- END -

OTHER ECHO BENEFITS

ISSUE DATE: July 3, 1997

AUTHORITY: [32 CFR 199.5\(c\)\(8\)](#)

I. CPT¹ PROCEDURE CODE

99199

II. HCPCS PROCEDURE CODE

T1013

III. POLICY

A. Assistive services. Subject to all applicable requirements, TRICARE may cost-share the services of a qualified interpreter or translator for Extended Care Health Option (ECHO) beneficiaries who are deaf and/or mute, readers for ECHO beneficiaries who are blind, and personal assistants for ECHO beneficiaries with other types of qualifying conditions, when such services are necessary to the rendering or delivery of an authorized ECHO service or item.

B. Equipment adaptation. Subject to all applicable requirements, TRICARE may cost-share such services and structural modification to the equipment as necessary to make the equipment serviceable for a particular disability.

C. Equipment maintenance. Reasonable repairs and maintenance for that portion of the useful life of beneficiary owned equipment that was cost-shared through the ECHO (or its predecessor, the **Program for Persons with Disabilities (PFPWD)**) and is concurrent with the beneficiary's ECHO eligibility may be cost-shared as an ECHO benefit subject to all applicable requirements.

IV. EXCLUSIONS

A. Services available under the TRICARE Basic Program are not eligible to be cost-shared under the ECHO.

B. **Service animals (seeing eye dogs, hearing/handicap assistance dogs, seizure and other detection animals, service monkeys, etc.) are excluded from coverage.**

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V. EFFECTIVE DATE September 1, 2005.

- END -

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3.9	Pastoral Counselor
3.10	Mental Health Counselor
3.11	Certified Nurse Midwife (CNM)
3.12	Certified Physician Assistant
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■	ADDENDUM C Participation Agreement For Freestanding Or Institution-Affiliated Birth Center Maternity Care Services
■	ADDENDUM D Application Form For Corporate Services Providers

CERTIFIED NURSE MIDWIFE (CNM)

ISSUE DATE: July 8, 1998

AUTHORITY: 32 CFR 199.6(c)(3)(iii)(D)

I. ISSUE

Certified Nurse Midwife (CNM).

II. POLICY

A. A CNM may provide covered care independent of physician referral and supervision, provided the nurse midwife is:

1. Licensed, when required, by the local licensing agency for the jurisdiction in which the care is provided; and

2. Certified by the American Midwifery Certification Board (AMCB). To receive certification, a candidate must be a Registered Nurse (RN) who has completed successfully an educational program approved by the AMCB, and passed the AMCB National Certification Examination.

B. The services of a RN who is not a CNM may be authorized only when the patient has been referred for care by a licensed physician and a licensed physician provides continuing supervision of the course of care.

III. EXCLUSION

A lay midwife who is neither a CNM nor a RN is not an authorized provider, regardless of whether the services rendered may otherwise be covered.

- END -

AUTHORIZATION REQUIREMENTS

ISSUE DATE:

AUTHORITY: [32 CFR 199.17](#)

I. POLICY

Each TOP TRICARE Area Office (TAO) Director may require authorizations. Such authorization requirements may differ between TOP regions. Beneficiaries and providers are responsible for contacting their TOP TAO Director or Health Care Finder (HCF) for a listing of TOP regional authorization requirements. Unless otherwise specifically excluded in this chapter, the adjudication of the following types of care requires TOP authorization/preauthorization.

A. Overseas Extended Care Health Option (ECHO) benefits must be authorized by the TOP TAO Director or designee, prior to receiving the ECHO benefit.

B. TOP non-enrollees do not require pre-authorization/authorization for care except for non-emergent inpatient mental health services (pre-admission and continued stay).

C. TOP Prime enrollees (other than TGRO/TPRC) are required to obtain authorization for care rendered in the following countries: Belgium, Germany, Guam, Iceland, Italy, Japan, Korea, Portugal (Azores), Spain, Turkey and the United Kingdom. Determination of overseas countries requiring authorization for care will be made by the appropriate overseas TAO Director or designee.

D. TOP **Active Duty Service Member** (ADSM) urgent/emergent care received in the continental United States (CONUS) does not require authorization. Authorization is required for all non-emergent/urgent care received in CONUS, including non-emergent/urgent inpatient mental health care. TOP ADSM claims for non-emergent/urgent care obtained in CONUS should only be paid when accompanied by the appropriate payment authorization forms (SF1034 or NAVMED6320/10).

E. TOP enrolled **Active Duty Family Members** (ADFM)s are not required to obtain authorization for CONUS non-emergent/non-urgent care except for CONUS non-emergent/urgent inpatient mental health care.

F. For TOP Prime ADFMs and TOP Standard beneficiaries, CONUS non-emergent inpatient mental health pre-authorizations/authorizations will be performed by the mental health review contractor. Claims for drugs, radiological diagnostics (excluding **Magnetic Resonance Imaging** (MRI) and **Positron Emission Tomography** (PET) scans), and ancillary

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services obtained from OCONUS providers are exempt from the TOP authorization requirements.

G. TRICARE Global Remote Overseas (TGRO) and TRICARE Puerto Rico Contract (TPRC) healthcare contractor claims do not require authorization by the overseas claims processing contractor responsible for processing overseas claims.

- END -

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