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MB&RO

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

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

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**CHANGE 134
6010.57-M
APRIL 1, 2015**

REMOVE PAGE(S)

CHAPTER 1

Section 8.1, pages 1 and 2

CHAPTER 5

Section 1.1, pages 1 and 2

CHAPTER 6

Section 1.1, pages 1 and 2

CHAPTER 7

Section 2.2, pages 5 through 8

Section 3.17, page 1

INSERT PAGE(S)

Section 8.1, pages 1 and 2

Section 1.1, pages 1 and 2

Section 1.1, pages 1 and 2

Section 2.2, pages 5 through 8

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SUMMARY OF CHANGES

CHAPTER 1

1. Section 8.1. This change removes language regarding referral and supervision of speech, physical, and occupational therapy, in accordance with current regulatory provisions.
EFFECTIVE DATE: 08/10/2010

CHAPTER 5

2. Section 1.1. This change clarifies when other [not specifically listed] indications for breast MRI may be covered. EFFECTIVE DATE: 03/31/2006

CHAPTER 6

3. Section 1.1. This change clarifies coverage of HPV Diagnostic Testing. EFFECTIVE DATE: 05/01/2015

CHAPTER 7

4. Section 2.2. This change implements the coverage of Lung Cancer Preventive Screening for persons that meet specific criteria under the Prime Uniform Health Maintenance Organization Benefit (HMO). EFFECTIVE DATE: 12/31/2013
5. Section 3.17. This change revises language in the Eating Disorder Treatment Policy to emphasize "eating" disorders, NOT 'feeding' disorders. EFFECTIVE DATE: 05/01/2015

Primary Care Managers (PCMs)

Issue Date: May 15, 1996
Authority: [32 CFR 199.17](#)

1.0 POLICY

1.1 TRICARE Prime enrollees shall select or have assigned to them Primary Care Managers (PCMs) according to guidelines established by the Military Treatment Facility (MTF) Commander and Regional Director (RD).

1.1.1 A PCM may be a network provider, or an MTF PCM by name/supported by a team. If a group practice is listed as a network provider, all members of the group practice must be TRICARE-authorized providers.

1.1.2 The following types of individual professional providers are considered primary care providers and may be designated PCMs, consistent with governing State rules and regulations: internists, family practitioners, pediatricians, general practitioners (GPs), obstetricians/gynecologists (OB/GYNs), physician assistants (PAs), nurse practitioners (NPs), and certified nurse midwives (CNMs).

1.2 A TRICARE Prime enrollee must seek all his or her primary health care from the PCM with the exception of Clinical Preventive Services. If the PCM is unable to provide a primary care service, the PCM is responsible for referring the enrollee to another primary care provider. A TRICARE Prime enrollee must be referred by the PCM for specialty care or for inpatient care. Failure to obtain a PCM referral when one is required will result in the service being paid under Point of Service procedures with a deductible for outpatient services and cost-shares for in- and outpatient services.

1.3 The PCM is responsible for notifying the contractor that a referral is being made. The contractor will assist the Prime enrollee in locating an MTF or network provider to provide the specialty care and in scheduling an appointment. Additionally, the contractor will conduct a prospective review and authorize the service in accordance with the contractor's best practices.

2.0 EXCEPTIONS

PCM referral is not required for the following services:

2.1 Services provided directly by the PCM.

2.2 Emergency care.

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Chapter 1, Section 8.1

Primary Care Managers (PCMs)

2.3 Services provided as part of the comprehensive clinical prevention program offered to Prime enrollees.

2.4 The first eight outpatient mental health visits per beneficiary in a fiscal year do not require PCM or Health Care Finder (HCF) referral and do not require preauthorization. Mental health visits exceeding eight in a fiscal year require authorization, but do not require a referral. The authorization of outpatient mental health care after the first eight visits (visits nine forward) shall be in accordance with the MCSC's best practices. This does not apply to mental health care received by active duty personnel. Mental health care for active duty personnel requires preauthorization.

See [Chapter 7, Section 3.10](#).

Note: Active Duty Service Members (ADSMs) require preauthorization before receiving mental health services. The contractor shall comply with the provisions of the TRICARE Operations Manual (TOM), [Chapters 16](#) and [17](#) when processing requests for service for active duty personnel.

