



OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
HEALTH AFFAIRS

16401 EAST CENTRETECH PARKWAY
AURORA, COLORADO 80011-9066

TRICARE
MANAGEMENT ACTIVITY

MB&RS

**CHANGE 1
6010.57-M
MARCH 13, 2008**

**PUBLICATIONS SYSTEM CHANGE TRANSMITTAL
FOR
TRICARE POLICY MANUAL (TPM)**

The TRICARE Management Activity has authorized the following addition(s)/revision(s) to the 6010.57-M, issued February 2008.

CHANGE TITLE: CONSOLIDATED UPDATE

PAGE CHANGE(S): See pages 2 and 3.

SUMMARY OF CHANGE(S): This change brings this Manual up-to-date with published changes in Aug 2002 TRICARE Policy Manual (TPM), 6010.54-M. The changes are a routine change to clarify cost-sharing for hearing aids (Aug 2002 TRM, Change 70), a correction (Aug 2002 TPM, Change 70), the Cancer Clinical Trials benefit (Aug 2002 TPM, Change 71), and the Autism Demonstration Project (Aug 2002 TPM, Change 72). This change also includes corrections for minor errors/clarifications.

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

This change is made in conjunction with Feb 2008 TOM, Change No. 1, Feb 2008 TRM, Change No. 1, and Feb 2008 TSM, Change No. 1.

**Reta Michak
Chief, Office of Medical Benefits and
Reimbursement Systems**

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Chapter 1, Section 2.1

Unproven Drugs, Devices, Medical Treatments, And Procedures

10.0 See [Chapter 7, Section 24.1](#) for policy on cancer clinical trials.

11.0 See [Chapter 8, Section 5.1](#) for policy on medical devices, including coverage of Humanitarian Use Devices and a FDA-approved IDE categorized by the FDA as non-experimental/investigational (FDA Category B).

12.0 See [Chapter 8, Section 9.1](#) for policy on off-label use of drugs.

- END -

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Chapter 1, Section 6.1

Non-Availability Statement (NAS) (DD Form 1251) For Inpatient Care

FIGURE 1.6.1-2 DELIVERY OF HEALTH CARE AT MILITARY TREATMENT FACILITIES (MTFs)

4.2. The Secretaries of the Military Departments shall:

4.2.1. Be responsible for reviewing procedures that the Military Departments establish to ensure compliance with this Instruction.

4.2.2. Comply with international reciprocal healthcare agreements.

4.2.3. Budget for the medical and dental care it anticipates furnishing to eligible foreign personnel under its sponsorship in non-military and U.S. Government facilities, other than military. They shall also use payment procedures and rates they use for U.S. personnel.

4.2.4. Ensure that each Commander of an MTF submit, to their respective biometrics agencies, workload information, including live births, admissions and dispositions, days of care, visits, and ancillary services, by the fifth of the next month. The biometrics agencies review it and, if necessary, work with the site to correct it. The MTF shall release the report by the fifteenth of the following month.

4.2.5. Act on requests for changes in clinical services at MTFs as recommended by respective military command authorities and inform the regional Lead Agent regarding these decisions.

4.2.6. Ensure that each Commander of an MTF designates a BCAC, and Alternate BCAC, either full time or as a collateral duty.

4.3. The Director, TRICARE Management Activity (TMA) shall:

4.3.1. Ensure each Lead Agent designates a full-time BCAC and an Alternate BCAC.

4.3.2. Assume responsibility to coordinate with the Services regarding any modifications to that portion of this Instruction dealing with BCAC support.

4.3.3. Ensure toll-free telephone communication between beneficiaries and Lead Agent BCACs.

4.3.4. Ensure Lead Agent BCACs receive the most current TRICARE policy information to help address beneficiary issues and concerns.

4.3.5. Ensure that Lead Agent BCACs receive customer service training.

4.3.6. Ensure that appropriate directorates within TMA provide Lead Agent BCACs with current TRICARE policy information and customer service training.

5. PROCEDURES

5.1. NAS

5.1.1. A NAS is not required when there is a medical emergency, when a beneficiary has another health insurance plan that provides primary coverage for the cost of their medical services, or when the beneficiary is enrolled in TRICARE Prime. For TRICARE Prime enrollees, the primary care manager or healthcare finder shall write a referral. The MTFs, **TAOs**, **TOP contractor**, the Military Medical Support Office, or regional managed care support contractors issue a "valid care authorization."

5.1.1.1. Electronically issued NASs shall be valid for thirty (30) days. All issued NASs shall be reported on the Defense Eligibility Enrollment Reporting System or Composite Health Care System.

5.1.1.2. The MTF Commander (or senior designated physician) may issue a NAS retroactively for medical care provided by civilian sources.

TRICARE Policy Manual 6010.57-M, February 1, 2008

Chapter 1, Section 6.1

Non-Availability Statement (NAS) (DD Form 1251) For Inpatient Care

FIGURE 1.6.1-2 DELIVERY OF HEALTH CARE AT MILITARY TREATMENT FACILITIES (MTFs)

5.1.2. The MTF Commander (or senior designated physician) shall determine the availability of equitable services provided within the MTF. A decision regarding the medical necessity of each beneficiary's request for inpatient care is not to be a consideration in the issuance of a NAS. The timeframe to issue a NAS, once requested, is the same as the pre-authorization review timeline standards specified in the managed care support contracts.

5.1.3. The first-level appeal for decisions surrounding NAS issuance is the MTF Commander, the second-level appeal is the TRICARE Lead Agent, and the third and final level of appeal is the Service Surgeon General of the sponsor's Service.

6. INFORMATION REQUIREMENTS

The patient care data collected for compliance with this requirement shall be reported using the Report Control Symbol of RCS DD-HA(AR)1453, in accordance with DoD 8910.1-M (reference (h)). Definitions of the data elements and codes must be the same for all three Military Services. New facilities must be given identification codes by the OASD(HA) and properly identified when initially reporting their data. The reporting requirement identified at subparagraph 4.2.4. is exempt from licensing in accordance with section 6 of DoD Directive 8910.1 (reference (i)).

7. EFFECTIVE DATE

This Instruction is effective immediately.



William Winkenwerder, Jr., MD
Assistant Secretary of Defense (Health Affairs)

Enclosures - 2

E.1. References, continued

E.2. Roles and Responsibilities for Beneficiary Counseling and Assistance Coordinators

Individual Case Management Program For Persons With Extraordinary Conditions (ICMP-PEC)

Issue Date: August 1, 2002

Authority: ASD(HA) Interim Policy Memorandum, March 28, 2002; Section 703, Pub. L. 106-65;
Section 107(d), Pub L. 107-107

1.0 DESCRIPTION

1.1 The Individual Case Management Program For Persons With Extraordinary Conditions (ICMP-PEC), also known as the Individual Case Management Program, was a discretionary program for TRICARE beneficiaries with extraordinary medical or psychological conditions. As authorized by the National Defense Authorization Act (NDAA) of 1993, the Individual Case Management Program (ICMP) expanded the former Home Health Demonstration Project which was directed by the 1986 Defense Appropriations Act.

1.2 The purpose of the ICMP-PEC was to provide coverage of medical or psychological services, supplies, or durable medical equipment that are normally excluded by law or regulation as a TRICARE benefit when the provision of such benefits was cost-effective and clinically appropriate. The ICMP-PEC was designed to provide a cost-effective plan of care by targeting appropriate resources to meet the medical needs of a beneficiary with a qualifying condition. In addition, the ICMP-PEC authorized a waiver of the exclusion of custodial care or domiciliary care such that for high cost cases under the parameters of the existing Managed Care Support (MCS) contracts, the ICMP-PEC authorized payment for comprehensive home health care services, supplies and equipment.

1.3 Following publication of the Final Rule in February 1999 (67 FR 7084), the ICMP began March 1, 1999. The ASD(HA) Interim Policy Memorandum of March 28, 2000 changed the name to the ICMP-PEC to focus on beneficiaries with extraordinary or catastrophic conditions.

1.4 Section 701 of the NDAA for Fiscal Year 2002 (NDAA FY 2002) terminated the ICMP/ICMP-PEC effective December 28, 2001. For beneficiaries in the ICMP-PEC as of December 28, 2001, the NDAA Fiscal Year (FY) 2002 also provided that payment will continue as if the ICMP-PEC were still in effect for home health care or custodial care services provided to a beneficiary that would otherwise be excluded from coverage under the new Home Health Agency Prospective Payment System (HHA PPS), the Extended Care Health Option (ECHO), or the Skilled Nursing Facility Prospective Payment System (SNF PPS), until those services are no longer required or can be appropriately provided by other TRICARE programs.

2.0 POLICY

2.1 For TRICARE beneficiaries authorized benefits under the ICMP-PEC as of December 28, 2001, payment will continue to be provided as if the ICMP-PEC were in effect for home health care or custodial care services provided to a beneficiary that would otherwise be excluded from coverage under the new HHA PPS, ECHO, or the SNF PPS.

2.2 For TRICARE For Life (TFL) beneficiaries authorized benefits under the ICMP-PEC as of December 28, 2001, payment will continue to be provided as if the ICMP-PEC were in effect for home health care or custodial care services provided to a beneficiary that would otherwise be excluded from coverage under the new HHA PPS, ECHO, or the SNF PPS. See also the TRICARE Operations Manual (TOM), [Chapter 7, Section 1, paragraph 11.0](#).

2.3 TRICARE payment of services which were authorized by the Home Health Demonstration Project will continue as long as those beneficiaries who were "grandfathered" when that program was terminated, remain eligible for TRICARE.

2.4 ICMP-PEC beneficiaries as of December 28, 2001, whose level of services authorized as of December 28, 2001 can be appropriately provided through other TRICARE programs, such as the HHA PPS, ECHO, or the SNF PPS, shall be transitioned into such program upon identification by the Managed Care Support Contractors (MCSCs) in conjunction with the Director, TRICARE Management Activity (TMA) Office of the Chief Medical Officer, or designee.

2.5 Requirements for continued payment of ICMP-PEC authorized services:

2.5.1 Eligibility. The beneficiary must be TRICARE eligible.

2.5.2 Authorized Beneficiaries. Only those beneficiaries authorized services under the ICMP-PEC upon its termination on December 28, 2001, are eligible for continued coverage.

2.5.3 Authorized Services. Only those services authorized under the ICMP-PEC upon its termination on December 28, 2001, are eligible for continued coverage.

2.5.4 Custodial Care. Beneficiaries must continue to meet the TRICARE definition of custodial care in effect prior to December 28, 2001, that is, custodial care is care rendered to a patient who:

- Is disabled mentally or physically and such disability is expected to continue and be prolonged, and
- Requires a protected, monitored, or controlled environment whether in an institution or in the home, and
- Requires assistance to support the essentials of daily living, and
- Is not under active and specific medical, surgical, or psychiatric treatment that will reduce the disability to the extent necessary to enable the patient to function outside the protected, monitored, or controlled environment.

TRICARE Policy Manual 6010.57-M, February 1, 2008

Chapter 1, Section 10.1

Individual Case Management Program For Persons With Extraordinary Conditions (ICMP-PEC)

2.5.5 Beneficiaries covered under [paragraphs 2.1](#) or [2.2](#) must have a primary caregiver in the home.

2.5.6 Reassessment. Continuation of receipt of services requires reassessment on a regular basis. The MCSCs will provide supporting clinical documentation of all authorized participant's medically necessary skilled needs, to include a plan of care signed by the attending physician. Each letter of authorization for continued coverage issued by the Director, TMA Office of the Chief Medical Officer, or designee, will include a statement regarding the frequency of a periodic reassessment of the beneficiary. Generally, periodic reassessment will occur annually, but will be based on the needs of the beneficiary. MCSCs shall provide a complete clinical documentation update and recommendation for continuation of coverage at the same level or indicate if either an increase or decrease in services is indicated by the beneficiary's current needs. TMA will provide a courtesy reminder when a periodic reassessment is due for a beneficiary. Once TMA reviews the reassessment and updated recommendations of the MCSC, a revised or updated authorization letter will be issued to the MCSC.

2.5.7 Revisions. If at any time an MCSC determines a need for a change in authorized funding for a beneficiary (e.g., due to a change in TMAC rates, a change in patient condition, such as a need for more or fewer covered hours, change in HHA, etc.), then the MCSC must submit a written request for such change to the Director, TMA Office of the Chief Medical Officer, or designee, that includes a detailed explanation of why the change is required. The Director, TMA Office of the Chief Medical Officer, or designee, will evaluate each request and provide a written decision to the MCSC.

2.5.8 Cost-shares. Cost-shares shall not be applied to services authorized under the ICMP-PEC prior to December 28, 2001 nor to those services provided under this policy. Cost-shares will continue to apply to all other TRICARE benefits.

2.5.9 Appeals. Appeals should be made directly to the TMA Appeals and Hearings Division. There are three appealable issues related to the ICMP-PEC:

2.5.9.1 A custodial care determination;

2.5.9.2 A determination by the MCSC that ICMP-PEC does not apply;

2.5.9.3 The types and extent of services authorized for a beneficiary by TMA. The following language is to be included in subsequent determination of custodial care letters and notification of benefits related to ICMP-PEC:

"Should you disagree with this initial determination, you have the right to appeal and request a formal review. Appealable issues include the types and extent of the services and supplies authorized under the ICMP-PEC and the determination that the care is custodial. The request must be in writing, be signed, and must be postmarked or received by the *Appeals and Hearings Division, TRICARE Management Activity, 16401 East Centretech Parkway, Aurora, Colorado 80011-9066*, within 90 days from the date of this determination. For the purposes of TRICARE, a postmark is a cancellation mark issued by the United States Postal Service.

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Chapter 1, Section 10.1

Individual Case Management Program For Persons With Extraordinary Conditions (ICMP-PEC)

Additional documentation in support of the appeal may be submitted. However, because a request for a formal review must be received within 90 days of the date of the initial determination, a request for formal review should not be delayed pending the acquisition of any additional documentation. If additional documentation is to be submitted at a later date, the letter requesting the formal review must include a statement that additional documentation will be submitted and the expected date of the submission."

2.5.10 Claims Processing. MCSCs are to use the special processing code "CM" in addition to the appropriate branch of service code for all claims for care and services authorized under this policy. MCSCs are to use the special processing code "E" in addition to the special processing code "CM" for claims for services authorized for those beneficiaries indicated in [paragraph 2.3](#). Claims for services not provided in accordance with [paragraphs 2.1, 2.2, or 2.3](#) (i.e., acute outpatient and inpatient care and services, including Durable Medical Equipment (DME)) must be processed in accordance with the TOM, the TRICARE Reimbursement Manual (TRM), and the TRICARE Systems Manual (TSM), and without the use of the special processing codes "E" and "CM".

2.5.11 MCSCs shall notify the Director, TMA Office of the Chief Medical Officer, or designee upon any of the following changes to any beneficiary who is covered by [paragraphs 2.1, 2.2, or 2.3](#).

- death;
- eligibility status, including becoming a Transitional Survivor or a Survivor as those terms are used in [Chapter 10, Section 7.1](#);
- residential relocation (pending or completed);
- custodial care status;
- inpatient admission;
- requests for disengagement.

- END -

Category II Codes - Performance Measurement

Issue Date: October 15, 2003

Authority: [32 CFR 199.17\(j\)](#) and [\(p\)\(3\)](#)

1.0 CPT¹ PROCEDURE CODES

0001F, 0005F, 0012F, 0500F - 0503F, 0505F, 0507F, 1000F - 1008F, 1015F, 1018F, 1019F, 1022F, 1026F, 1030F, 1034F - 1036F, 1038F - 1040F, 2000F - 2004F, 2010F, 2014F, 2018F, 2022F - 2024F, 2026F, 2028F, 2030F, 2031F, 3000F, 3002F, 3006F, 3011F, 3014F, 3017F, 3020F, 3025F, 3027F, 3028F, 3035F, 3037F, 3040F, 3042F, 3046F - 3050F, 3061F, 3062F, 3066F, 3072F, 3076F - 3080F, 3082F - 3085F, 3088F - 3093F, 4000F - 4003F, 4006F, 4009F, 4011F, 4012F, 4014F - 4018F, 4025F, 4030F, 4033F, 4035F, 4037F, 4040F, 4045F, 4050F - 4056F, 4059F, 4060F, 4062F, 4064F - 4067F, 6005F

2.0 DESCRIPTION

The CPT Category II codes are supplemental tracking codes that can be used for performance measurement.

3.0 POLICY

3.1 Category II codes are to be used to collect data about the quality of care by coding certain services and/or test results that support performance measures and that have been agreed upon as contributing to good patient care. TRICARE has opted not to track Category II codes.

3.2 Category II codes are excluded under TRICARE.

4.0 EFFECTIVE DATE

January 1, 2004.

- END -

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Category III Codes

Issue Date: March 6, 2002

Authority: [32 CFR 199.2\(b\)](#) and [32 CFR 199.4\(g\)\(15\)](#)

1.0 CPT¹ PROCEDURE CODES

0003T, 0008T, 0016T - 0019T, 0021T, 0024T, 0026T - 0032T, 0041T - 0161T

2.0 DESCRIPTION

Category III codes are a set of temporary codes for emerging technology, services, and procedures. These codes are used to track new and emerging technology to determine applicability to clinical practice. When a Category III code receives a Category I code from the American Medical Association (AMA) it does not automatically become a benefit under TRICARE. However, the codes that may have moved from unproven to proven must be forwarded to the Office of Medical Benefits and Reimbursement Systems (MB&RS) for coverage determination/policy clarification.

3.0 POLICY

3.1 Category III codes are to be used instead of unlisted codes to allow the collection of specific data. TRICARE has not opted to track Category III codes at this time.

3.2 Category III codes are excluded from coverage since clinical safety and efficacy or applicability to clinical practice has not been established.

