



DEFENSE
HEALTH AGENCY

MB&RO

**OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
HEALTH AFFAIRS
16401 EAST CENTRETECH PARKWAY
AURORA, CO 80011-9066**

**CHANGE 131
6010.57-M
MARCH 11, 2015**

**PUBLICATIONS SYSTEM CHANGE TRANSMITTAL
FOR
TRICARE POLICY MANUAL (TPM), FEBRUARY 2008**

The TRICARE Management Activity has authorized the following addition(s)/revision(s).

CHANGE TITLE: CONSOLIDATED CHANGE 14-007

CONREQ: 17176

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): See page 3.

EFFECTIVE DATE: April 13, 2015.

IMPLEMENTATION DATE: April 13, 2015.

This change is made in conjunction with Feb 2008 TOM, Change No. 142.

**GREEN.ELAN.PA
RKER.138650575
2**

Digitally signed by
GREEN.ELAN.PARKER.1386505752
DN: c=US, o=U.S. Government, ou=DoD,
ou=PKI, ou=DHA,
cn=GREEN.ELAN.PARKER.1386505752
Date: 2015.03.09 10:20:25 -06'00'

**Ann N. Fazzini
Team Chief, Medical Benefits &
Reimbursement Office (MB&RO)
Defense Health Agency (DHA)**

**ATTACHMENT(S): 5 PAGE(S)
DISTRIBUTION: 6010.57-M**

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

CHANGE 131
6010.57-M
MARCH 11, 2015

REMOVE PAGE(S)

CHAPTER 2

Section 4.1, pages 3 and 4

CHAPTER 10

Section 2.1, pages 3

Section 4.1, pages 5 and 6

INSERT PAGE(S)

Section 4.1, pages 3 and 4

Section 2.1, pages 3

Section 4.1, pages 5 and 6

SUMMARY OF CHANGES

CHAPTER 2

1. Section 4.1. This change deletes obsolete language.

CHAPTER 10

2. Section 2.1. This change adds language to allow “telephonic” enrollment/disenrollment.
3. Section 4.1. This change revises language to note TRICARE Service Centers (TSCs) are only available at overseas locations.

TRICARE Policy Manual 6010.57-M, February 1, 2008

Chapter 2, Section 4.1

Emergency Department (ED) Services

emergency admission (but the admission can be authorized as medically or psychologically necessary), the effective date of the authorization shall be the date of the receipt of the request or the date of admission, whichever occurs first (refer to the TRICARE Operations Manual (TOM)).

5.8 ED services as defined in "POLICY" above are cost-shared as follows:

5.8.1 Outpatient care when the beneficiary is discharged home, regardless of any subsequent hospital admission related to the reason for the ED visit.

5.8.2 As inpatient care when:

5.8.2.1 An immediate inpatient admission for acute care follows the outpatient ED services.

5.8.2.1.1 "Immediate" includes the time lapse associated with the beneficiary's direct transfer to an acute care facility more capable of providing the required level-of-care. ED care includes otherwise payable services of both the transferring and receiving facilities.

5.8.2.1.2 This will be done even when the ED care is billed separately, as is required for all hospital services provided on an outpatient basis when the related inpatient stay is subject to the TRICARE DRG-based payment system. In determining if the ED care was immediately followed by an inpatient admission, the TRICARE contractor is required only to examine the claim for ED care for evidence of a subsequent admission and to examine its in-house claims records (history).

5.8.2.2 An ED patient dies while awaiting formal hospital admission for continued medically necessary acute care.

Note: See [paragraph 6.0](#) for Prime, Extra, and Standard-specific cost-sharing provisions for non-emergency care sought in an ED.

6.0 LIMITATIONS

6.1 TRICARE PRIME Beneficiaries

6.1.1 Prime enrollees must obtain all non-emergency primary health care from the Primary Care Manager (PCM) or from another provider to which the enrollee is referred by the PCM or the contractor. Therefore, if a TRICARE Prime beneficiary seeks treatment in an ED and there was not a referral by his/her PCM, and it is clearly a case of routine illness where the beneficiary's medical condition never was, or never appeared to be, a condition as defined in POLICY above, then payment shall be in accordance with the Point of Service (POS) option.