- END -

Diagnostic Radiology (Diagnostic Imaging)

Issue Date: March 7, 1986

Authority: [32 CFR 199.4\(a\)](#), [\(b\)\(2\)\(x\)](#), [\(c\)\(2\)\(viii\)](#), [\(e\)\(14\)](#) and [32 CFR 199.6\(d\)\(2\)](#)

1.0 CPT¹ PROCEDURE CODES

70010 - 72292, 73000 - 76499, 77071 - 77084, 95965 - 95967

2.0 HCPCS PROCEDURE CODES

G0204, G0206

3.0 DESCRIPTION

3.1 Radiology is the science that deals with the use of radiant energy, such as X-rays, radium, and radioactive isotopes, in the diagnosis and treatment of disease. Radiology is an important diagnostic tool useful for the evaluation. The techniques used for diagnostic radiology are as follows:

3.2 Magnetic Resonance Imaging (MRI) is a non-invasive method of graphically representing the distribution of water and other hydrogen-rich molecules in the human body. MRI uses radio frequency radiation in the presence of a carefully controlled magnetic field to produce high quality cross-sectional images of the head and body in any plane. These tomographic images represent the tissue being analyzed and the environment surrounding it. MRI has become a useful diagnostic imaging modality that is capable of demonstrating a wide variety of soft-tissue lesions with contrast resolution equal or superior to Computerized Tomography (CT) scanning in various parts of the body. Among the advantages of MRI are the absence of ionizing radiation and the ability to achieve high levels of tissue contrast resolution without injected iodinated contrast agents.

3.3 Magnetic Resonance Angiography (MRA) techniques generate contrast between flowing blood and surrounding tissue, and provide anatomic images that can be provided in a format similar to that of conventional x-ray angiography, and can also provide physiologic information.

3.4 A CT/Computerized Axial Tomography (CAT) scan is interchangeably referred to as either a CT or CAT scan. This diagnostic test uses x-ray technology to create three-dimensional, computerized images of internal organs. However, unlike a traditional x-ray, CT/CAT scans are able to distinguish between obscured and overlapping parts of the body. CAT scans are also capable of producing images of several different internal components, including soft tissue, blood vessels and bones.

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4.0 POLICY

4.1 MRI and MRI with contrast media are covered when medically necessary, appropriate, and the standard of care. (CPT² procedure codes 70336, 70540 - 70543, 70551 - 70553, 71550 - 71552, 72141 - 72158, 72195 - 72197, 73218 - 73223, 73718 - 73723, 74181 - 74183, 75552 - 75556, and 76400.)

4.2 Breast MRI (CPT² procedure codes 77058 and 77059) is covered for the following indications. This list of indications is not all inclusive. Other indications may be covered when **determined by the contractor to be medically necessary and appropriate**:

4.2.1 To detect breast implant rupture (the implantation of the breast implants must have been covered by TRICARE).

4.2.2 For detection of occult breast cancer in the setting of axillary nodal adenocarcinoma with negative physical exam and negative mammography.

4.2.3 For presurgical planning for locally advanced breast cancer before and after completion of neoadjuvant chemotherapy, to permit tumor localization and characterization.

4.2.4 For presurgical planning to evaluate the presence of multicentric disease in patients with localized or locally advanced breast cancer who are candidates for breast conservation treatment.

4.2.5 Evaluation of suspected cancer recurrence.

4.2.6 To determine the presence of pectoralis major muscle/chest wall invasion in patients with posteriorly located tumor.

4.2.7 For guidance of interventional procedures such as vacuum assisted biopsy and preoperative wire localization for lesions that are occult on mammography or sonography and are demonstrable only with MRI.

Note: For policy on breast MRI to screen for breast cancer in high risk women, see [Chapter 7, Sections 2.1 and 2.2](#).

4.3 Open MRI and Open MRI with contrast media are covered when medically necessary, appropriate, and the standard of care.

4.4 Cardiovascular Magnetic Resonance (CMR) (CPT² procedure codes 75557, 75559, 75561, 75563, and 75565) is covered for the following indications:

4.4.1 Detection Of Coronary Artery Disease (CAD). Symptomatic--evaluation of chest pain syndrome (use of vasodilator perfusion CMR or dobutamine stress function CMR).