4.0 EXCEPTIONS

4.1 Category III code 0024T may be covered under the Rare Disease Policy for children.

4.2 FDA IDE (Category B) clinical trial. See [Chapter 8, Section 5.1](#).

5.0 EXCLUSION

Unlisted codes for category III codes. Effective January 1, 2002.

- END -

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Healthcare Common Procedure Coding System (HCPCS) "C" And "S" Codes

Issue Date: November 6, 2007
Authority:

1.0 HCPCS "C" AND "S" CODES

C1000 - C9999; S0000 - S9999

2.0 DESCRIPTION

2.1 HCPCS "C" codes include device categories, new technology procedures, and drugs, biologicals and radiopharmaceuticals that do not have other HCPCS assigned.

2.2 HCPCS "S" codes are temporary codes used by the private sector to report drugs, services, and supplies for which there are no national codes.

3.0 POLICY

3.1 Upon implementation of TRICARE's Outpatient Prospective Payment System (OPPS), HCPCS "C" codes shall be paid according to OPPS guidelines as outlined in the TRICARE Reimbursement Manual (TRM), [Chapter 13](#). For Hospital Outpatient Department (HOPD) services provided prior to the implementation of TRICARE's OPPS, and thereafter, for services by exempt OPPS hospitals, the contractor shall allow payment of HCPCS "C" codes consistent with current policy as stated in the TRM, [Chapter 1, Section 24, paragraph 3.2](#).

3.2 Under TRICARE, "S" codes are not reimbursable **except as follows:**

3.2.1 S9122, S9123, and S9124 for the Extended Care Health Option (ECHO) respite care benefit and the ECHO Home Health Care (EHHC) benefit; **and**

3.2.2 S0812, S1030, S1031, S1040, S2066, S2067, S2068, S2075, S2076, S2077, S2083, S2202, S2400, S2401, S2402, S2403, S2405, S2411, S3818, S3819, S3820, S3822, S3823, S8185, S8265, S8270, and S9430 for all beneficiaries;

3.2.3 S5108 for direct Educational Interventions for Autism Spectrum Disorders (EIA) services provided to TRICARE beneficiaries and S5110 for training services provided to family members of beneficiaries receiving EIA services under the Department of Defense (DoD) Enhanced Access to Autism Services Demonstration. (See the TRICARE Operations Manual (TOM), [Chapter 18, Section 9](#)).

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Chapter 1, Section 13.1

Healthcare Common Procedure Coding System (HCPCS) "C" And "S" Codes

3.3 Under TRICARE, HCPCS code S9999 is a recognized code for purposes of reporting sales tax but is not payable.

4.0 EXCLUSIONS

HCPCS "C" codes are not allowed to be billed by independent professional providers.

- END -

Post-Mastectomy Reconstructive Breast Surgery and Breast Prosthesis

Issue Date: October 7, 1982

Authority: [32 CFR 199.4\(e\)\(8\)\(i\)\(D\)](#) and 10 USC 1079(a)(12)

1.0 CPT¹ PROCEDURE CODES

19160 - 19240, 19340 - 19499 (For post-mastectomy reconstruction surgery)

19316, 19318, 19324 - 19325 (For contralateral symmetry surgery)

2.0 DESCRIPTION

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

3.0 POLICY

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

3.2 Payment may be made for contralateral symmetry surgery (i.e., reduction mammoplasty, augmentation mammoplasty, or mastopexy performed on the other breast to bring it into symmetry with the post-mastectomy reconstructed breast). Benefits are limited to those symmetry procedures performed no later than (NLT) December 31 of the year following the year in which the related post-mastectomy reconstructive breast surgery occurred.

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

3.3 Treatment of complications following reconstruction (including implant removal) regardless of when the reconstruction was performed, and complications that may result following symmetry surgery, removal and reinsertion of implants are covered. See [Chapter 4, Section 5.5](#).

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

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

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Chapter 4, Section 5.2

Post-Mastectomy Reconstructive Breast Surgery and Breast Prostheses

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

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

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

- END -

Silicone Or Saline Breast Implant Removal

Issue Date: June 30, 1993

Authority: [32 CFR 199.4\(a\)\(1\)](#), [\(e\)\(8\)\(iv\)](#), and [\(e\)\(9\)](#)

1.0 CPT¹ PROCEDURE CODES

19328, 19330

2.0 DESCRIPTION

The removal of silicone or saline mammary implant material.

3.0 POLICY

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

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

- Signs and symptoms that may signal implant rupture; and
- Capsular contracture.

3.3 If the initial silicone or saline breast implant surgery was for an indication not covered or coverable by TRICARE, implant removal may be covered only if it is necessary treatment of a complication which represents a separate medical condition. See [Section 1.1](#).

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

4.0 EXCLUSIONS

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

4.2 In the case of implants not originally covered or coverable, implant damage, hardening, leakage, and autoimmune disorder do not qualify as separate medical conditions. They are

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Chapter 4, Section 5.5

Silicone Or Saline Breast Implant Removal

considered unfortunate sequelae resulting from the initial non-covered surgery, and, therefore, are excluded.

- END -

Breast Reconstruction As A Result Of A Congenital Anomaly

Issue Date: April 16, 1986

Authority: [32 CFR 199.4\(c\)\(2\)](#) and [\(e\)\(8\)](#)

1.0 CPT¹ PROCEDURE CODES

19361 - 19369, 19499

2.0 DESCRIPTION

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

3.0 POLICY

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

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

3.1.2 Congenital hypoplasia of one breast and gigantomastia of the contralateral breast, if the breast reduction meets medical necessity criteria outlined in [Section 5.4](#).

3.1.3 Paucity of breast tissue due to chest wall deformities.

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

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

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

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Breast Reconstruction As A Result Of A Congenital Anomaly

4.0 EXCLUSION

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

- END -

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

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

3.12 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.

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

3.14 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.

3.15 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.

3.16 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 POS rules.

4.0 EXCLUSIONS

Benefits will not be paid for:

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

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

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

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

4.5 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).

4.6 Transportation of a donor.

- 4.7** Allogeneic bone marrow transplantation for treatment of low grade non-Hodgkin's lymphoma is not a benefit.
- 4.8** Autologous UCBT therapy as this procedure is considered unproven.
- 4.9** Allogeneic bone marrow transplantation for neuroblastoma as this procedure is considered unproven.
- 4.10** 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.
- 4.11** HDC with ABMT or PSCT is not a benefit for treatment of desmoplastic small round-cell tumor.
- 4.12** HDC with ABMT or PSCT is not covered for treatment of breast cancer.
- 4.13** HDC with allogeneic BMT is not a benefit for treatment of Waldenstrom's macroglobulinemia.
- 4.14** HDC with Stem Cell Rescue (SCR) is not a benefit for the treatment of epithelial ovarian cancer.
- 4.15** HDC with allogeneic stem cell transplantation is not covered for the treatment of cold agglutinin disease.
- 4.16** Donor lymphocyte infusion if not specifically listed as covered in [paragraph 3.4](#).

5.0 EFFECTIVE DATES

- 5.1** May 1, 1987, for HDC with ABMT or PSCT for Hodgkin's disease, non-Hodgkin's lymphoma and neuroblastoma.
- 5.2** November 1, 1987, for HDC with ABMT or PSCT for acute lymphocytic and nonlymphocytic leukemias.
- 5.3** November 1, 1983, for HDC with allogeneic bone marrow transplants using related donors.
- 5.4** July 1, 1989, for HDC with allogeneic bone marrow transplants using unrelated donors.
- 5.5** July 11, 1996, for HDC with ABMT or PSCT for multiple myeloma.
- 5.6** January 1, 1994, for HDC with ABMT and PSCT for Wilms' tumor.
- 5.7** January 1, 1995, for allogeneic UCBTs.
- 5.8** January 1, 1994, for HDC with ABMT or PSCT for chronic myelogenous leukemia.
- 5.9** January 1, 1996, for HDC with ABMT or PSCT for Waldenstrom's macroglobulinemia.

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Chapter 4, Section 23.1

High Dose Chemotherapy (HDC) And Stem Cell Transplantation

- 5.10** January 1, 1996, for allogeneic bone marrow transplants using related 3 antigen mismatch donors for patients with undifferentiated leukemia, CML, aplastic anemia, ALL or AML.
- 5.11** October 1, 1996, for HDC with ABMT or PSCT for AL Amyloidosis.
- 5.12** January 1, 1995, for allogeneic bone marrow transplant for hypereosinophilic syndrome.
- 5.13** May 1, 1997, for HDC with ABMT or PSCT for trilateral retinoblastoma/pineoblastoma.
- 5.14** January 1, 1997, for HDC with ABMT or PSCT for follicular lymphoma.
- 5.15** January 1, 1997, for HDC with ABMT or PSCT for non-Hodgkin's lymphoma in first complete remission.
- 5.16** November 28, 1997, for HDC with ABMT or PSCT for Hodgkin's disease in second or third remission.
- 5.17** January 1, 1996, for HDC with allogeneic BMT for multiple myeloma.
- 5.18** July 1, 1999, for HDC with ABMT or PSCT for germ cell tumors in a second or subsequent relapse.
- 5.19** January 1, 1998, for HDC with ABMT or PSCT for osteosarcoma (osteogenic sarcoma).
- 5.20** June 1, 1995, for allogeneic BMT for Chediak-Higashi syndrome.
- 5.21** January 1, 1998, for allogeneic peripheral stem cell transplantation.
- 5.22** June 1, 2003, for Langerhans Cell Histiocytosis, refractory to conventional treatment.
- 5.23** January 24, 2002, for allogeneic stem cell transplant for Hodgkin's disease.
- 5.24** May 19, 2005, for tandem autologous peripheral stem cell transplant for high-risk neuroblastoma.

- END -

Chapter 6

Section 1.1

General

Issue Date:

Authority: 32 CFR 199.4(a)(1)(i), (b)(2)(ix), (b)(2)(xviii), (b)(3)(vi), (b)(3)(xv), (c)(2)(ix), (c)(2)(x), and (g)(60)

1.0 CPT¹ PROCEDURE CODES

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

2.0 DESCRIPTION

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

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

3.0 POLICY

3.1 Pathology and laboratory services are covered except as indicated.

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

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

3.4 Dermatologists are qualified to perform surgical pathology services. Therefore, if a dermatologist bills for both the surgical procedure (e.g., CPT¹ procedure code 11100, skin biopsy) as well as the surgical pathology, both procedures are covered in full.

3.5 Human papillomavirus testing (CPT¹ procedure codes 87620 - 87622) is covered for the assessment of women with Atypical Squamous Cells of Undetermined Significance (ASCUS) cells detected upon initial pap smear.

3.6 For transfusion services, refer to [Section 2.1](#).

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4.0 EXCLUSIONS

- 4.1** Autopsy and postmortem (CPT² procedure codes 88000 - 88099).
- 4.2** Sperm penetration assay (hamster oocyte penetration test or the zona-free hamster egg test) is excluded for In vitro Fertilization (IVF) (CPT² procedure code 89329).
- 4.3** In-vitro chemoresistance and chemosensitivity assays (stem cell assay, differential staining cytotoxicity assay and thymidine incorporation assay) are unproven.
- 4.4** Hair analysis to identify mineral deficiencies from the chemical composition of hair is unproven. Hair analysis testing (CPT² procedure code 96902) may be reimbursed when necessary to determine lead poisoning.
- 4.5** Insemination of oocytes (CPT² procedure code 89268).
- 4.6** Extended culture of oocyte(s) embryo(s) four to seven days (CPT² procedure code 89272).
- 4.7** Assisted oocyte fertilization, microtechnique; less than or equal to 10 oocytes (CPT² procedure code 89280). Assisted oocyte fertilization, microtechnique; greater than 10 oocytes (CPT² procedure code 89281).
- 4.8** Biopsy oocyte polar body or embryo blastomere (CPT² procedure code 89290). Biopsy oocyte polar body or embryo blastomere; greater than four embryos (CPT² procedure code 89291).
- 4.9** Cryopreservation reproductive tissue, testicular (CPT² procedure code 89335).
- 4.10** Storage (per year) embryo(s) (CPT² procedure code 89342). Storage (per year) sperm/semens (CPT² procedure code 89343). Storage (per year) reproductive tissue, testicular/ovarian (CPT² procedure code 89344). Storage (per year) oocyte (CPT² procedure code 89346).
- 4.11** Thawing of cryopreserved, embryo(s) (CPT² procedure code 89352). Thawing of cryopreserved, sperm/semens, each aliquot (CPT² procedure code 89353). Thawing of cryopreserved, reproductive tissue, testicular/ovarian (CPT² procedure code 89354). Thawing of cryopreserved, oocytes, each aliquot (CPT² procedure code 89356).
- 4.12** CPT² procedure codes 83701 and 83704 and not covered for Low Density Lipoprotein (LDL) subclass testing.

- END -

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Chapter 7, Medicine

Section/Addendum	Subject/Addendum Title
22.1	Telemedicine/Telehealth Figure 7.22.1-1 Telehealth Originating Site Facility Fee
23.1	Augmentative Communication Devices (ACDs)
24.1	Phase II And Phase III Cancer Clinical Trials

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

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

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

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

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

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

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

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

4.1.1.4 Prostate Cancer

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

4.1.1.4.2 Prostate-Specific Antigen.

4.1.1.4.2.1 Annual testing 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.
- Men aged 40 and over with a family history of prostate cancer in two or more other family members.

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

4.1.1.4.3 The effective date for prostate cancer screening is October 6, 1997.

4.1.2 Infectious Diseases

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

4.1.2.2 Human Immunodeficiency Virus (HIV) testing.

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

4.1.2.2.2 Extra and Standard plans may share the cost of HIV testing when medically necessary; i.e., when performed on individuals with verified exposure to HIV or who exhibit symptoms of HIV infection (persistent generalized lymphadenopathy). Claims for HIV testing must include documentation by the attending physician verifying medical necessity. Claims that meet the criteria for coverage are to be reimbursed following the reimbursement methodology applicable to the provider's geographic location.

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

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

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

4.1.2.3.2 Services provided following an animal bite:

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

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

4.1.2.3.2.2 Extra and Standard plans may also cost-share the laboratory examination of the brain of an animal suspected of having rabies if performed by a laboratory which is an authorized

provider and if the laboratory customarily charges for such examinations. In order for the examination charges to be paid, the animal must have bitten a beneficiary, the charges for the examination must be submitted under the beneficiary's name, and the beneficiary must be responsible for the cost-share on the claim.

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

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

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

4.1.2.3.5 Isoniazid therapy for individuals at high risk for tuberculosis to include those:

4.1.2.3.5.1 With a positive Mantoux test without active disease;

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

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

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

4.1.2.3.6 Immunizations.

4.1.2.3.6.1 Coverage is extended for the age appropriate dose of vaccines that meet the following requirements:

- The vaccine has been recommended and adopted by the Advisory Committee on Immunization Practices (ACIP); and
- The ACIP adopted recommendations have been accepted by the Director of the Centers for Disease Control and Prevention (CDC) and the Secretary of Health and Human Services (HHS) and published in a CDC **Morbidity and Mortality Weekly Report** (MMWR).
- Refer to the CDC's web site (<http://www.cdc.gov>) for a current schedule of CDC recommended vaccines. The effective date of coverage for the Human Papilloma Virus (HPV) vaccine is October 13, 2006. **The effective date of coverage for the zoster vaccine is October 19, 2007.**

4.1.2.3.6.2 Coverage is extended for immunizations required by dependents of active duty military personnel who are traveling outside the United States as a result of an active duty

member's duty assignment, and such travel is being performed under orders issued by a Uniformed Service are covered.

4.1.3 Genetic Testing

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

4.1.3.1.1 The pregnant woman is 35 years of age or older;

4.1.3.1.2 One of the parents of the fetus has had a previous child born with a congenital abnormality;

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

4.1.3.1.4 The pregnant woman contracted rubella during the first trimester of the pregnancy.

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

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

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

4.1.3.1.8 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.

4.1.4 School Physicals

4.1.4.1 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.

4.1.4.2 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).

4.1.4.3 Standard office visit evaluation and management CPT⁵ 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

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Preventive Medicine Service codes for beneficiaries ages five through 11 (CPT⁶ procedure codes 99383 and 99393).

4.1.5 Other

4.1.5.1 Physical examinations and immunizations provided to the spouse and children of Active Duty Service Members (ADSMs) 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.

4.1.5.2 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.

4.2 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:

4.2.1 Cancer Screening Examinations

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

4.2.1.2 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.

4.2.1.3 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.

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

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4.2.2 Infectious Diseases

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

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

4.2.3 Cardiovascular Disease

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

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

4.2.4 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.

4.2.5 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.

4.2.6 Audiology Screening

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

4.2.7 Counseling Services

4.2.7.1 Patient and parent education counseling for:

- Dietary assessment and nutrition;
- Physical activity and exercise;
- Cancer surveillance;
- Safe sexual practices;
- Tobacco, alcohol and substance abuse;
- Promoting dental health;
- Accident and injury prevention; and
- Stress, bereavement and suicide risk assessment.