6.1.2 Claims shall not be denied or paid at the POS option because a condition, which appeared to be a serious medical condition when presenting to the ED, turns out to be non-emergency in nature based on the final diagnosis (i.e., claims shall not be denied in situations where the beneficiary presents to the ED with a condition that would cause a prudent layperson to believe an emergency exists, but the final diagnosis is determined to be a non-emergency condition.) A common example of this situation is when a beneficiary seeks treatment in the ED for chest pain, but the final diagnosis is indigestion.

6.2 Non-Enrolled TRICARE Beneficiaries (Standard And Extra)

6.2.1 While TRICARE Extra/Standard beneficiaries have the freedom to choose a provider of care, all TRICARE benefits must be “medically necessary” and “appropriate medical care”. (See the BACKGROUND section of this policy). If an Extra/Standard beneficiary seeks treatment in an ED and it was clearly a case of routine illness where the beneficiary’s medical condition never was, or never appeared to be, a condition as defined in [paragraph 4.0](#), then the facility charge shall be denied (i.e., the ED fee billed on the current Centers for Medicare and Medicaid Services (CMS) forms) and the professional services shall be allowed. Other professional ancillary services, including professional components of laboratory and radiology services, if appropriate can be also covered on an allowable charge basis. If an Extra or Standard beneficiary is referred to the ED by the contractor, (e.g., for after hours care), the care is to be allowed.

6.2.2 Claims shall not be denied because a condition, which appeared to be a serious medical condition upon presenting to the ED, turns out to be non-emergency in nature based on the final diagnosis. (i.e., claims shall not be denied in situations where the beneficiary presents to the ED with a condition that would cause a prudent layperson to believe an emergency exists, but the final diagnosis is determined to be a non-emergency condition.) A common example of this situation is when a beneficiary seeks treatment in the ED for chest pain, but the final diagnosis is indigestion.

7.0 EXCLUSIONS

In the absence of other qualifying conditions, pain associated with pregnancy or incipient birth after the 34th week of gestation when associated with a pregnancy, are not emergency conditions for adjudication purposes.

- END -

request and fee are received after the twentieth (20th) day of the month, enrollment will begin on the first day of the second month after the month in which they were received by the contractor.

1.1.4.2 Reenrollments for those who were enrolled in Prime immediately prior to a change in their status:

1.1.4.2.1 When an active duty member's retirement is effective other than the first of the month a Prime enrollment request to reenroll (enrollment form, BWE transaction, or telephonic request received by the contractor) must be completed within 30 days of the member's retirement. Otherwise, the request shall be considered an initial enrollment in Prime. The effective date of reenrollment shall be the date of retirement which will then result in seamless TRICARE Prime benefits with no break in coverage.

1.1.4.2.2 When an active duty member separates other than the first of the month, but continues to be eligible (e.g., is the spouse of an active duty member; or is eligible for Transitional Assistance Management Program (TAMP) they and any eligible family members shall be allowed to reenroll in TRICARE Prime with no break in coverage. TAMP eligibles must request enrollment in Prime (enrollment form, BWE transaction, or telephonic request received by the contractor) prior to the expiration of their period of TAMP eligibility to reenroll in Prime. Non-TAMP eligibles separating but who remain eligible for TRICARE must request enrollment in Prime within 30 days of their change in status. Otherwise, the request shall be considered an initial enrollment in Prime. The effective date of reenrollment shall be the start date of TAMP eligibility or the date of the separation which will then result in seamless TRICARE Prime benefits with no break in coverage.

1.1.4.2.3 TAMP eligible family members who were enrolled in Prime immediately prior to their sponsor's change in status to active duty may continue their enrollment in TRICARE Prime with no break in coverage if they request reenrollment in TRICARE Prime (enrollment form, BWE transaction, or telephonic request received by the contractor) within 30 days of their sponsor's return to active duty status. If they request reenrollment within 30 days of the sponsor's return to active duty status, the reenrollment will be retroactive to the date of the change in status from TAMP to active duty. If reenrollment is not accomplished within 30 days of the sponsor's return to active duty status, the twentieth of the month rule will apply. For information on the effective dates of enrollments for Active Duty Service Members (ADSMs), see the TOM, [Chapter 6, Section 1](#).