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

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Chapter 7, Section 2.1

Clinical Preventive Services - TRICARE Standard

5.0 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 -

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Chapter 7, Section 2.2

Clinical Preventive Services - TRICARE Prime

SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT CPT CODE ¹
Prostate Cancer:	Physical Examinations: Digital rectal examination should be offered annually for all men aged 50 years and over; men aged 45 and over with a family history of prostate cancer in at least one other family member; all African American men aged 45 and over regardless of family history; and men aged 40 and over with a family history of prostate cancer in two or more other family members.	See appropriate level evaluation and management codes.
	Prostate Specific Antigen: Annually for the following categories of males: all men aged 50 years and older; men aged 45 years and over with a family history of prostate cancer in at least one other family member; all African American men aged 45 and over regardless of family history; and men aged 40 and over with a family history of prostate cancer in two or more other family members.	84153
Colorectal Cancer:	Physical Examination: Digital rectal examination should be included in the periodic health examination of individuals 40 years of age and older.	See appropriate level evaluation and management codes.
	Fecal occult blood testing: Once every 12 months (either guaiac-based testing or immunochemical-based testing) for beneficiaries who have attained age 50 (i.e., at least 11 months have passed following the month in which the last covered screening fecal-occult blood test was done). The effective date for coverage of immunochemical-based testing is August 20, 2003.	82270, 82274, and HCPCS code G0107.
	Proctosigmoidoscopy or Sigmoidoscopy: Once every three to five years beginning at age 50.	45300 - 45321, 45327, 45330 - 45339.
	Colonoscopy for Individuals at Average Risk for Colon Cancer: Once every 10 years for individuals age 50 or above. The effective date for coverage of colonoscopy for individuals at average risk is March 15, 2006. Colonoscopy for Individuals at Increased Risk for Colon Cancer: Performed every two years beginning at age 25, or five years younger than the earliest age of diagnosis of colorectal cancer, whichever is earlier and then annually after age 40 for individuals with hereditary non-polyposis colorectal cancer syndrome. Individuals with familial risk of sporadic colorectal cancer (i.e., individuals with first degree relatives with sporadic colorectal cancer or adenomas before the age 60 or multiple first degree relatives with colorectal cancer or adenomas) may receive a colonoscopy every three to five years beginning at age 10 years earlier than the youngest affected relative.	45355, 45378 - 45385, and HCPCS codes G0105 and G0121.
Skin Cancer:	Physical Examination: Skin examination should be performed for individuals with a family or personal history of skin cancer, increased occupational or recreational exposure to sunlight, or clinical evidence of precursor lesions.	See appropriate level evaluation and management codes.
Oral Cavity and Pharyngeal Cancer:	Physical Examination: A complete oral cavity examination should be part of routine preventive care for adults at high risk due to exposure to tobacco or excessive amounts of alcohol. Oral examination should also be part of a recommended annual dental check-up.	See appropriate level evaluation and management codes.

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Chapter 7, Section 2.2

Clinical Preventive Services - TRICARE Prime

SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT CPT CODE ¹
Thyroid Cancer:	Physical Examination: Palpation for thyroid nodules should be performed in adults with a history of upper body irradiation.	See appropriate level evaluation and management codes.
Infectious Diseases:	Tuberculosis screening: Screen annually, regardless of age, all individuals at high risk for tuberculosis (as defined by CDC) using Mantoux tests.	86580 and 86585
	Rubella antibodies: females, once, age 12-18, unless documented history of adequate rubella vaccination with at least one dose of rubella vaccine on or after the first birthday.	86762
	Hepatitis B screening: Screen pregnant women for HBsAG during prenatal period.	87340
Cardiovascular Diseases:	Cholesterol: Non-fasting total blood cholesterol: At least once every five years, beginning age 18.	80061
	Blood pressure screening: For children: annually between three and six years of age, and every two years thereafter. For adults: a minimum frequency of every two years.	See appropriate level evaluation and management codes.
	Abdominal Aortic Aneurysm (AAA): One time AAA screening by ultrasonography for men, age 65 - 75, who have ever smoked.	76999
Other:	Body Measurement: For children: Height and weight should be measured regularly throughout infancy and childhood. Head circumference should be measured through age 24 months. For adults: Height and weight should be measured periodically. The optimal frequency is a matter of clinical discretion. Those individuals who are 20% or more above desirable weight should receive appropriate nutritional and exercise counseling.	See appropriate level evaluation and management codes.
	Vision Care: Pediatric vision screening at birth and approximately 6 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 retirees and eligible family members age three and older who are enrolled in Prime. Active Duty Family Member (ADFM) age three and older who are enrolled in Prime may receive a routine eye exam annually (see Section 6.1). Diabetic patients, at any age, should have routine eye examinations at least yearly.	92002, 92004, 92012, 92014, 92015, 99172, and 99173.
	Note: Routine eye examinations are meant to be more than the standard visual acuity screening test conducted by the member's primary care physician through the use of a standard Snellen wall chart. Self-referral will be allowed for routine eye examinations since PCMs are incapable of providing this service; i.e., a prime beneficiary will be allowed to set up his or her own appointment for a routine eye examination with any network optometrist or ophthalmologist.	
	Hearing screening: For children: all high risk neonates (as defined by the Joint Committee on Infant Hearing) audiology screening before leaving the hospital. If not tested at birth, high-risk children should be screened before three months of age. Evaluate hearing of all children as part of routine examinations and refer those with possible hearing impairment as appropriate.	92551, 92587, and 92588

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Clinical Preventive Services - TRICARE Prime

SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT CPT CODE ¹
Other (Continued)	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 six years. Screening by blood lead level determination for all children at high risk for lead exposure per CDC guidelines.	83655
COUNSELING SERVICES:		
These are expected components of good clinical practice that are integrated into the appropriate office visit at no additional charge.	Patient & parent education counseling: Dietary Assessment & Nutrition; Physical Activity & Exercise; Cancer Surveillance; Safe Sexual Practices; Tobacco, Alcohol and Substance Abuse; Accident & Injury Prevention; Promoting Dental Health; Stress, Bereavement, & Suicide Risk Assessment.	These are expected components of good clinical practice that are integrated into the appropriate office visit at no additional charge.
IMMUNIZATIONS:		
Age appropriate dose of vaccines that have been recommended and adopted by the Advisory Committee on Immunization Practices (ACIP) and accepted by the Director of the CDC and the Secretary of Health and Human Services (HHS) and published in a CDC Morbidity and Mortality Weekly Report (MMWR). Refer to the CDC's home page (http://www.cdc.gov) for current schedule of CDC recommended vaccines. The effective date of coverage for the Human Papilloma Virus (HPV) vaccine is October 13, 2006.		

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- END -

Well-Child Care

Issue Date: April 19, 1983

Authority: [32 CFR 199.4\(c\)\(2\)\(xiii\)](#) and [\(c\)\(3\)\(xi\)](#)

1.0 CPT¹ PROCEDURE CODES

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

2.0 DESCRIPTION

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

3.0 POLICY

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

4.0 POLICY CONSIDERATIONS

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

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

4.3 Immunizations are covered for age appropriate dose of vaccines that have been recommended and adopted by the Advisory Committee on Immunization Practices (ACIP) and accepted by the Director of the Centers for Disease Control and Prevention (CDC) and the Secretary of Health and Human Services (HHS) and published in a CDC **Morbidity and Mortality Weekly Report** (MMWR). Refer to the CDC's web site (<http://www.cdc.gov>) for access to the MMWRs and a current schedule of CDC recommended vaccines. Immunizations required by dependents of active duty military personnel who are traveling outside the United States as a result of an active duty

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member's duty assignment, and such travel is being performed under orders issued by a Uniformed Service, are covered.

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

4.4 Well-child care for newborns includes the routine care of the newborn in the hospital, newborn circumcision, and newborn metabolic screening as recommended by the AAP. In 2005, the AAP endorsed the newborn screening report from the American College of Medical Genetics that significantly expanded metabolic screening for newborn infants. These conditions include a core panel of 28 conditions and an additional secondary panel of 25 conditions. The most recently endorsed conditions for screening are reflected in the Department of Defense/Veteran Administration (DoD/VA) Clinical Practice Guideline. Only routine well-child care for newborns is covered as part of the mother's maternity episode, i.e., a separate cost-share is not required for the infant.

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

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

4.6.1 History and physical examination and mental health assessment.

4.6.2 Developmental and behavioral appraisal.

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

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

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

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

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

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

4.6.2.4 Dental screenings.

4.6.2.5 Discussion with parents, anticipatory guidance.

4.7 The following specific **services** are covered in a program of well-child care:

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Well-Child Care

- 4.7.1** Immunizations are covered for age appropriate dose of vaccines recommended and adopted by CDC's ACIP. Immunizations recommended by dependents of active duty military personnel who are traveling outside the United States as a result of an active duty member's duty assignment, and such travel is being performed under orders issued by a Uniformed Service.
- 4.7.2** Tuberculin test: at 12 months of age and once during second year of age.
- 4.7.3** Hemoglobin or hematocrit testing: once during first year of age, once during second year of age.
- 4.7.4** Urinalysis: once during first year of age, once during second year of age.
- 4.7.5** Annual blood pressure screening for children between three and six years of age.
- 4.7.6** Blood lead test: (CPT² procedure code 83655): Assessment of risk for lead exposure by structured questionnaire based on CDC Preventing Lead Poisoning in Young (October 1991) during each well-child visit from age six months to under six years of age.
- 4.7.7** Health guidance and counseling, including breast feeding and nutrition counseling.
- 4.7.8** One routine eye examination by an ophthalmologist or optometrist every two years beginning at age three. The routine eye exams offered between the ages of three and six should include screening for amblyopia and strabismus.
- 4.7.9** Additional services or visits required because of specific findings or because the particular circumstances of the individual case are covered if medically necessary and otherwise authorized for benefits.
- 4.8** Well-child services are considered preventive and are subject to the same cost-sharing/ copayment and authorization requirements as prescribed under TRICARE Preventive Services (see [Section 2.1 and 2.2](#)).

- END -

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Psychological Testing

Issue Date: March 13, 1992

Authority: [32 CFR 199.4\(c\)\(3\)\(ix\)](#)

1.0 CPT¹ PROCEDURE CODES

96101-96103, 96118-96120

2.0 DESCRIPTION

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

3.0 POLICY

3.1 Psychological testing and assessment is a covered benefit when medically or psychologically necessary and is provided in conjunction with otherwise covered psychotherapy. Testing and assessment is generally limited to six hours in a fiscal year. Testing or assessment in excess of these limits requires review for medical necessity.

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

Note: Psychological tests are considered diagnostic services and are not counted against the two psychotherapy visits per week.

4.0 EXCLUSIONS

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

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

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

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

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Psychological Testing

4.5 Teacher and parental referrals for psychological testing.

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

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

- END -

Ophthalmological Services

Issue Date: November 3, 1992

Authority: [32 CFR 199.4\(c\)\(2\)\(xvi\)](#), [\(e\)\(6\)](#), [\(g\)\(46\)](#), [\(g\)\(50\)](#), and 10 USC 1079(a)(3)

1.0 CPT¹ PROCEDURE CODE RANGES

92002 - 92060, 92070 - 92335, 92390 - 92499

2.0 DESCRIPTION

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

3.0 POLICY

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

3.2 For Active Duty Family Members (ADFM)s payment can be made for one routine eye examination per year.

3.2.1 Routine eye examinations as defined in [32 CFR 199.2](#) includes coverage of those services rendered in order to determine the refractive state of the eyes. The CPT¹ procedure codes for payment of routine eye examinations are as follows:

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

3.2.2 TRICARE Prime and Standard ADFMs are entitled to one annual routine eye. Prime ADFMs may receive their annual routine eye examination from any network provider without referral, authorization, or preauthorization from the Primary Care Manager (PCM), or any other authority; i.e., a Prime ADFM will be allowed to set up his or her own appointment for a routine eye

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examination with any network optometrist or ophthalmologist. Standard ADFMs may self-refer to any TRICARE authorized provider regardless of whether or not they are a network provider; i.e., a Standard ADFM may set up his or her own appointment with either a network or non-network, TRICARE authorized, optometrist or ophthalmologist.

3.3 For Prime enrollees, see [Section 2.2](#) for additional information on routine eye examinations.

4.0 EXCLUSIONS

4.1 Routine eye examinations are NOT covered for Standard retirees or their dependents that are not enrolled in Prime **except for eye exams allowed under the well-child benefit in [Section 2.5](#)**.

4.2 Orthoptics, also known as vision training, vision therapy, eye exercises, eye therapy, is excluded by [32 CFR 199.4\(g\)\(46\)](#) (CPT² procedure code 92065).

4.3 Heidelberg Retina Tomograph (HRT) is unproven.

- END -

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Chapter 7

Section 7.1

Speech Services

Issue Date: April 19, 1983

Authority: [32 CFR 199.5\(c\)](#) and 10 USC 1079(e)

1.0 CPT¹ PROCEDURE CODE RANGE

92506 - 92508

2.0 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.

3.0 POLICY

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

3.2 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 [Section 18.1](#).

4.0 EXCLUSIONS

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

4.2 For beneficiaries under the age of three, 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 (IDEA), and which are otherwise allowable under the TRICARE Basic Program or the Extended Care Health Option (ECHO) but determined not to be medically or psychologically necessary, are excluded.

4.3 For beneficiaries ages three 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 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.

4.4 Myofunctional or tongue thrust therapy.

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Speech Services

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

4.6 Videofluoroscopy evaluation in speech pathology is unproven.

- END -

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Physical Medicine/Therapy

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

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

- END -

Occupational Therapy

Issue Date: July 3, 1997

Authority: [32 CFR 199.4\(c\)\(3\)\(x\)](#)

1.0 CPT¹ PROCEDURE CODES

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

2.0 DESCRIPTION

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

3.0 POLICY

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

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

4.0 EXCLUSIONS

4.1 The following occupational therapy services are not covered:

- Vocational assessment and training.
- General exercise programs.
- Separate charges for instruction of the patient and family in therapy procedures.
- Repetitive exercise to improve gait, maintain strength and endurance, and assisted walking such as that provided in support of feeble or unstable patients.

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

- Range of motion and passive exercises which are not related to restoration of a specific loss of function.
- CPT² procedure code 97532 or 97533 is not a covered benefit when used as a restorative approach. That is, cognitive function improves as a result of neuronal growth, which is enhanced through the repetitive exercise of neuronal circuits and that recovery of functions is determined by biological events.
- CPT² procedure codes 97532 and 97533 for sensory integration training is excluded.

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

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

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

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

5.0 EFFECTIVE DATE

October 28, 1997.

- END -

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Phase II And Phase III Cancer Clinical Trials

Issue Date: March 13, 2008
Authority: 32 CFR 199.4(e)(26)

1.0 DESCRIPTION

The Department of Defense (DoD) Cancer Prevention and Treatment Clinical Trials Demonstration was conducted from 1996 through March 2008 to improve access to promising new cancer therapies, assist in meeting the National Cancer Institute's (NCI) clinical trial goals, and to assist in the formulation of conclusions regarding the safety and efficacy of emerging therapies in the prevention and treatment of cancer. This Demonstration included Phase II and Phase III protocols sponsored by the NCI for the prevention, screening, early detection, and treatment of all types of cancer (see the TRICARE Operations Manual (TOM), [Chapter 18, Section 2](#)). The Demonstration is to end on March 31, 2008 and applicable coverage guidance has been incorporated into this policy. A new Interagency Agreement between DoD and the NCI has been entered into which is effective April 1, 2008.

2.0 POLICY

2.1 Cancer clinical trial participation is authorized for those TRICARE-eligible patients selected to participate in NCI-sponsored Phase II and Phase III studies for the prevention, screening, early detection, and treatment of cancer. TRICARE will cost-share all medical care and testing required to determine eligibility for an NCI-sponsored trial, including the evaluation for eligibility at the institution conducting the NCI-sponsored study. TRICARE will cost-share all medical care required as a result of participation in NCI sponsored studies. This includes purchasing and administering all approved chemotherapy agents (except for NCI-funded investigational drugs), all inpatient and outpatient care, including diagnostic and laboratory services not otherwise reimbursed under an NCI grant program if the following conditions are met:

- 2.1.1** The provider seeking treatment for a TRICARE-eligible beneficiary in an NCI approved protocol has obtained preauthorization for the proposed treatment before initial evaluation; and
- 2.1.2** Such treatments are NCI sponsored Phase II or Phase III protocols; and
- 2.1.3** The patient continues to meet entry criteria for said protocol; and
- 2.1.4** The institutional and individual providers are TRICARE-authorized providers.

3.0 POLICY CONSIDERATIONS

3.1 Referral by Attending Physician

The attending physician, Primary Care Manager (PCM), or oncologist shall determine the eligible patient's needs and consult with the TRICARE contractor's cancer clinical trials case manager/NCI to determine which, if any, Phase II or Phase III, NCI-sponsored studies are appropriate for the patient.

3.2 Identification of Eligible NCI-sponsored Clinical Trials

3.2.1 NCI sponsorship of clinical trials occurs through the Cancer Therapy Evaluation Program (CTEP), Cooperative Group Studies, NCI Grants or Cancer Center Studies. Evidence of NCI sponsorship in one of these categories will be that it is identified in the NCI comprehensive database, Physicians's Data Query (PDQ), or NCI supplements to that database; formal notification of approval from The Clinical Protocol Review and Monitoring Committee; or verification from the NCI project officer; or through protocols co-sponsored by the NCI and other Federal Agencies.

3.2.2 Unlike the NCI-sponsored protocols for CTEP, Cooperative Group Studies, or NCI Grants, protocols for Cancer Center Studies are not individually reviewed by the NCI. Instead, the NCI designates specific institutions as meeting NCI criteria for clinical and comprehensive cancer centers. Cancer center protocols receive approval through an NCI approved institutional peer review and quality control system at the institution. Protocols which have been through this process receive formal notification of approval from The Clinical Protocol Review and Monitoring Committee and, therefore, are considered NCI sponsored, but may not appear in the PDQ. A provider who is seeking to enter a patient into a Cancer Center Study must provide evidence of NCI sponsorship by forwarding the formal notification of approval from this specific committee. Formal notification of approval by the Clinical Protocol Review and Monitoring Committee will be required for approval of treatment in Cancer Center Studies which are not otherwise sponsored through the CTEP program, NCI cooperative groups, or NCI grants.

3.2.3 Certain protocols listed in the PDQ may not be clearly identified in terms of NCI sponsorship. Clinical trials conducted as part of an NCI grant, or those identified with a "V" number, must be verified for NCI sponsorship with the NCI project officer. Physicians who are holders of the grant at the institution must provide written clarification that the proposed treatment is a protocol under their NCI grant. The grant title and number must be specified.

3.2.4 Requests for treatment in clinical trials overseas must be verified as to NCI sponsorship with the NCI project officer.

3.2.5 Protocols that are co-sponsored by the NCI and other Federal Agencies must be verified by the NCI project officer.

3.2.6 Some NCI-sponsored clinical trials are designated as multiple-phased trials (e.g., Phase I/II). Multi-phase NCI-sponsored clinical trials are eligible for TRICARE coverage as long as the beneficiary is a participant in a trial phase that would normally be covered in a single-phase trial.

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Phase II And Phase III Cancer Clinical Trials

3.3 The DoD has no authority regarding the NCI protocol eligibility for the sponsored study. Therefore, if a patient does not meet the protocol eligibility criteria for enrollment, appeal rights do not apply.

3.4 Retroactive authorizations can be authorized in accordance with the provisions outlined in [32 CFR 199.4\(g\)\(19\)](#).

3.5 Claims will be paid from the applicable underwritten Contract Line Item Number (CLIN) and submitted through normal TRICARE Encounter Data (TED) system processing as required in the TRICARE Systems Manual (TSM) with the applicable coding for cancer clinical trials with enrollment effective on or after April 1, 2008.

3.6 Normal TRICARE eligibility, reimbursement, co-payments, cost-shares, deductibles, TRICARE for Life (TFL), and double coverage rules apply.

3.7 The contractor shall:

3.7.1 Provide a registered nurse to serve as case manager for inquiries and actions pertinent to the cancer clinical trials benefit.

3.7.2 Ensure the provider has submitted a letter on the facility's letterhead:

3.7.2.1 Provide the patient's name and the last four digits of the sponsor's Social Security Number (SSN); and

3.7.2.2 Certify the protocol is an NCI-sponsored study and providing the title and phase of the protocol and the NCI number of the protocol and/or other appropriate evidence of NCI sponsorship; and

3.7.2.3 Certify the patient meets all entry criteria for said protocol; and

3.7.2.4 Certify notification will be provided to the contractor's cancer clinical trials benefit case manager of the patient's registration date when treatment actually begins; and

3.7.2.5 Certify notification will be provided to the contractor's cancer clinical trials benefit case manager if the patient becomes ineligible for the study prior to the treatment.

3.7.3 Utilize the NCI's Comprehensive Cancer Database known as the Physician's Data Query (PDQ), to assist in determining whether a particular study meets the requirements of the cancer clinical trials benefit and whether the patient is eligible for a particular protocol. For those studies that are not listed on the PDQ, the contractor will work with NCI staff to verify NCI sponsorship and phase of the study.

3.8 The contractor may at its discretion establish a dedicated toll-free telephone number to receive inquiries from both patients and providers regarding the cancer clinical trials benefit. If a dedicated toll-free telephone number is established, the phone shall be staffed seven hours a day during normal business hours in the contractor's time zone where the inquiries are received. In the absence of a dedicated toll-free number for cancer clinical trials benefit inquiries, contractors shall

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use their primary toll-free telephone inquiry system (see the TOM, Chapter 11, Section 7 and Chapter 20, Section 4).

The contractor may at its discretion establish a dedicated mailing address where cancer clinical trials benefit inquiries and claims shall be sent for expedited response and/or claims adjudication. In the absence of a dedicated mailing address for cancer clinical trials benefit inquiries and claims, contractors shall use their primary address(es) for written correspondence and claims (see the TOM, [Chapter 11, Sections 5 and 6](#), and [Chapter 20, Section 4](#)).

3.9 The Cancer Clinical Trials Demonstration project rules in the TOM [Chapter 18, Section 2](#), will continue to apply to those TRICARE beneficiaries who began participation in Cancer Clinical Trials Demonstration before termination of the Demonstration. Such rules will continue to apply until the beneficiary is discharged from the clinical trial.

4.0 EXCLUSIONS

4.1 Care rendered in the National Institutes of Health Clinical Center.

4.2 Costs associated with non-treatment research activities related to clinical trials.

4.3 Phase I clinical trials (including Phase I arm of multi-phase clinical trials).

5.0 EFFECTIVE DATE

April 1, 2008.

- END -

Chapter 8

Other Services

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

External And Implantable Infusion Pump (IIP)

Issue Date: February 26, 1986
Authority: [32 CFR 199.4\(d\)\(1\)](#)

1.0 CPT¹ PROCEDURE CODES

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

2.0 HCPCS PROCEDURE CODES

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

3.0 DESCRIPTION

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

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

4.0 POLICY

4.1 External Infusion Pump (EIP)

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

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

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

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

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

4.1.4.1 Cancer chemotherapy agents.

4.1.4.2 Morphine when used in the treatment of intractable pain.

4.1.4.3 Desferoxamine.

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

4.1.4.5 Antibiotic therapy.

4.1.4.6 Heparin therapy in treatment of thromboembolic disease.

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

4.2 Implantable Infusion Pump (IIP)

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

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

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

4.2.3 Treatment of chronic intractable pain of malignant or nonmalignant origin by administration of opioid drugs (e.g., morphine) intrathecally or epidurally in patients who have a life expectancy of at least 3 months and who have not responded to less invasive medical therapy. Documentation of the following must be provided in order for TRICARE to consider a claim for payment:

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

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

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

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

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

4.2.5 Second level review is required for all other IIP uses. Reimbursement may be considered for other uses of IIPs (not specifically excluded in [paragraph 6.0](#)) with documentation of the following:

4.2.5.1 The medical necessity of the drug;

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

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

5.0 POLICY CONSIDERATIONS

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

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

5.3 In addition to IIPs, implanted access ports and pulsatile pumps forming a self-sealing patent access portal for the administration of intravenous medications (e.g., Port-a cath, Medi-port and Infusiport systems) may be cost-shared. These systems are distinguished from IIPs by the method of controlling the drug delivery rate. Access ports deliver drugs by passive diffusion. Pulsatile pumps

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External And Implantable Infusion Pump (IIP)

deliver drugs when the patient manually compresses the device. Drug delivery rates in IIPs are controlled by vapor pressure or by direct electromechanical action.

6.0 EXCLUSIONS

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

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

7.0 EFFECTIVE DATES

7.1 Chemotherapy for malignancies: March 14, 1988.

7.2 Antibiotics for osteomyelitis: February 2, 1989.

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

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

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

- END -

Chapter 9

Section 1.1

General

Issue Date: July 3, 1997

Authority: [32 CFR 199.5](#), 10 USC 1079(g)

1.0 DESCRIPTION

The Extended Care Health Option (ECHO) is a supplemental program to the TRICARE Basic Program and provides eligible Active Duty Family Members (ADFMs) with an additional financial resource for an integrated set of services and supplies designed to assist in the reduction of the disabling effects of the beneficiary's qualifying condition (see [Sections 2.1](#) through [2.4](#)). The ECHO is not an enrollment program but does require registration (see [Section 3.1](#)).

2.0 POLICY

2.1 The ECHO is available only to eligible ADFMs.

2.2 Eligibility and registration are prerequisites to ECHO benefits being authorized.

2.3 Written authorization for ECHO benefits is a prerequisite to claim adjudication.

2.4 ECHO-eligible beneficiaries who are enrolled in TRICARE Prime shall meet all applicable requirements of that program, including those regarding the assignment and use of a Primary Care Manager (PCM) when services are requested and provided through the ECHO.

2.5 TRICARE is primary payer for medical services and items that are provided under Part C of the Individuals with Disabilities Education Act (IDEA) in accordance with the Individualized Family Service Plan and which are otherwise allowable under the TRICARE Basic Program or the ECHO.

3.0 EXCLUSIONS

3.1 All benefits available through the TRICARE Basic Program are excluded from the ECHO.

3.2 Inpatient care for medical or surgical treatment of an acute illness, or of an acute exacerbation of the qualifying condition. These services may be cost-shared through the Basic Program.

3.3 Structural alterations to living space and permanent fixtures, including alterations necessary to accommodate installation of equipment or to facilitate entrance or exit.

3.4 Except as provided by the ECHO Home Health Care (EHC) benefit ([Section 15.1](#)) homemaker services that provide assistance with household chores are excluded.

3.5 Dental care and orthodontic treatment.

3.6 The price differential between the price for a type of accommodation which provides services or features that exceed the requirements of the beneficiary's condition for safe transport and the price for a type of accommodation without those deluxe features. Payment of such price differential is the responsibility of the beneficiary.

3.7 Durable equipment is excluded from the ECHO when:

3.7.1 The beneficiary is a patient in an institution or facility that ordinarily provides the same type of equipment to its patients at no additional charge in the usual course of providing services; or

3.7.2 The item is available to the beneficiary from a Uniformed Services Medical Treatment Facility (USMTF); or

3.7.3 The item has deluxe, luxury, immaterial or nonessential features that increase the cost to the government relative to a similar item without those features; or

3.7.4 The item is duplicate equipment as defined in [32 CFR 199.2](#).

3.8 Maintenance agreements for beneficiary-owned equipment are excluded.

3.9 Services or items for which the beneficiary or sponsor has no legal obligation to pay, or for which no charge would be made if the beneficiary was not eligible for benefits.

3.10 Services or items paid for, or eligible for payment, directly or indirectly by a Public Facility, as defined in [32 CFR 199.2](#), or by the Federal government, other than the Department of Defense (DoD), are excluded, except when such services or items are eligible for payment under a State plan for medical assistance under Title XIX of the Social Security Act (Medicaid).

3.11 Services and items provided as a part of a scientific clinical study, grant, or research program.

3.12 Unproven services and items whose safety and efficacy have not been established as described in [32 CFR 199.4](#), **except for Phase II and Phase III cancer clinical trials sponsored or approved by the National Institutes of Health National Cancer Institute (NIH NCI) as described in [32 CFR 199.4\(e\)\(26\)](#).**

3.13 Services or items provided or prescribed by a member of the beneficiary's immediate family, or a person living in the beneficiary's or sponsor's household.

3.14 Services or items ordered by a court or other government agency that are not otherwise an allowable ECHO benefit.

3.15 Additional or special charges for excursions, except for other otherwise allowable transportation, even when they are part of a program offered by an approved provider.

3.16 Drugs and medicines which do not meet the requirements of [32 CFR 199.4](#).

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General

3.17 Therapeutic absences from an inpatient facility.

3.18 Custodial care, as defined in [32 CFR 199.2](#), as a stand alone ECHO benefit is excluded. Services provided in support of activities of daily living may be cost-shared only when provided through the EHHC benefit (see [Section 15.1](#)).

3.19 Domiciliary care, as defined in [32 CFR 199.2](#), may not be cost-shared through the ECHO.

3.20 Services for a beneficiary aged 3 to 21 that are written in the beneficiary's special education Individualized Educational Program (IEP) and that are required to be provided without charge by the local public education facility in accordance with the IDEA.

4.0 EFFECTIVE DATE

4.1 September 1, 2005.

4.2 The cancer clinical trials exception in [paragraph 3.12](#) is effective as provided in [Chapter 7, Section 24.1](#) and the TRICARE Operations Manual (TOM), [Chapter 18, Section 2](#).

- END -

Eligibility - General

Issue Date: July 3, 1997

Authority: [32 CFR 199.5\(b\)](#), 10 USC 1079(g)

1.0 POLICY

1.1 Extended Care Health Option (ECHO) benefits are available only to the following categories of TRICARE eligible beneficiaries with a qualifying condition:

1.1.1 A spouse, dependent child, or unmarried person (as defined by 10 United States Code (USC) 1072(2)(I)) whose sponsor is an active duty member of one of the Uniformed Services of the United States, including members of the Reserve Component (RC) activated for a period of more than 30 days.

1.1.2 A spouse, dependent child, or unmarried person (as defined by 10 USC 1072(2)(I)) whose sponsor is a former member of a Uniformed Service of the United States when such spouse, child, or unmarried person is the victim of physical or emotional abuse. (Benefits are limited to the period that the abused dependent is in receipt of transitional compensation under 10 USC 1059.)

1.1.3 A Transitional Survivor as defined in 10 USC 1079(g)(2) and [Chapter 10, Section 7.1](#) of this Manual.

1.1.4 A spouse, dependent child, or unmarried person who is receiving ECHO benefits at the time the sponsor dies and the sponsor was eligible at the time of death for receipt of hostile-fire pay or died as a result of a disease or injury incurred while eligible for such pay is entitled to retain the benefits under the ECHO for the greater of the period they qualify as a "Transitional Survivor" as defined by 10 USC 1079(g)(2) and [Chapter 10, Section 7.1](#) of this Manual or until the dependent reaches the age of 21.

1.1.5 A spouse, dependent child, or unmarried person (as defined by 10 USC 1072(2)(I)) who is eligible for continued TRICARE medical benefits through the Transitional Assistance Management Program (TAMP). See [Chapter 10, Section 5.1](#).

1.2 Eligibility for ECHO benefits ceases as of 12:01 a.m. of the day following the day of the earliest occurrence of the following events:

1.2.1 The sponsor ceases to be an active duty member for any reason other than death; or

1.2.2 Eligibility based upon the abused dependent provisions of [paragraph 1.1.2](#) expires; or

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1.2.3 Eligibility based on the deceased sponsor provisions of [paragraph 1.1.3](#) or [1.1.4](#) expires; or

1.2.4 Eligibility based upon a beneficiary's participation in the TAMP program ends; or

1.2.5 The Managed Care Support Contractor (MCSC) or the TRICARE Area Office (TAO) Director determines that the beneficiary no longer has a ECHO qualifying condition.

Note: In locations outside the Continental United States (OCONUS), the TAO Directors shall advise the OCONUS health care contractor of all ECHO eligibility determinations.

1.3 The MCSC or the [TRICARE Overseas Program \(TOP\)](#) contractor will notify the beneficiary in writing of the results of an eligibility determination.

1.4 A determination that a TRICARE beneficiary is not eligible for the ECHO is considered a factual determination based on a requirement of the law or regulation and as such is not appealable. Denial of ECHO services and supplies to an ineligible beneficiary is not appealable.

2.0 EXCLUSION

1 [North Atlantic Treaty Organization \(NATO\)](#) family members are not eligible for benefits through the ECHO.

3.0 EFFECTIVE DATE

September 1, 2005.

- END -

Chapter 9

Section 3.1

Registration

Issue Date: February 14, 2004

Authority: [32 CFR 199.5\(h\)\(2\)](#), 10 USC 1079(d)

1.0 ISSUE

Section 1079(d)(1) of Title 10 United States Code (USC) requires that TRICARE beneficiaries must be “registered” in order to receive the benefits provided under Section 1079(d)-(f) of Title 10, United States Code (USC). This registration policy will enhance the efforts to provide an integrated set of services and supplies to eligible TRICARE beneficiaries and insure effective utilization of program resources.

2.0 POLICY

2.1 The active duty sponsor (or other authorized individual acting on behalf of the beneficiary) will submit the following to the Managed Care Support Contractor (MCSC) or TRICARE Area Office (TAO) Director responsible for administering the Extended Care Health Option (ECHO) in the geographic area where the beneficiary resides:

2.1.1 Evidence that the sponsor is an Active Duty Service Member (ADSM) in one of the Uniformed Services.

2.1.2 Medical records, as determined necessary by the MCSC or TAO Director which demonstrate that the Active Duty Family Member (ADFM) has a qualifying condition in accordance with [Sections 2.2](#) through [2.4](#), and who otherwise meets all applicable ECHO requirements.

2.1.3 Evidence, as provided by the sponsor’s branch of service, that the family, or family member seeking ECHO registration, is enrolled in the Exceptional Family Member Program (EFMP) provided by the sponsor’s branch of service.

2.1.3.1 This requirement is waived when either:

2.1.3.1.1 The sponsor’s branch of service does not provide the EFMP; or

2.1.3.1.2 The beneficiary seeks ECHO eligibility based on the “deceased sponsor” provisions listed in [Section 2.1](#), or

2.1.3.1.3 Other circumstances exist that make enrollment in the EFMP unnecessary or inappropriate, such as when an individual resides with the custodial parent who is not the active duty sponsor.

2.1.3.2 To avoid delaying receipt of ECHO services while completing the ECHO registration process, in particular awaiting completion of enrollment in the EFMP of the sponsor's service, the MCSC or TAO Director may grant otherwise ECHO-eligible beneficiaries a provisional eligibility status for a period of not more than 90 days during which ECHO benefits will be authorized and payable. This provisional status is portable across managed care support contract regions and, except for the ECHO Home Health Care (EHC) benefit, it applies to the TRICARE Overseas Program (TOP).

Note: The provisional status will terminate upon completion of the registration process or at the end of the 90 day period, whichever occurs first. The government liability for ECHO benefits will terminate at the end of the 90 day period. The government will not recoup claims paid for ECHO benefits provided during the provisional period.

Note: To provide services under the ECHO and the Department of Defense (DoD) Enhanced Access to Autism Services Demonstration ("Demonstration") while completing the ECHO registration process and the required diagnostic testing and clinical review (TRICARE Operations Manual (TOM), Chapter 18, Section 9) by beneficiaries not registered in the ECHO, the provisional status period is 120 days concurrently for the ECHO and the Demonstration. Subject to all other applicable requirements, ECHO and Demonstration benefits will be authorized and payable during the provisional status period. The provisional status period and the Government's liability for benefits received while a beneficiary is in the provisional status period will terminate upon the earliest occurrence of completion of enrollment in the Demonstration, or the end of the 120 day period, or upon determination that the requesting beneficiary is not otherwise eligible for either the ECHO or the Demonstration. The Demonstration is not available through the TOP.

2.1.4 Such other information as may be required by the MCSC or TAO Director in order to determine whether or not the requesting beneficiary is eligible for the ECHO.

2.1.5 In locations outside the 50 United States and the District of Columbia, the TAO Director shall advise the TOP contractor of all ECHO eligibility determinations.

2.2 Upon determination that an ADFM is eligible for the ECHO, the MCSC or the TOP contractor will use the Defense Online Enrollment System (DOES) to annotate the beneficiary's Defense Enrollment Eligibility Reporting System (DEERS) record to reflect ECHO eligibility.