1.1.5 Beneficiaries shall be disenrolled when they are no longer eligible for TRICARE or when they do not submit payment for prescribed enrollment fees by the required date.

1.2 Portability. Enrollees may transfer enrollment when they move (within a contract area or outside a contract area). **The transfer request or disenrollment may be submitted using an enrollment form, BWE transaction or telephonic request received and documented by the contractor.** The losing contractor shall provide continuing coverage until (1) the enrollee requests enrollment in the new location, (2) the enrollee disenrolls, (3) the enrollee is no longer eligible for enrollment in TRICARE Prime, or (4) the contractor must disenroll the beneficiary for failure to pay required enrollment fees, whichever occurs first. The authorization and referral rules of the losing contractor will continue to apply until enrollment is transferred or the beneficiary is disenrolled (see the TOM, [Chapter 6, Section 2](#)).

- END -

3.4 Application To Purchase Care

3.4.1 General

In order to purchase CHCBP coverage, an eligible individual must submit a CHCBP enrollment application to the contractor. The name and address of the contractor will be extensively publicized and is available through the CHCBP contractor, Managed Care Support Contractors (MCSCs), overseas TRICARE Service Centers (TSCs), DoD transition offices, Military Treatment Facilities (MTFs), and other DoD and Uniformed Services entities which provide information regarding TRICARE. A member or former member of the Uniformed Services who is eligible to purchase CHCBP may purchase self-only or family coverage. If the member or former member purchases family coverage, family members cannot purchase self-only coverage.

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 TRICARE web site (<http://www.tricare.mil/chcbp>) and through the contractor's web site. It is also available in hardcopy from the contractor or, in overseas locations, at a TSC. Supporting eligibility documentation may be requested by the contractor.

3.4.2.2 Payment of the premium for the first quarter (three months) coverage must be submitted along with the application. 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 available at <http://www.tricare.mil/chcbp> and is also available from the contractor or wherever the applicant obtains information regarding the CHCBP.

3.5 Period of Coverage

3.5.1 Limits on Coverage Periods. Coverage under the CHCBP varies depending on the category of beneficiary as listed in [Figure 10.4.1-1](#).

3.5.2 If coverage under the CHCBP is terminated because the former beneficiary regains eligibility for TRICARE coverage under 10 USC Chapter 55 or 10 USC § 1145(a), once that eligibility for TRICARE coverage ends, CHCBP coverage is again available per [Figure 10.4.1-1](#).

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

3.6 CHCBP Administration

3.6.1 General

Only TRICARE Standard and Extra benefits and procedures apply to the CHCBP.

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 CHCBP purchasers are not required to obtain a NAS.

3.6.2.2.2 CHCBP purchasers are not eligible to receive care at MTFs except in a medical emergency. Should emergency MTF care be required, payment may be made to the MTF as 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 beneficiary's sponsor last belonged shall continue to apply. Because separating active duty members were not eligible for TRICARE Standard, amounts applicable to family members of active duty members shall apply to this category of beneficiary.

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

3.6.2.3.3 Former spouses shall pay retiree cost-shares the same as 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 **CC&D**. Similarly, CHCBP cost-shares and deductibles do not carry over to a TRICARE plan should the beneficiary regain TRICARE eligibility except for the purchase of retroactive TYA coverage (see the TRICARE Operations Manual (TOM), [Chapter 25](#)). The CHCBP contractor and the pharmacy contractor shall have an **automated** process to monitor CHCBP CC&D totals for accurately calculating deductible and cost-share amounts. See the TOM, [Chapter 23, Section 3](#), for details.

3.6.2.3.5 A dependent spouse who is Medicare-eligible and is also covered under TRICARE for Life (TFL), and who then divorces their sponsor, is eligible to purchase CHCBP if they otherwise meet CHCBP requirements (including requirements to remain unmarried and not otherwise be eligible for TRICARE as a 20/20/20 or 20/20/15 former spouse). In such circumstances CHCBP is a second payor to Medicare.