2.2.1 The MCSC or TOP contractor will provide the sponsor/beneficiary with written notification of the eligibility determination and that the beneficiary is registered in ECHO. Except as otherwise provided in paragraph 2.1.3.2, the beneficiary is eligible to receive ECHO benefits as of the date of registration.

Note: Upon query through the Composite Health Care System (CHCS), the DEERS Eligibility Response will return the Health Care Delivery Plan (HCDP) code "400", which indicates the beneficiary is registered and eligible to receive ECHO benefits.

2.2.2 Determination that a beneficiary is not eligible for the ECHO is factual, therefore, such determination can not be appealed.

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Registration

2.3 At the time of registration, the MCSC or **TOP** contractor will also provide the sponsor/beneficiary with informational materials that, at a minimum, emphasize the ECHO is an optional program for ADFMs only and has unique qualifying and cost-sharing requirements.

2.4 The eligibility determination will remain in effect until such time as the MCSC or the TAO Director determines the beneficiary is no longer eligible for the ECHO. This may result from a loss of TRICARE eligibility, remediation of the qualifying condition, or a determination that the beneficiary does not otherwise meet the eligibility requirements of the ECHO.

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

3.0 EFFECTIVE DATE

September 1, 2005.

- END -

Chapter 9

Section 4.1

Benefit Authorization

Issue Date: July 3, 1997

Authority: [32 CFR 199.5\(h\)\(3\)](#)

1.0 POLICY

1.1 Except as provided in [paragraph 1.2](#), the Managed Care Support Contractor (MCSC) will provide the required authorization for requested services and items under the Extended Care Health Option (ECHO).

1.2 In the case of beneficiaries residing outside the 50 United States and the District of Columbia, the TRICARE Area Office (TAO) or designees are responsible for authorizing ECHO benefits. The TAOs shall notify the [TRICARE Overseas Program \(TOP\)](#) contractor of all ECHO benefit authorizations or authorization waivers.

1.3 The authorization is based upon the following:

1.3.1 The beneficiary is registered in the ECHO; and

1.3.2 The requested service or item is allowable as a ECHO benefit; and

1.3.3 The requested service or item meets the public facility use requirements when applicable.

1.4 The authorization shall specify the services by type, scope, frequency, duration, dates, amounts, requirements, limitations, provider name and address, and all other information necessary to provide exact identification of approved benefits. Claims can not be adjudicated without this information.

1.5 The authorization shall remain in effect until such time as the MCSC determines that:

1.5.1 The beneficiary is no longer eligible for the ECHO; or

1.5.2 The authorized ECHO service or item is no longer appropriate or required by the beneficiary; or

1.5.3 The authorized ECHO service or item becomes a benefit through the TRICARE Basic Program.

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Benefit Authorization

1.6 The MCSC or TAO Director may waive the required written authorization for rendered services and items that, except for the absence of the written authorization, would be allowable as an ECHO benefit.

1.7 The MCSC or TAO Director may waive the required public facility use certification when such waiver is appropriate. See [Section 5.1](#).

2.0 EFFECTIVE DATE

September 1, 2005.

- END -

Special Education

Issue Date: July 3, 1997

Authority: [32 CFR 199.5\(c\)\(3\)](#) and [\(c\)\(4\)](#)

1.0 CPT¹ PROCEDURE CODES

99199, 99600

2.0 POLICY

2.1 Special education, within the meaning of such term as used in the Individuals with Disabilities Education Act (IDEA) and its implementing regulations and policies, may be cost-shared subject to all applicable Extended Care Health Option (ECHO) requirements, and in particular, the requirement that other public programs and facilities be used to the extent available and adequate.

2.2 Identification of appropriate public facilities. The local educational agency with responsibility for the beneficiary is the sole public facility to provide public facility use certification for special education services.

2.3 The educational modality known as “Applied Behavioral Analysis (ABA)” is included as a benefit under this issuance when provided by a TRICARE-authorized provider. Payable services include periodic evaluation of the beneficiary, development of a treatment plan, and training of immediate family members to provide services in accordance with the treatment plan. TRICARE can also pay for the “hands-on” ABA services when provided by a TRICARE authorized provider. However, TRICARE can not pay for such services when provided by family members, trainers or other individuals who are not TRICARE-authorized providers (see [Section 17.1](#)) and for children less than three and included in the Individualized Family Service Plan (IFSP).

2.4 Services cost-shared through the ECHO may be provided by an authorized institutional or individual professional provider on an inpatient or outpatient basis and rendered in the beneficiary’s natural environment. This includes at home, at school, or other location that is suitable for the type of services being rendered.

2.5 See the TRICARE Operations Manual (TOM), [Chapter 18, Section 9](#) for information about the Department of Defense (DoD) Enhanced Access to Autism Services Demonstration.

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Special Education

3.0 EXCLUSION

Special education services are generally unavailable under the TRICARE Basic Program except as authorized under Section 1079(a)(g) of Title 10 United States Code (USC), and when authorized are not eligible to be cost-shared under ECHO.

4.0 EFFECTIVE DATE

September 1, 2005.

- END -

Chapter 9

Section 17.1

Providers

Issue Date: August 4, 1988

Authority: [32 CFR 199.6\(e\)](#)

1.0 POLICY

1.1 Services and items cost-shared through the Extended Care Health Option (ECHO) must be rendered by TRICARE authorized providers.

1.2 ECHO inpatient care providers: A provider of residential institutional care authorized under the ECHO must:

1.2.1 Be a not-for-profit organization which primarily provides services to the disabled, OR

1.2.2 Be a facility operated by the state or under state contract, AND

1.2.3 Meet all applicable licensing or certification requirements that are extant in the state, county, municipality, or other political jurisdiction in which the provider is located.

1.3 ECHO outpatient care providers. A provider of ECHO outpatient, ambulatory, or in-home services shall be:

1.3.1 An authorized provider of services as defined in [32 CFR 199.6](#), or

1.3.2 An individual, corporation, foundation, or public entity that predominantly renders services of a type uniquely allowable as a ECHO benefit and not otherwise allowable as a benefit of [32 CFR 199.4](#), that meets all applicable licensing or other regulatory requirements that are extant in the state, county, municipality, or other political jurisdiction in which the ECHO service is rendered.

1.4 Individual professional providers authorized by [32 CFR 199.6](#) for the Basic Program are also authorized providers for the ECHO. Individual professional providers who can be authorized only under the ECHO must meet all applicable licensing and other regulatory requirements that are extant in that state, county, municipality, or other political jurisdiction in which the ECHO service is rendered, or, in the absence of such licensing or regulatory requirements, as determined by the Director, TRICARE Management Activity (TMA) or designee.

1.5 For the purpose of services rendered in conjunction with Applied Behavioral Analysis (ABA) under the ECHO Special Education benefit (see [Section 9.1](#)), TRICARE-authorized providers are those that:

1.5.1 Have a current State license to provide ABA services; or

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1.5.2 Are currently State-certified as an Applied Behavioral Analyst; or

1.5.3 Where such State license or certification is not available, are certified by the Behavioral Analyst Certification Board (BACB) as either a Board Certified Behavior Analyst or a Board Certified Associate Behavior Analyst; and

1.5.4 Otherwise meet all applicable requirements of TRICARE-authorized providers.

1.6 ECHO vendor. A provider of an allowable ECHO item, supply, equipment, orthotic, or device shall be deemed to be an authorized vendor for the provision of the specific item, supply, equipment, orthotic, or device when the vendor supplies such information as the Managed Care Support Contractor (MCSC) or Director, TRICARE Area Office (TAO) determines necessary to adjudicate a specific claim.

1.7 Provider requirements for the Department of Defense (DoD) Enhanced access to autism Services Demonstration are indicated in the TRICARE Operations Manual (TOM), Chapter 18, Section 9.

2.0 EFFECTIVE DATE

September 1, 2005.

- END -

Chapter 10

Section 4.1

Continued Health Care Benefit Program (CHCBP)

Issue Date: September 8, 1994

Authority: Section 4408 of P.L. 102-484, [32 CFR 199.20](#)

1.0 ISSUE

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

2.0 BACKGROUND

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

3.0 POLICY

3.1 Eligibility

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

3.1.1 Members of the Uniformed Services who:

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

3.1.1.2 Immediately preceding that discharge or release, were entitled to medical and dental care under a military Health Care Plan (HCP)--including transitional health care under the

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

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

3.1.2 A person who:

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

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

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

3.1.3 A person who:

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

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

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

3.1.4 An unmarried person who:

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

3.1.4.2 Meets [paragraphs 3.1.4.2.1, 3.1.4.2.2, or 3.1.4.2.3](#):

3.1.4.2.1 Has not attained the age of 21;

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

3.1.4.2.3 Is incapable of self-support because of a mental or physical incapacity. This incapacity must have occurred while the person was considered a family member of the member or former member under [paragraphs 3.1.4.2.1 or 3.1.4.2.2](#); and

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

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

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

3.2 Notification of Eligibility

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

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

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

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

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

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

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

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

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

3.3 Election of Coverage

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

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

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

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

3.3.1.4 The day after the date the beneficiary loses eligibility for care under the Military Health System (MHS).

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

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

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

3.4 Enrollment

3.4.1 General

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

3.4.2 Application

3.4.2.1 Applicants for enrollment in CHCBP are required to use DoD Document (DD) Form 2837, CHCBP Application. DD Form 2837 is available electronically on the web at <http://www.dtic.mil/whs/directives/infomgt/forms/eforms/dd2837.pdf>, through the TRICARE web site, and through the CHCBP contractor's web site. It is also available in hardcopy from the CHCBP contractor or any of the TSCs. The individual must submit with the application supporting documentation as requested by the CHCBP contractor to validate the individual's eligibility for enrollment in CHCBP.

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

3.4.3 Enrollment Determinations

3.4.3.1 Verification of Enrollment. Once eligibility for the CHCBP has been verified by the CHCBP contractor, the CHCBP contractor will make the appropriate entries in Defense Enrollment Eligibility Reporting System (DEERS) and will notify the applicant of the enrollment approval (or denial) and provide the enrollee with a CHCBP identification card.

3.4.3.2 Family members not identified on DEERS. When a contractor receives a CHCBP claim which includes a family member not identified on DEERS as enrolled, but the sponsor indicates CHCBP coverage, the contractor is to take the following action: If the claim includes a copy of an appropriately marked CHCBP ID card for the beneficiary, the claim is to be processed. If the claim is

for a beneficiary who is less than 60 days old, the claim is to be processed, even if no copy of an CHCBP ID card is attached. In all other cases, the claim is to be denied.

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

3.4.4 Disenrollment in Other Programs

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

3.5 Period of Coverage

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

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

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

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

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

3.5.1.2 Unmarried dependent child. For an unmarried dependent child of a member or former member, coverage under the CHCBP is limited to 36 months from the date on which the person first ceases to meet the requirements for being considered an unmarried dependent child. However, if the person ceases to meet the requirements for being considered an unmarried dependent child during a period of continued coverage of the member for self and family members, the person's coverage under the CHCBP ends 36 months after the date the child became ineligible for medical and dental care under a military HCP or the date the child first ceases to be eligible for care under TAMP, whichever is later.

3.5.1.3 Unremarried former spouse.

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

3.5.1.3.1.1 The date on which the final decree of divorce, dissolution, or annulment occurs; or

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

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

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

3.5.1.3.2.1 Has not remarried before the age of 55; and

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

3.5.1.3.2.3 Is receiving any portion of the retired or retainer pay of the member or former member or an annuity based on the retired or retainer pay of the member; or

3.5.1.3.2.4 Has a court order for payment of any portion of the retired or retainer pay; or

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

3.5.1.3.3 If an unremarried former spouse who is enrolled in the CHCBP subsequently remarries, enrollment in CHCBP will end as of the date of the marriage. The CHCBP contractor will refund any portion of the former spouse's previously paid premium for any days after CHCBP enrollment ends. Regardless of the period of coverage used by the former spouse, remarriage results in loss of all further eligibility for CHCBP coverage unless future eligibility can be subsequently established based on the criteria in [paragraph 3.1](#).

3.5.1.4 Family member placed in the legal custody of a member or former member. For a family member who is placed in the legal custody of a member or former member, coverage under the CHCBP is limited to 36 months from the date on which the person was formally placed in legal custody. If the family member ceases to meet the eligibility criteria in [paragraph 3.1.4](#) prior to the expiration of the 36 months (e.g., is removed from legal custody of the member or former member), eligibility will end as of the date the family member no longer meets the criteria.

3.5.2 Beginning of Enrollment. Although beneficiaries have 60 days to enroll in the CHCBP (as described in [paragraph 3.4](#)), the period of coverage must begin on the day after entitlement to a

military HCP (including transitional health care under TAMP) ends but no earlier than October 1, 1994.

3.6 CHCBP Administration

3.6.1 General

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

3.6.2 Exceptions

3.6.2.1 Eligibility

The CHCBP has unique eligibility requirements as contained in [paragraph 3.1](#).

3.6.2.2 Non-Availability Statements (NAS) and Use of MTFs

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

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

3.6.2.3 Beneficiary Liability

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

3.6.2.3.2 Active duty cost-shares shall apply to emancipated children and family members placed in legal custody whose sponsor is an active duty member at the time of enrollment. If the sponsor retires during the period of enrollment of the emancipated child or family member placed in legal custody, retirees' cost-shares shall apply to the enrollee as of the date of retirement of the sponsor.

3.6.2.3.3 Former spouses are responsible for retiree cost-shares just as they are under TRICARE.

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

3.6.2.4 Special Programs

3.6.2.4.1 Available to CHCBP. TRICARE Extra.

3.6.2.4.2 Not Available to CHCBP. The following special TRICARE programs are not available to CHCBP beneficiaries.

- Extended Care Health Option (ECHO).
- TRICARE Dental Plan.
- Supplemental Health Care Program.
- TRICARE Enrollment Program (except for TRICARE Extra as noted above).

3.7 Premiums

3.7.1 Rates

3.7.1.1 General. Premium rates are established by the Assistant Secretary of Defense (Health Affairs) for two rate groups--individual and family. The rates are based on Federal Employee Health Benefit Program employee and agency contributions which would be required for a comparable health benefits plan, plus an administrative fee. The administrative fee, which is not to exceed 10% of the basic premium amount, is determined based on actual expected administrative costs for administration of the CHCBP. The premium rates may be updated annually and will be published when updated. The rates are also available from the CHCBP contractor.

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

3.7.1.3 Changing Rate Groups. Only those individuals identified in [paragraph 3.1.1](#) are eligible to change rate groups.

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

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

3.7.1.3.2.1 The birth of a child;

3.7.1.3.2.2 Marriage of the sponsor;

3.7.1.3.2.3 Legal adoption of a child; or

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

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

3.7.1.3.3.1 The qualifying event occurred after the beneficiary's enrollment in the CHCBP;

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

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

3.7.2 Payments

3.7.2.1 Frequency. Premiums are to be paid quarterly to the CHCBP contractor. Payment must be made NLT 30 days after the start of the enrollment quarter.

3.7.2.2 Failure to Make Payments. Failure by enrollees to make a premium payment as required in [paragraph 3.7.2.1](#) will result in denial of continued enrollment in the CHCBP and denial of payment of medical claims for services provided on or after the first day of the quarter for which the premium payment was not paid. Beneficiaries denied continued enrollment due to lack of premium payments will not be allowed to reenroll.

4.0 EFFECTIVE DATE

October 1, 1994.

FIGURE 10.4.1-1 CHCBP IMPLEMENTING INSTRUCTIONS

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

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

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

1. Validate Eligibility for CHCBP.

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

- a.** Individual sponsor and his/her family: a copy of the DD Form 214, "Certificate of Release or Discharge from Active Duty," or a copy of the sponsor's active duty orders
- b.** Unremarried former spouse and stepchildren of the sponsor: a copy of the final divorce decree
- c.** Child who loses military coverage due to marriage: a copy of marriage certificate
- d.** Child who loses military health coverage on his/her 21st birthday if not a full-time student or on his/her 23rd birthday if a full-time student: a copy of the front and back of military ID card
- e.** Child who loses military coverage due to college graduation: a copy of college transcript
- f.** Child who ceases to be a full-time student: a letter from the college stating the student's status
- g.** Child placed in sponsor's legal custody: a copy of the court order

For any other situations in which an individual loses military coverage and may potentially be eligible for CHCBP, the CHCBP contractor shall request such other information as it needs to verify eligibility.

FIGURE 10.4.1-1 CHCBP IMPLEMENTING INSTRUCTIONS (CONTINUED)

2.I. CHCBP Enrollment Data and Report.

The CHCBP contractor shall maintain systems and databases to collect, track and process enrollment applications and to report monthly enrollment information to the government as well as any ad hoc reports that may be requested regarding CHCBP enrollments. The CHCBP contractor must also be able to retroactively retrieve pertinent enrollment information on any individual who has been accepted or denied enrollment in the program, to include the basis for such denials.

3. CHCBP Program Materials.

All CHCBP informational materials, booklets, brochures, and other public material are subject to review and approval by the COR prior to finalizing the material, and all must contain the CHCBP contractor's name, mailing address, toll-free telephone number and web site.

4. CHCBP Inquiries and Customer Service Functions.

The CHCBP contractor is responsible for responding to any CHCBP inquiries from any geographic area, to include locations **outside the 50 United States and the District of Columbia**. The CHCBP contractor is also responsible for providing timely, accurate and thorough responses to the inquiries it receives from any source, e.g., prospective applicants, enrollees, providers, other CHCBP contractors, government officials, etc. CHCBP inquiries shall be handled like any other TRICARE inquiry the CHCBP contractor receives as it relates to the attention that the CHCBP contractor devotes to the issue, as well as to the accuracy, timeliness and responsiveness of answering the inquiry.

The CHCBP contractor shall maintain the same customer service functions, services, level of performance, oversight and CHCBP contractor availability for the CHCBP inquiries as it has for its TRICARE line of business.

5. Fiduciary Responsibilities.

The CHCBP contractor shall act as a fiduciary for all funds acquired from CHCBP premium collections, which are government property. The CHCBP contractor shall develop strict funds control processes for its collection, retention and transfer of CHCBP premiums to the government. All CHCBP enrollment premiums received by the CHCBP contractor shall be maintained in accordance with these procedures.

The CHCBP contractor shall select a commercial bank that is a member of the Federal Reserve Bank. A non-interest bearing account shall be established for the collection and disbursement of CHCBP premiums. The bank name, address, and account number shall be provided to the COR and to the TMA Contract Resource Management (CRM) no later than 60 calendar days prior to the start of the contract. The CHCBP contractor must provide written notification to the COR and TMA-CRM of any subsequent changes of banking institution and/or account numbers at least 30 calendar days prior to the effective date of such change. The CHCBP contractor is required to deposit all CHCBP premiums received within two workdays of receipt.

The CHCBP contractor shall make daily deposits of premiums, net of refund payments, to the US Treasury as directed by TMA-CRM Finance and Accounting Office. The government will provide the CHCBP contractor with information for this deposit no later than 45 calendar days prior to the start-work date of the contract. The CHCBP contractor shall notify the TMA-CRM Finance and Accounting Office by e-mail within one workday of the deposit specifying the date and amount of the deposit.

The CHCBP contractor shall maintain a system for tracking and reporting premiums and enrollments. The system is subject to government review and approval.

FIGURE 10.4.1-1 CHCBP IMPLEMENTING INSTRUCTIONS (CONTINUED)

The CHCBP contractor shall submit the following monthly reports to the government in electronic format. The CHCBP contractor may propose to combine any of these reports with any other CHCBP reports that are required by the government or developed by the CHCBP contractor:

- a. Monthly Enrollee Premiums Report.
- b. Adjusted Premiums Report.
- c. Monthly Premiums Summary Report.

6. DEERS.

Refer to the DEERS instructions in the TOM for additional DEERS issues related to CHCBP.

7. Reporting Responsibilities.

In addition to enrollment and premium reports, the CHCBP contractor is responsible for providing a written report of major CHCBP workload data elements.

In addition to the written monthly reports, the CHCBP contractor may be required to produce CHCBP ad hoc reports as requested by the government. The data elements or information for such reports would be limited to that information that the CHCBP contractor has collected or should reasonably have collected in the performance of CHCBP work. Some manipulation and formatting of the data and information may be required to meet the requirements of the ad hoc reports. The government estimates that the CHCBP contractor would not receive more than three such requests per contract year and that the level of effort for the CHCBP contractor to produce the ad hoc reports is not expected to be significant.

- END -

Transitional Survivor Status And Survivor Status

Issue Date: September 28, 2006

Authority: [32 CFR 199.3](#), 10 USC 1079(g)(2)

1.0 DESCRIPTION

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

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

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

2.0 BACKGROUND

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

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

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

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

2.3 Section 704 of the Floyd D. Spence NDAA FY 2001 created a three year period, beginning with the date of death, for health care to be cost-shared at the active duty dependent payment rate. After three years, survivors remained eligible for TRICARE, but at the retiree payment rate. This provision was effective October 30, 2000.

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2.4 Section 715 of the NDAA for FY 2006, as codified in 10 USC 1079(g)(2), extended the transitional survivor status for the dependent children as outlined in [paragraph 3.0](#). It made this benefit retroactive to October 7, 2001.

3.0 POLICY

3.1 Effective with respect to deaths occurring on or after October 7, 2001, Section 715 of the NDAA FY 2006, PL 109-163, extended the time frame that certain eligible dependents (children and unmarried persons) remain in Transitional Survivor status. See [paragraph 3.2](#).

3.2 Time Frames for Transitional Survivor Status.

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

3.2.2 Children and Unmarried Persons (those defined in 10 United States Code (USC) 1072(2)(D) or (I)) whose sponsor died on or after October 7, 2001. Transitional survivor status ends at age 21 or 23 if enrolled in a full-time course of study in a secondary school or in a full-time course of study in an institution of higher education (subject to the eligibility limitations as described in the [Note](#)).

3.2.3 Incapacitated Children and Incapacitated Unmarried Persons (those defined in 10 United States Code (USC) 1072(2)(D) or (I)) whose sponsor died on or after October 7, 2001. Transitional Survivor status (subject to the eligibility limitations as described in the [Note](#)) is the greater of:

- Three years from the sponsor's date of death, **OR**
- The date on which such dependent attains 21 years of age, **OR**
- The date on which the dependent attains 23 years of age if enrolled in a full-time course of study in a secondary school or in a full-time course of study in an institution of higher education.

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

3.3 Actions necessary due to retroactive implementation of 10 USC 1079(g)(2).

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

3.3.1.1 In Transitional Survivor status shall remain in Transitional Survivor status in accordance with time frames found in [paragraph 3.2](#). The Transitional Survivor's Health Care Plan (HCP) (e.g., Prime, Standard, etc.) shall continue until such time it is changed by the beneficiary.

State Licensure And Certification

Issue Date: September 20, 1990

Authority: [32 CFR 199.6\(c\)\(2\)\(i\)](#) and [\(c\)\(2\)\(ii\)](#)

1.0 ISSUE

TRICARE requirement for state licensure and certification.

2.0 POLICY

2.1 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 a full clinical practice level and do not meet the requirements to be an authorized provider.** The services provided must be within the scope of the license, certification, or other legal authorization. Licensure or certification is required to be an authorized provider when offered in the state where the service is rendered, even if such licensure or certification is not required by the state where the service is rendered. Providers who practice in a state where licensure or certification is optional are required to obtain that licensure or certification to become an authorized provider. A temporary professional state license which allows full and unrestricted scope of practice fully satisfies any Individual Professional Provider certification requirement for the period during which the temporary license is valid. The authorized status of the provider expires when the temporary license expires unless the temporary license is renewed or a regular license is issued to the provider.

2.2 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.

2.3 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

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State Licensure And Certification

certification, authorized providers must obtain the license as soon as the State begins issuance. A period of time, not to exceed a maximum of six months, will be authorized to obtain the license.

- END -

Chapter 11

Section 3.11

Mental Health Counselor

Issue Date: February 24, 1988

Authority: [32 CFR 199.6\(c\)\(3\)\(iv\)\(C\)](#)

1.0 ISSUE

Mental Health Counselor.

2.0 POLICY

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

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

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

2.1.3 Licensure or certification as a mental health counselor.

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

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

- END -

Certification Of Organ Transplant Centers

Issue Date: June 20, 1988

Authority: [32 CFR 199.6\(b\)\(4\)\(ii\)](#) and [\(b\)\(4\)\(iii\)](#)

1.0 POLICY

1.1 Certifying Authority

The TRICARE contractor is the certifying authority for applications for status as a TRICARE-authorized institutional provider for liver, heart, Combined Heart-Kidney (CHKT), Combination Liver-Kidney (CLKT), lung, heart-lung, and Small Intestine (SI) within its region. Medicare is the approving authority for kidney transplant centers.

1.2 General Certification Requirements

To obtain TRICARE certification as an organ transplant center, the center must have:

- 1.2.1 An active solid organ transplantation program.
 - 1.2.2 Participation in a donor organ procurement program and network.
 - 1.2.3 An interdisciplinary body to determine the suitability of candidates for transplantation on an equitable basis.
 - 1.2.4 An anesthesia team that is available at all time.
 - 1.2.5 A nursing service team trained in the hemodynamic support of the patient and in managing immunosuppressed patients.
 - 1.2.6 Pathology and immunology resources that are available for studying and reporting the pathological responses to transplantation.
 - 1.2.7 Evidence that the center safeguards the rights and privacy of patients.
 - 1.2.8 Continual compliance with state transplantation laws and regulations, if any.
 - 1.2.9 Legal counsel familiar with transplantation laws and regulations.
- 1.3 The continued compliance of a certified transplantation center must be verified by the contractor no less than every 24 months.

1.4 Reporting Requirements

The transplant center must report to the TRICARE certifying authority any decrease in actuarial survival rates below the actuarial survival rate established by TRICARE for initial facility certification.

1.5 Liver Transplantation Centers

TRICARE shall provide coverage for liver transplantation procedures performed only by experienced transplant surgeons at centers complying with the provisions outlined in [paragraph 1.2](#) and the following criteria or status as a TRICARE-certified liver transplantation center may be granted based upon Medicare certification as a liver transplant center.

1.5.1 The transplant center must:

1.5.1.1 Have staff board eligible or board certified physicians and other experts in the fields of hepatology, pediatrics, infectious disease, nephrology with dialysis capability, pulmonary medicine with respiratory therapy support, pathology, immunology, and anesthesiology to complement a qualified transplantation team.

1.5.1.2 Have a transplant surgeon who is specifically trained for liver grafting and who can assemble and train a team to function successfully whenever a donor liver is available.

1.5.1.3 Have at least a 50% one year actuarial survival rate for 10 cases as calculated using the Kaplan-Meier product limit method. A 50% one-year actuarial survival rate for all subsequent liver transplantations must be maintained for continued TRICARE approval.

1.6 Heart Transplantation Centers

TRICARE shall provide coverage for heart transplantation procedures performed only by experienced transplant surgeons at centers complying with provisions outlined in [paragraph 1.2](#) and the following criteria or status as a TRICARE-certified heart transplantation center may be granted based upon Medicare certification as a heart transplantation center.

1.6.1 The transplant center must:

1.6.1.1 Have experts in the fields of cardiology, cardiovascular surgery, anesthesiology, immunology, infectious disease, nursing, social services, and organ procurement to complement the transplant team.

1.6.1.2 Have an active cardiovascular medical and surgical program as evidenced by a minimum of 500 cardiac catheterizations and coronary arteriograms and 250 open heart procedures per year.

1.6.1.3 Have an established heart transplantation program with documented evidence of 12 or more heart transplants in each of the three consecutive preceding 12-month periods prior to the date of application (a total of 36 or more heart transplantation procedures).

Acronyms And Abbreviations

3D	Three Dimensional
AA	Anesthesiologist Assistant
AA&E	Arms, Ammunition and Explosives
AAA	Abdominal Aortic Aneurysm
AAAHC	Accreditation Association for Ambulatory Health Care, Inc.
AAFES	Army/Air Force Exchange Service
AAMFT	American Association for Marriage and Family Therapy
AAP	American Academy of Pediatrics
AAPC	American Association of Pastoral Counselors
AARF	Account Authorization Request Form
AATD	Access and Authentication Technology Division
ABA	American Banking Association Applied Behavioral Analysis
ABMT	Autologous Bone Marrow Transplant
ABPM	Ambulatory Blood Pressure Monitoring
ABR	Auditory Brainstem Response
ACD	Augmentative Communication Devices
ACI	Autologous Chondrocyte Implantation
ACIP	Advisory Committee on Immunization Practices
ACO	Administrative Contracting Officer
ACOG	American College of Obstetricians and Gynecologists
ACOR	Administrative Contracting Officer's Representative
ACS	American Cancer Society
ACTUR	Automated Central Tumor Registry
AD	Active Duty
ADA	American Dental Association American Diabetes Association Americans with Disabilities Act
ADAMHA	Alcohol, Drug Abuse, And Mental Health Administration
ADAMHRA	Alcohol, Drug Abuse, And Mental Health Reorganization Act
ADCP	Active Duty Claims Program
ADD	Active Duty Dependent
ADFM	Active Duty Family Member
ADL	Activities of Daily Living
ADP	Automated Data Processing

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Acronyms And Abbreviations

ADSM	Active Duty Service Member
AFOSI	Air Force Office of Special Investigations
AHA	American Hospital Association
AHLTA	Armed Forces Health Longitudinal Technology Application
AHRQ	Agency for Healthcare Research and Quality
AI	Administrative Instruction
AIDS	Acquired Immune Deficiency Syndrome
AIIM	Association for Information and Image Management
AIS	Automated Information Systems
AIX	Advanced IBM Unix
AJ	Administrative Judge
ALA	Annual Letter of Assurance
ALB	All Lines Busy
ALL	Acute Lymphocytic Leukemia
ALOS	Average Length-of-Stay
ALS	Action Lead Sheet Advanced Life Support
ALT	Autolymphocyte Therapy
AM&S	Acquisition Management and Support (Directorate)
AMA	Against Medical Advice American Medical Association
AMH	Accreditation Manual for Hospitals
AMHCA	American Mental Health Counselor Association
AML	Acute Myelogenous Leukemia
ANSI	American National Standards Institute
AOA	American Osteopathic Association
APA	American Psychiatric Association American Podiatry Association
APC	Ambulatory Payment Classification
API	Application Program Interface
APN	Assigned Provider Number
APO	Army Post Office
ART	Assisted Reproductive Technology
ARU	Automated Response Unit
ASA	Adjusted Standardized Amount American Society of Anesthesiologists
ASAP	Automated Standard Application for Payment
ASC	Accredited Standards Committee Ambulatory Surgical Center
ASCA	Administrative Simplification Compliance Act
ASCUS	Atypical Squamous Cells of Undetermined Significance

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Acronyms And Abbreviations

ASD	Assistant Secretary of Defense Atrial Septal Defect Autism Spectrum Disorder
ASD(C3I)	Assistant Secretary of Defense for Command, Control, Communications, and Intelligence
ASD(HA)	Assistant Secretary of Defense (Health Affairs)
ASD (MRA&L)	Assistant Secretary of Defense for Manpower, Reserve Affairs, and Logistics
ASP	Average Sale Price
ATB	All Trunks Busy
ATO	Approval to Operate
AVM	Arteriovenous Malformation
AWOL	Absent Without Leave
AWP	Average Wholesale Price
B&PS	Benefits and Provider Services
B2B	Business to Business
BACB	Behavioral Analyst Certification Board
BBA	Balanced Budget Act
BBP	Bloodborne Pathogen
BBRA	Balanced Budget Refinement Act
BCABA	Board Certified Associate Behavior Analyst
BCAC	Beneficiary Counseling and Assistance Coordinator
BCBA	Board Certified Behavior Analyst
BCBS	Blue Cross Blue Shield
BC	Birth Center
BCC	Biostatistics Center
BI	Background Investigation
BIPA	Benefits Improvement Protection Act
BL	Black Lung
BLS	Basic Life Support
BMT	Bone M arrow Transplantation
BP	Behavioral Plan
BPC	Beneficiary Publication Committee
BPS	Beneficiary and Provider Services
BRAC	Base Realignment and Closure
BRCA	BReast CAncer
BS	Bachelor of Science
BSID	Bayley Scales of Infant Development
BSR	Beneficiary Service Representative
BWE	Beneficiary Web Enrollment
C&A	Certification and Accreditation
C&CS	Communications and Customer Service
C/S	Client/Server
CA	Care Authorization

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Acronyms And Abbreviations

CA/NAS	Care Authorization/Non-Availability Statement
CABG	Coronary Artery Bypass Craft
CAC	Common Access Card
CAD	Coronary Artery Disease
CAF	Central Adjudication Facility
CAH	Critical Access Hospital
CAP/DME	Capital and Direct Medical Education
CAPD	Continuous Ambulatory Peritoneal Dialysis
CAPP	Controlled Access Protection Profile
CAT	Computerized Axial Tomography
CB	Consolidated Billing
CBC	Cypher Block Chaining
CBHCO	Community Based Health Care Organizations
CBSA	Core Based Statistical Area
CC	Common Criteria Criminal Control (Act)
CC&D	Catastrophic Cap and Deductible
CCDD	Catastrophic Cap and Deductible Data
CCEP	Comprehensive Clinical Evaluation Program
CCMHC	Certified Clinical Mental Health Counselor
CCN	Case Control Number
CCPD	Continuous Cycling Peritoneal Dialysis
CCR	Cost-To-Charge Ratio
CCTP	Custodial Care Transitional Policy
CD	Compact Disc
CDC	Centers for Disease Control and Prevention
CDCF	Central Deductible and Catastrophic Cap File
CDD	Childhood Disintegrative Disorder
CDH	Congenital Diaphragmatic Hernia
CD-I	Compact Disc - Interactive
CDR	Clinical Data Repository
CDRL	Contract Data Requirements List
CD-ROM	Compact Disc - Read Only Memory
CDT	Current Dental Terminology
CEIS	Corporate Executive Information System
CEO	Chief Executive Officer
CEOB	CHAMPUS Explanation of Benefits
CFO	Chief Financial Officer
CFR	Code of Federal Regulations
CFS	Chronic Fatigue Syndrome
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CHAMPVA	Civilian Health and Medical Program of the Department of Veteran Affairs

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Acronyms And Abbreviations

CHBC	Criminal History Background Check
CHBR	Criminal History Background Review
CHC	Civilian Health Care
CHCBP	Continued Health Care Benefits Program
CHCS	Composite Health Care System
CHEA	Council on Higher Education Accreditation
CHKT	Combined Heart-Kidney Transplant
CHOP	Children's Hospital of Philadelphia
CI	Counterintelligence
CIA	Central Intelligence Agency
CIO	Chief Information Officer
CIPA	Classified Information Procedures Act
CJCSM	Chairman of the Joint Chiefs of Staff Manual
CL	Confidentiality Level (Classified, Public, Sensitive)
CLIA	Clinical Laboratory Improvement Amendment
CLIN	Contract Line Item Number
CLKT	Combined Liver-Kidney Transplant
CLL	Chronic Lymphocytic Leukemia
CMAC	CHAMPUS Maximum Allowable Charge
CMHC	Community Mental Health Center
CML	Chronic Myelogenous Leukemia
CMN	Certificate(s) of Medical Necessity
CMO	Chief Medical Officer
CMP	Civil Money Penalty
CMS	Centers for Medicare and Medicaid Services
CMVP	Cryptographic Module Validation Program
CNM	Certified Nurse Midwife
CNS	Central Nervous System Clinical Nurse Specialist
CO	Contracting Officer
COB	Close of Business Coordination of Benefits
COBC	Coordination of Benefits Contractor
COBRA	Consolidated Omnibus Budget Reconciliation Act
CoCC	Certificate of Creditable Coverage
COCO	Contractor Owned-Contractor Operated
COE	Common Operating Environment
CONUS	Continental United States
COO	Chief Operating Officer
COOP	Continuity of Operations Plan
COPA	Council on Postsecondary Accreditation
COPD	Chronic Obstructive Pulmonary Disease

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Acronyms And Abbreviations

COR	Contracting Officer's Representative
CORF	Comprehensive Outpatient Rehabilitation Facility
CORPA	Commission on Recognition of Postsecondary Accreditation
COTS	Commercial-off-the-shelf
CPA	Certified Public Accountant
CPE	Contract Performance Evaluation
CPI	Consumer Price Index
CPI-U	Consumer Price Index - Urban (Wage Earner)
CPNS	Certified Psychiatric Nurse Specialists
CPR	CAC PIN Reset
CPT	Chest Physiotherapy Current Procedural Terminology
CPT-4	Current Procedural Terminology, 4th Edition
CQMP	Clinical Quality Management Program
CQMP AR	Clinical Quality Management Program Annual Report
CQS	Clinical Quality Studies
CRM	Contract Resource Management (Directorate)
CRNA	Certified Registered Nurse Anesthetist
CRT	Computer Remote Terminal
CSA	Clinical Support Agreement
CSE	Communications Security Establishment (of the Government of Canada)
CSP	Corporate Service Provider Critical Security Parameter
CST	Central Standard Time
CSU	Channel Sending Unit
CSV	Comma-Separated Value
CSW	Clinical Social Worker
CT	Central Time Computerized Tomography
CTEP	Cancer Therapy Evaluation Program
CTCL	Cutaneous T-Cell Lymphoma
CVAC	CHAMPVA Center
CVS	Contractor Verification System
CY	Calendar Year
DAA	Designated Approving Authority
DAO	Defense Attache Offices
DBA	Doing Business As
DC	Direct Care
DCAA	Defense Contract Audit Agency
DCAO	Debt Collection Assistance Officer
DCID	Director of Central Intelligence Directive
DCII	Defense Clearance and Investigation Index
DCIS	Defense Criminal Investigating Service

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DCN	Document Control Number
DCP	Data Collection Period
DCR	Developed Character Reference
DCS	Duplicate Claims System
DCSI	Defense Central Security Index
DD (Form)	Department of Defense (Form)
DDAS	DCII Disclosure Accounting System
DDP	Dependent Dental Plan
DDS	DEERS Dependent Suffix
DE	Durable Equipment
DECC	Defense Enterprise Computing Center
DED	Dedicated Emergency Department
DEERS	Defense Enrollment Eligibility Reporting System
DENC	Detailed Explanation of Non-Concurrence
DepSecDef	Deputy Secretary of Defense
DES	Data Encryption Standard
DFAS	Defense Finance and Accounting Service
DG	Diagnostic Group
DGH	Denver General Hospital
DHHS	Department of Health and Human Services
DHP	Defense Health Program
DIA	Defense Intelligence Agency
DIACAP	DoD Information Assurance Certification And Accreditation Process
DII	Defense Information Infrastructure
DIS	Defense Investigative Service
DISA	Defense Information System Agency
DISCO	Defense Industrial Security Clearance Office
DISN	Defense Information Systems Network
DISP	Defense Industrial Security Program
DITSCAP	DoD Information Technology Security Certification and Accreditation Process
DLAR	Defense Logistics Agency Regulation
DLE	Dialyzable Leukocyte Extract
DM	Disease Management
DMDC	Defense Manpower Data Center
DME	Durable Medical Equipment
DMEPOS	Durable medical equipment, prosthetics, orthotics, and supplies
DMI	DMDC Medical Interface
DMIS	Defense Medical Information System
DMIS-ID	Defense Medical Information System Identification (Code)
DMLSS	Defense Medical Logistics Support System
DMZ	Demilitarized Zone
DNA	Deoxyribonucleic Acid

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DNA-HLA	Deoxyribonucleic Acid - Human Leucocyte Antigen
DNACI	DoD National Agency Check Plus Written Inquiries
DO	Doctor of Osteopathy Operations Directorate
DOB	Date of Birth
DoD	Department of Defense
DoD AI	Department of Defense Administrative Instruction
DoDD	Department of Defense Directive
DoDI	Department of Defense Instruction
DoDIG	Department of Defense Inspector General
DoD P&T	Department of Defense Pharmacy and Therapeutics (Committee)
DOE	Department of Energy
DOEBA	Date of Earliest Billing Action
DOES	DEERS Online Enrollment System
DOHA	Defense Office of Hearings and Appeals
DOJ	Department of Justice
DOLBA	Date of Latest Billing Action
DP	Designated Provider
DPA	Differential Power Analysis
DPI	Designated Providers Integrator
DPO	DEERS Program Office
DRA	Deficit Reduction Act
DREZ	Dorsal Root Entry Zone
DRG	Diagnostic Related Group
DRPO	DEERS RAPIDS Program Office
DSAA	Defense Security Assistance Agency
DSC	DMDC Support Center
DSCC	Data and Study Coordinating Center
DSM	Diagnostic and Statistical Manual of Mental Disorders
DSM-III	Diagnostic and Statistical Manual of Mental Disorders, Third Edition
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition
DSMC	Data and Safety Monitoring Committee
DSMO	Designated Standards Maintenance Organization
DSO	DMDC Support Office
DSU	Data Sending Unit
DTF	Dental Treatment Facility
DTR	Derived Test Requirements
DTRO	Director, TRICARE Regional Office
DUA	Data Use Agreement
DVA	Department of Veterans Affairs
DVAHCF	Department of Veterans Affairs Health Care Finder
DVD	Digital Video Disc

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DWR	DSO Web Request
Dx	Diagnosis
E-ID	Early Identification
E-NAS	Electronic Non-Availability Statement
E&M	Evaluation & Management
E2R	Enrollment Eligibility Reconciliation
EAL	Common Criteria Evaluation Assurance Level
EAP	Ethandamine phosphate
EBC	Enrollment Based Capitation
ECA	External Certification Authority
ECG	Electrocardiogram
ECHO	Extended Care Health Option
ECT	Electroconvulsive Therapy
ED	Emergency Department
EDC	Error Detection Code
EDI	Electronic Data Information Electronic Data Interchange
EDIPI	Electronic Data Interchange Person Identifier
EDIPN	Electronic Data Interchange Person Number
EDI_PN	Electronic Data Interchange Patient Number
EEG	Electroencephalogram
EEPROM	Erasable Programmable Read-Only Memory
EFM	Electronic Fetal Monitoring
EFMP	Exceptional Family Member Program
EFP	Environmental Failure Protection
EFT	Electronic Funds Transfer Environmental Failure Testing
EGHP	Employer Group Health Plan
E/HPC	Enrollment/Health Plan Code
EHHC	ECHO Home Health Care Extended Care Health Option Home Health Care
EHP	Employee Health Program
EIA	Educational Interventions for Autism Spectrum Disorders
EIDS	Executive Information and Decision Support
EIN	Employer Identification Number
EIP	External Infusion Pump
EKG	Electrocardiogram
ELN	Element Locator Number
ELISA	Enzyme-Linked Immunoabsorbent Assay
E/M	Evaluation and Management
EMC	Electronic Media Claim Enrollment Management Contractor
EMDR	Eye Movement Desensitization and Reprocessing

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EMG	Electromyograma
EMTALA	Emergency Medical Treatment & Active Labor Act
ENTNAC	Entrance National Agency Check
EOE	Evoked Otoacoustic Emission
EOB	Explanation of Benefits
EOBs	Explanations of Benefits
EOC	Episode of Care
EOG	Electro-oculogram
EOMB	Explanation of Medicare Benefits
ePHI	electronic Protected Health Information
EPO	Erythropoietin Exclusive Provider Organization
EPR	EIA Program Report
EPROM	Erasable Programmable Read-Only Memory
ER	Emergency Room
ERISA	Employee Retirement Income and Security Act of 1974
ESRD	End Stage Renal Disease
EST	Eastern Standard Time
ESWT	Extracorporeal Shock Wave Therapy
ET	Eastern Time
ETIN	Electronic Transmitter Identification Number
EWPS	Enterprise Wide Provider System
EWRAS	Enterprise Wide Referral and Authorization System
F&AO	Finance and Accounting Office(r)
FAR	Federal Acquisition Regulations
FASB	Federal Accounting Standards Board
FBI	Federal Bureau of Investigation
FCC	Federal Communications Commission
FCCA	Federal Claims Collection Act
FDA	Food and Drug Administration
FDB	First Data Bank
FDL	Fixed Dollar Loss
Fed	Federal Reserve Bank
FEHBP	Federal Employee Health Benefit Program
FEL	Familial Erythrophagocytic Lymphohistiocytosis
FEV ₁	Forced Expiratory Volume
FFM	Foreign Force Member
FHL	Familial Hemophagocytic Lymphohistiocytosis
FI	Fiscal Intermediary
FIPS	Federal Information Processing Standards (or System)
FIPS PUB	FIPS Publication
FISH	Fluorescence In Situ Hybridization

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FISMA	Federal Information Security Management Act
FL	Form Locator
FMCRA	Federal Medical Care Recovery Act
FOC	Full Operational Capability
FOIA	Freedom of Information Act
FPO	Fleet Post Office
FQHC	Federally Qualified Health Center
FR	Federal Register Frozen Records
FRC	Federal Records Center
FTE	Full Time Equivalent
FTP	File Transfer Protocol
FX	Foreign Exchange (lines)
FY	Fiscal Year
GAAP	Generally Accepted Accounting Principles
GAO	General Accounting Office
GBL	Government Bill of Lading
GDC	Guglielmi Detachable Coil
GFE	Government Furnished Equipment
GHz	Gigahertz
GIFT	Gamete Intrafallopian Transfer
GIQD	Government Inquiry of DEERS
GP	General Practitioner
GPCI	Geographic Practice Cost Index
H/E	Health and Environment
HAC	Health Administration Center
HAVEN	Home Assessment Validation and Entry
HBA	Health Benefits Advisor
HBO	Hyperbaric Oxygen Therapy
HCC	Health Care Coverage
HCDP	Health Care Delivery Program
HCF	Health Care Finder
HCFA	Health Care Financing Administration
HCG	Human Chorionic Gonadotropin
HCIL	Health Care Information Line
HCP	Health Care Provider
HCPC	Healthcare Common Procedure Code (formerly HCFA Common Procedure Code)
HCPCS	Healthcare Common Procedure Coding System (formerly Healthcare Common Procedure Coding System)
HCPR	Health Care Provider Record
HCSR	Health Care Service Record
HDC	High Dose Chemotherapy

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HDC/SCR	High Dose Chemotherapy with Stem Cell Rescue
HDL	Hardware Description Language
HEAR	Health Enrollment Assessment Review
HEDIS	Health Plan Employer Data and Information Set
HepB-Hib	Hepatitis B and Hemophilus influenza B
HHA	Home Health Agency
HHA PPS	Home Health Agency Prospective Payment System
HHC	Home Health Care
HHC/CM	Home Health Care/Case Management
HHRG	Home Health Resource Group
HHS	Health and Human Services
HI	Health Insurance
HIC	Health Insurance Carrier
HICN	Health Insurance Claim Number
HINN	Hospital-Issued Notice Of Noncoverage
HIPAA	Health Insurance Portability and Accountability Act (of 1996)
HIPPS	Health Insurance Prospective Payment System
HIQH	Health Insurance Query for Health Agency
HIV	Human Immunodeficiency Virus
HL7	Health Level 7
HLA	Human Leukocyte Antigen
HMAC	Hash-Based Message Authentication Code
HMO	Health Maintenance Organization
HNPCC	Hereditary Nonpolypsis Colorectal Cancer
HPA&E	Health Program Analysis & Evaluation
HPSA	Health Professional Shortage Area
HPV	Human Papilloma Virus
HRG	Health Resource Group
HRT	Heidelberg Retina Tomograph Hormone Replacement Therapy
HSCRC	Health Services Cost Review Commission
HTML	HyperText Markup Language
HTTP	HyperText Transfer (Transport) Protocol
HTTPS	Hypertext Transfer (Transport) Protocol Secure
HUAM	Home Uterine Activity Monitoring
HUS	Hemolytic Uremic Syndrome
HVPT	Hyperventilation Provocation Test
IA	Information Assurance
IATO	Interim Approval to Operate
IAVA	Information Assurance Vulnerability Alert
IAVM	Information Assurance Vulnerability Management
IAW	In accordance with

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IC	Individual Consideration Integrated Circuit
ICASS	International Cooperative Administrative Support Services
ICD-9-CM	International Classification of Diseases, 9th Revision, Clinical Modification
ICF	Intermediate Care Facility
ICMP	Individual Case Management Program
ICMP-PEC	Individual Case Management Program For Persons With Extraordinary Conditions
ICN	Internal Control Number
ICSP	Individual Corporate Services Provider
ID	Identification Identifier
IDE	Investigational Device Exemption Investigational Device
IDEA	Individuals with Disabilities Education Act
IDET	Intradiscal Electrothermal Therapy
IDME	Indirect Medical Education
IE	Interface Engine Internet Explorer
IEP	Individualized Educational Program
IFSP	Individualized Family Service Plan
IG	Implementation Guidance
IGCE	Independent Government Cost Estimate
IHI	Institute for Healthcare Improvement
IHS	Indian Health Service
IIHI	Individually Identifiable Health Information
IIP	Implantable Infusion Pump
IM	Information Management Intramuscular
IND	Investigational New Drugs
INR	Intramuscular International Normalized Ratio
INS	Immigration and Naturalization Service
IOC	Initial Operational Capability
IOD	Interface Operational Description
IOLs	Intraocular Lenses
IOM	Internet Only Manual
IORT	Intra-Operative Radiation Therapy
IP	Inpatient
IPC	Information Processing Center (outdated term, see SMC)
IPN	Intraperitoneal Nutrition
IPPS	Inpatient Prospective Payment System
IPS	Individual Pricing Summary
IPSEC	Secure Internet Protocol
IQ	Intelligence Quotient

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IQM	Internal Quality Management
IRB	Institutional Review Board
IRR	Individual Ready Reserve
IRS	Internal Revenue Service
IRTS	Integration and Runtime Specification
IS	Information System
ISN	Investigation Schedule Notice
ISO	International Standard Organization
ISP	Internet Service Provider
IT	Information Technology
ITSEC	Information Technology Security Evaluation Criteria
IV	Initialization Vector Intravenous
IVF	In Vitro Fertilization
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
JCOS	Joint Chiefs of Staff
JFTR	Joint Federal Travel Regulations
JNI	Japanese National Insurance
JTF-GNO	Joint Task Force for Global Network Operations
JUSDAC	Joint Uniformed Services Dental Advisory Committee
JUSMAC	Joint Uniformed Services Medical Advisory Committee
JUSPAC	Joint Uniformed Services Personnel Advisory Committee
KB	Knowledge Base
KO	Contracting Officer
LAA	Limited Access Authorization
LAC	Local Agency Check
LAK	Lymphokine-Activated Killer
LAN	Local Area Network
LASER	Light Amplification by Stimulated Emission of Radiation
LCF	Long-term Care Facility
LDL	Low Density Lipoprotein
DLT	Living Donor Liver Transplantation
LOC	Letter of Consent
LOD	Letter of Denial/Revocation
LOI	Letter of Intent
LOS	Length-of-Stay
LOT	Life Orientation Test
LPN	Licensed Practical Nurse
LSIL	Low-grade Squamous Intraepithelial
LSN	Location Storage Number
LTC	Long-Term Care
LUPA	Low Utilization Payment Adjustment

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LVEF	Left Ventricular Ejection Fraction
LVN	Licensed Vocational Nurse
LVRS	Lung Volume Reduction Surgery
MAC	Maximum Allowable Charge Maximum Allowable Cost
MAC III	Mission Assurance Category III
MAID	Maximum Allowable Inpatient Day
MB&RS	Medical Benefits and Reimbursement Systems
MCIO	Military Criminal Investigation Organization
MCS	Managed Care Support
MCSC	Managed Care Support Contractor
MCSS	Managed Care Support Services
MCTDP	Myelomeningocele Clinical Trial Demonstration Protocol
MD	Doctor of Medicine
MDI	Mental Developmental Index
MDR	MHS Data Repository
MDS	Minimum Data Set
MEC	Marketing and Education Committee
MEI	Medicare Economic Index
MEPS	Military Entrance Processing Station
MEPRS	Medical Expense Performance Reporting System
MFCC	Marriage and Family Counseling Center
MGCRB	Medicare Geographic Classification Review Board
MGIB	Montgomery GI Bill
MHO	Medical Holdover
MHS	Military Health System
MHSO	Managing Health Services Organization
MHSS	Military Health Services System
MI&L	Manpower, Installations, and Logistics
MIA	Missing In Action
MIDCAB	Minimally Invasive Direct Coronary Artery Bypass
MIRE	Monochromatic Infrared Energy
MMA	Medicare Modernization Act
MMP	Medical Management Program
MMSO	Military Medical Support Office
MMWR	Morbidity and Mortality Weekly Report
MNR	Medical Necessity Report
MOA	Memorandum of Agreement
MOMS	Management of Myelomeningocele Study
MOP	Mail Order Pharmacy
MOU	Memorandum of Understanding
MPI	Master Patient Index

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MR	Medical Review Mentally Retarded
MRA	Magnetic Resonance Angiography
MRI	Magnetic Resonance Imaging
MRPU	Medical Retention Processing Unit
MS	Microsoft®
MSA	Metropolitan Statistical Area
MSC	Military Sealift Command
MSIE	Microsoft® Internet Explorer
MSP	Medicare Secondary Payer
MST	Mountain Standard Time
MSUD	Maple Syrup Urine Disease
MSW	Masters of Social Work Medical Social Worker
MT	Mountain Time
MTF	Military Treatment Facility
MV	Multivisceral (transplant)
MVS	Multiple Virtual Storage
MWR	Morale, Welfare, and Recreation
N/A	Not Applicable
N/D	No Default
NAC	National Agency Check
NACI	National Agency Check Plus Written Inquiries
NACLC	National Agency Check with Law Enforcement and Credit
NADFM	Non-Active Duty Family Member
NARA	National Archives and Records Administration
NAS	Non-Availability Statement
NATO	North Atlantic Treaty Organization
NAVMED	Naval Medical (Form)
NBCC	National Board of Certified Counselors
NCCI	National Correct Coding Initiatives
NCF	National Conversion Factor
NCI	National Cancer Institute
NCPAP	Nasal Continuous Positive Airway Pressure
NCPDP	National Council of Prescription Drug Program
NCQA	National Committee for Quality Assurance
NCVHS	National Committee on Vital and Health Statistics
NDAA	National Defense Authorization Act
NDC	National Drug Code
NDMS	National Disaster Medical System
NED	National Enrollment Database
NETT	National Emphysema Treatment Trial

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NF	Nursing Facility
NHLBI	National Heart, Lung and Blood Institute
NHSC	National Health Service Corps
NICHD	National Institute of Child Health and Human Development
NIH	National Institutes of Health
NIPRNET	Nonsecure Internet Protocol Router Network
NIS	Naval Investigative Service
NISPOM	National Industrial Security Program Operating Manual
NIST	National Institute of Standards and Technology
NLT	No Later Than
NMES	Neuromuscular Electrical Stimulation
NMOP	National Mail Order Pharmacy
NMR	Nuclear Magnetic Resonance
NMT	Nurse Massage Therapist
NOAA	National Oceanic and Atmospheric Administration
NoPP	Notice of Private Practices
NOSCASTC	National Operating Standard Cost as a Share of Total Costs
NP	Nurse Practitioner
NPDB	National Practitioner Data Bank
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
NPR	Notice of Program Reimbursement
NPS	Naval Postgraduate School
NQF	National Quality Forum
NRC	Nuclear Regulatory Commission
NTIS	National Technical Information Service
NUBC	National Uniform Billing Committee
NUCC	National Uniform Claims Committee
O/ATIC	Operations/Advanced Technology Integration Center
OASD(HA)	Office of the Assistant Secretary of Defense (Health Affairs)
OASD (H&E)	Office of the Assistant Secretary of Defense (Health and Environment)
OASD (MI&L)	Office of the Assistant Secretary of Defense (Manpower, Installations, and Logistics)
OASIS	Outcome and Assessment Information Set
OB/GYN	Obstetrician/Gynecologist
OBRA	Omnibus Budget Reconciliation Act
OCE	Outpatient Code Editor
OCHAMPUS	Office of Civilian Health and Medical Program of the Uniformed Services
OCONUS	Outside of the Continental United States
OCR	Office of Civil Rights
OCSP	Organizational Corporate Services Provider
OD	Optical Disk

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OGC	Office of General Counsel
OGP	Other Government Program
OHI	Other Health Insurance
OHS	Office of Homeland Security
OIG	Office of Inspector General
OMB	Office of Management and Budget
OP/NSP	Operation/Non-Surgical Procedure
OPD	Outpatient Department
OPM	Office of Personnel Management
OPPS	Outpatient Prospective Payment System
OSA	Obstructive Sleep Apnea
OSAS	Obstructive Sleep Apnea Syndrome
OSD	Office of the Secretary of Defense
OSHA	Occupational Safety and Health Act
OSS	Office of Strategic Services
OT	Occupational Therapy (Therapist)
OTC	Over-The-Counter
OUSD	Office of the Undersecretary of Defense
OUSD (P&R)	Office of the Undersecretary of Defense (Personnel and Readiness)
P/O	Prosthetic and Orthotics
P&T	Pharmacy And Therapeutics (Committee)
PA	Physician Assistant
PACAB	Port Access Coronary Artery Bypass
PACO ₂	Partial Pressure of Carbon Dioxide
PAO ₂	Partial Pressure of Oxygen
PAK	Pancreas After Kidney (transplant)
PAP	Papanicolaou
PatID	Patient Identifier
PAVM	Pulmonary Arteriovenous Malformation
PBM	Pharmacy Benefit Manager
PCMBN	PCM By Name
PCMRS	PCM Reassignment System
PC	Personal Computer Professional Component
PCA	Patient Controlled Analgesia
PCDIS	Purchased Care Detail Information System
PCM	Primary Care Manager
PCMRA	PCM Research Application
PCMRS	PCM Panel Reassignment (Application)
PCO	Procurement (Procuring) Contracting Officer
PCP	Primary Care Physician Primary Care Provider

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PCS	Permanent Change of Station
PD	Passport Division
PDA	Patent Ductus Arteriosus Personal Digital Assistant
PDDBI	Pervasive Developmental Disorders Behavior Inventory
PDDNOS	Pervasive Developmental Disorder Not Otherwise Specified
PDF	Portable Document Format
PDQ	Physicians's Data Query
PDR	Person Data Repository
PDS	Person Demographics Service
PDTS	Pharmacy Data Transaction System
PE	Physical Examination
PEC	Pharmacoeconomic Center
PEP	Partial Episode Payment
PEPR	Patient Encounter Processing and Reporting
PERMS	Provider Education and Relations Management System
PET	Positron Emission Tomography
PFCRA	Program Fraud Civil Remedies Act
PFP	Partnership For Peace
PFPWD	Program for Persons with Disabilities
Phen-Fen	Pondimin and Redux
PHI	Protected Health Information
PHIMT	Protected Health Information Management Tool
PHP	Partial Hospitalization Program
PHS	Public Health Service
PI	Program Integrity (Office)
PIA	Privacy Impact Assessment (Online)
PIC	Personnel Investigation Center
PIE	Pulsed Irrigation Evacuation
PIN	Personnel Identification Number
PIP	Personal Injury Protection Personnel Identity Protection
PIT	PCM Information Transfer
PIV	Personal Identity Verification
PKI	Public Key Infrastructure
PKU	Phenylketonuria
PL	Public Law
PLS	Preschool Language Scales
PM-DRG	Pediatric Modified-Diagnosis Related Group
PMR	Percutaneous Myocardial Laser Revascularization
PNET	Primitive Neuroectodermal Tumors
PNT	Policy Notification Transaction

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POA	Power of Attorney
POC	Pharmacy Operations Center Plan of Care Point of Contact
POL	May 1996 TRICARE/CHAMPUS Policy Manual 6010.47-M
POS	Point of Sale (Pharmacy only) Point of Service Public Official's Statement
POV	Privately Owned Vehicle
PPD	Per Patient Day
PPN	Preferred Provider Network
PPO	Preferred Provider Organization
PPS	Prospective Payment System Ports, Protocols and Services
PPV	Pneumococcal Polysaccharide Vaccine
PQI	Potential Quality Indicator Potential Quality Issue
PR	Periodic Reinvestigation
PRC	Program Review Committee
PRG	Peer Review Group
PRO	Peer Review Organization
ProDUR	Prospective Drug Utilization Review
PROM	Programmable Read-Only Memory
PRP	Personnel Reliability Program
PSA	Prime Service Area Physician Scarcity Area
PSAB	Personnel Security Appeals Board
PSCT	Peripheral Stem Cell Transplantation
PSI	Personnel Security Investigation
PST	Pacific Standard Time
PT	Pacific Time Physical Therapist Physical Therapy Prothrombin Time
PTA	Pancreas Transplant Alone Percutaneous Transluminal Angioplasty
PTC	Processed To Completion
PTCA	Percutaneous Transluminal Coronary Angioplasty
PTK	Phototherapeutic Keratectomy
PVCs	Premature Ventricular Contractions
QA	Quality Assurance
QC	Quality Control
QI	Quality Improvement Quality Issue

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QII	Quality Improvement Initiative
QIO	Quality Improvement Organization
QIP	Quality Improvement Program
QLE	Qualifying Life Event
QM	Quality Management
QUIG	Quality Indicator Group
RA	Remittance Advice
RAM	Random Access Memory
RAP	Request for Anticipated Payment
RAPIDS	Real-Time Automated Personnel Identification System
RC	Reserve Component
RCN	Recoupment Case Number Refund Control Number
RCS	Report Control Symbol
RD	Regional Director
RDBMS	Relational Database Management System
RDDDB	Reportable Disease Database
REM	Rapid Eye Movement
RFI	Request For Information
RFP	Request For Proposal
RHC	Rural Health Clinic
RHHI	Regional Home Health Intermediary
RhoGAM	RRho (D) Immune Globulin
RN	Registered Nurse
RNG	Random Number Generator
RO	Regional Office
ROC	Resumption of Care
ROFR	Right of First Refusal
ROM	Read-Only Memory Rough Order of Magnitude
ROT	Read-Only Table
ROTC	Reserved Officer Training Corps
ROVER	RHHI Outcomes and Assessment Information Set Verification
RPM	Record Processing Mode
RRA	Regional Review Authority
RTC	Residential Treatment Center
RUG	Resource Utilization Group
RV	Residual Volume
RVU	Relative Value Unit
SAAR	System Authorization Access Request
SAD	Seasonal Affective Disorder
SADMERC	Statistical Analysis Durable Medical Equipment Regional Carrier

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SAO	Security Assistant Organizations
SAP	Special Access Program
SAS	Sensory Afferent Stimulation
SAT	Service Assist Team
SBCC	Service Branch Classification Code
SBI	Special Background Investigation
SCH	Sole Community Hospital
SCHIP	State Children's Health Insurance Program
SCI	Sensitive Compartmented Information Spinal Cord Injury
SCIC	Significant Change in Condition
SCOO	Special Contracts and Operations Office
SCR	Stell Cell Rescue
S/D	Security Division
SD (Form)	Secretary of Defense (Form)
SEP	Sensory Evoked Potentials
SES	Senior Executive Service
SelRes	Selected Reserve
SF	Standard Form
SGDs	Speech Generating Devices
SHCP	Supplemental Health Care Program
SI	Sensitive Information Small Intestine (transplant) Status Indicator
SIDS	Sudden Infant Death Syndrome
SII	Special Investigative Inquiry
SI/L	Small Intestine-Live (transplant)
SIOP-ESI	Single Integrated Operational plan-Extremely Sensitive Information
SIP	System Identification Profile
SIT	Standard Insurance Table
SMC	System Management Center
SNF	Skilled Nursing Facility
SNS	Sacral Nerve Root Stimulation
SOC	Start of Care
SOFA	Status Of Forces Agreement
SOIC	Senior Officer of the Intelligence Community
SON	Submitting Office Number
SOR	Statement of Reasons
SP	Special Processing Code
SPA	Simple Power Analysis
SPECT	Single Photon Emission Computed Tomography
SPK	Simultaneous Pancreas Kidney (transplant)
SPOC	Service Point of Contact

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SPR	SECRET Periodic Reinvestigation
SQL	Structured Query Language
SRE	Serious Reportable Event
SSA	Social Security Act Social Security Administration
SSAA	Social Security Authorization Agreement
SSAN	Social Security Administration Number
SSBI	Single-Scope Background Investigation
SSL	Secure Socket Layer
SSM	Site Security Manager
SSN	Social Security Number
SSO	Short-Stay Outlier
STF	Specialized Treatment Facility
STS	Specialized Treatment Services
STSF	Specialized Treatment Service Facility
SUDRF	Substance Use Disorder Rehabilitation Facility
SVO	SIT Validation Office
SVT	Supraventricular Tachycardia
SWLS	Satisfaction With Life Scale
TAD	Temporary Additional Duty
TAFIM	Technical Architecture Framework for Information Management
TAMP	Transitional Assistance Management Program
TAO	TRICARE Alaska Office TRICARE Area Office
TARO	TRICARE Alaska Regional Office
TB	Tuberculosis
TBD	To Be Determined
TBE	Tick Borne Encephalitis
TBI	Traumatic Brain Injury
TC	Technical Component
TCP/IP	Transmission Control Protocol/Internet Protocol
TDEFIC	TRICARE Dual Eligible Fiscal Intermediary Contract
TDP	TRICARE Dental Plan
TDY	Temporary Duty
TED	TRICARE Encounter Data
TEFRA	Tax Equity and Fiscal Responsibility Act
TEOB	TRICARE Explanation of Benefits
TEPRC	TRICARE Encounter Pricing (Record)
TEPRV	TRICARE Encounter Provider (Record)
TET	Tubal Embryo Transfer
TF	Transfer Factor
TFL	TRICARE For Life

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TFMDP	TRICARE (Active Duty) Family Member Dental Plan
TGRO	TRICARE Global Remote Overseas
TGROHC	TGRO Host Country
TIFF	Tagged Imaged File Format
TIL	Tumor-Infiltrating Lymphocytes
TIMPO	Tri-Service Information Management Program Office
TIN	Taxpayer Identification Number
TIPS	Transjugular Intrahepatic Portosystemic Shunt
TIS	TRICARE Information Service
TLAC	TRICARE Latin America/Canada
TLC	Total Lung Capacity
TMA	TRICARE Management Activity
TMA-A	TRICARE Management Activity - Aurora
TMAC	TRICARE Maximum Allowable Charge
TMI&S	Technology Management Integration & Standards
TMOP	TRICARE Mail Order Pharmacy
TMR	Transmyocardial Revascularization
TNEX	TRICARE Next Generation (MHS Systems)
TOB	Type of Bill
TOE	Target of Evaluation
TOL	TRICARE Online
TOM	August 2002 TRICARE Operations Manual 6010.51-M February 2008 TRICARE Operations Manual 6010.56-M
TOP	TRICARE Overseas Program
TPA	Third Party Administrator
TPC	Third Party Collections
TPharm	TRICARE Pharmacy
TPL	Third Party Liability
TPM	August 2002 TRICARE Policy Manual 6010.54-M February 2008 TRICARE Policy Manual 6010.57-M
TPN	Total Parenteral Nutrition
TPOCS	Third Party Outpatient Collections System
TPR	TRICARE Prime Remote
TPRADFM	TRICARE Prime Remote Active Duty Family Member
TPRADSM	TRICARE Prime Remote Active Duty Service Member
TPRC	TRICARE Puerto Rico Contract(or)
TQMC	TRICARE Quality Monitoring Contractor
TRDP	TRICARE Retiree Dental Program
TRI	TED Record Indicator
TRM	August 2002 TRICARE Reimbursement Manual 6010.55-M February 2008 TRICARE Reimbursement Manual 6010.58-M
TRO	TRICARE Regional Office
TRPB	TRICARE Retail Pharmacy Benefits

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TRRx	TRICARE Retail Pharmacy
TRS	TRICARE Reserve Select
TRSA	TRICARE Reserve Select Application
TSC	TRICARE Service Center
TSF	Target of Evaluation Security Functions
TSM	August 2002 TRICARE Systems Manual 7950.1-M February 2008 TRICARE Systems Manual 7950.2-M
TSP	Target of Evaluation Security Policy
TSR	TRICARE Select Reserve
TSRDP	TRICARE Select Reserve Dental Program
TSRx	TRICARE Senior Pharmacy
TSS	TRICARE Senior Supplement
TSSD	TRICARE Senior Supplement Demonstration
TTY	Teletypewriter
TUNA	Transurethral Needle Ablation
UAE	Uterine Artery Embolization
UB	Uniform Bill
UBO	Uniform Business Office
UCBT	Umbilical Cord Blood Stem Cell Transplantation
UCC	Uniform Commercial Code
UCCI	United Concordia Companies, Inc.
UCSF	University of California San Francisco
UIC	Unit Identification Code
UIN	Unit Identifier Number
UM	Utilization Management
UMO	Utilization Management Organization
UMP	User Maintenance Portal
UPIN	Unique Physician Identification Number
URF	Unremarried Former Spouses
URL	Universal Resource Locator
US	United States
USA	United States of America
USACID	United States Army Criminal Investigation Division
USAF	United States Air Force
USAO	United States Attorneys' Office
USC	United States Code
USCG	United States Coast Guard
USCO	Uniformed Services Claim Office
USD	Undersecretary of Defense
USD (P&R)	Undersecretary of Defense (Personnel and Readiness)
USDI	Undersecretary of Defense for Intelligence
USFHP	Uniformed Services Family Health Plan

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USHBP	Uniformed Services Health Benefit Plan
USMC	United States Marine Corps
USMTF	Uniformed Services Medical Treatment Facility
USN	United States Navy
USPDI	United States Pharmacopoeia Drug Information
USPHS	United States Public Health Service
USPS	United States Postal Service
USPSTF	U.S. Preventive Services Task Force
USS	United Seaman's Service
USTF	Uniformed Services Treatment Facility
UV	Ultraviolet
VA	Veteran Affairs (hospital) Veteran Administration
VAD	Ventricular Assist Device
VAMC	VA Medical Center
VATS	Video-Assisted Thoroscopic Surgery
VAX-D	Vertebral Axial Decompression
VD	Venereal Disease
VO	Verifying Office (Official)
VPN	Virtual Private Network
VPOC	Verification Point of Contact
VSAM	Virtual Storage Access Method
VSD	Ventricular Septal Defect
WAC	Wholesale Acquisition Cost
WAN	Wide Area Network
WATS	Wide Area Telephone Service
WC	Worker's Compensation
WEDI	Workgroup for Electronic Data Interchange
WIC	Women, Infants, and Children (Program)
WORM	Write Once Read Many
WRAMC	Walter Reed Army Medical Center
WTC	World Trade Center
WTRR	Wire Transfer Reconciliation Report
X-Linked SCID	X-Linked Severe Combined Immunodeficiency Syndrome
XML	eXtensible Markup Language
ZIFT	Zygote Intrafallopian Transfer

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