- Intermediate pre-test probability of CAD.
- Electrocardiogram (ECG) uninterpretable OR unable to exercise.

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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, 87640, 87641, 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 as a **diagnostic test** for the assessment of women with Atypical Squamous Cells of Undetermined Significance (ASCUS) detected **during a Pap smear**.

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3.6 The Nuclear magnetic Resonance (NMR) LipoProfile-2 test, used with the NMR Profiler (CPT² procedure codes 83701 and 83704) is proven and covered for the management of lipoprotein disorders associated with cardiovascular disease.

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

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 AlloMap[®] for molecular testing is unproven for use in cardiac transplant rejection surveillance.

4.13 Oncotype Dx (S3854) is not covered due to the lack of U.S. Food and Drug Administration (FDA) status.

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Chapter 7, Section 2.2

Clinical Preventive Services - TRICARE Prime

SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT PROCEDURE CODE
Colorectal Cancer (Continued):	<p>Optical (Conventional) Colonoscopy for Individuals at <u>Average</u>, <u>Increased</u>, or <u>High Risk</u> for Colon Cancer (Continued):</p> <p>Increased Risk (Individuals with a family history):</p> <p>1. Once every five years for individuals with a first degree relative diagnosed with sporadic colorectal cancer or an adenomatous polyp before the age of 60, or in two or more first degree relatives at any age. Optical colonoscopy should be performed beginning at age 40 or 10 years younger than the earliest affected relative, whichever is earlier.</p> <p>2. Once every 10 years, beginning at age 40, for individuals with a first degree relative diagnosed with sporadic colorectal cancer or an adenomatous polyp at age 60 or older, or colorectal cancer diagnosed in two second degree relatives.</p> <p>High Risk:</p> <p>1. Once every one to two years for individuals with a genetic or clinical diagnosis of Hereditary Non-Polyposis Colorectal Cancer (HNPCC) or individuals at increased risk for HNPCC. Optical colonoscopy should be performed beginning at age 20 to 25 or 10 years younger than the earliest age of diagnosis, whichever is earlier.</p> <p>2. For individuals diagnosed with Inflammatory Bowel Disease (IBD), Chronic Ulcerative Colitis (CUC), or Crohn's disease, cancer risk begins to be significant eight years after the onset of pancolitis or 10 to 12 years after the onset of left-sided colitis. For individuals meeting these risk parameters, optical colonoscopy should be performed every one to two years with biopsies for dysplasia.</p> <p>The effective date for coverage of optical colonoscopy for individuals at increased or high risk is October 6, 1997.</p>	
I	<p>Computed Tomographic Colonography (CTC) for Individuals in whom an Optical Colonoscopy is Medically Contraindicated or Incomplete: CTC is covered as a colorectal cancer screening ONLY when an optical colonoscopy is medically contraindicated OR cannot be completed due to a known colonic lesion, structural abnormality, or other technical difficulty is encountered that prevents adequate visualization of the entire colon. CTC is NOT covered as a colorectal cancer screening for any other indication or reason.</p> <p>The effective date for coverage of CTC for this indication is March 15, 2006. CTC is NOT covered as a colorectal cancer screening for any other indication or reason.</p>	CPT code 74263 .
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Clinical Preventive Services - TRICARE Prime

SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT PROCEDURE CODE
Skin Cancer:	Physical Examination: Skin examination should be performed for individuals with a family or personal history of skin cancer, increased occupational or recreational exposure to sunlight, or clinical evidence of precursor lesions.	See appropriate level evaluation and management codes.
Oral Cavity and Pharyngeal Cancer:	Physical Examination: A complete oral cavity examination should be part of routine preventive care for adults at high risk due to exposure to tobacco or excessive amounts of alcohol. Oral examination should also be part of a recommended annual dental check-up.	See appropriate level evaluation and management codes.
Thyroid Cancer:	Physical Examination: Palpation for thyroid nodules should be performed in adults with a history of upper body irradiation.	See appropriate level evaluation and management codes.
Lung Cancer:	Low-Dose Computed Tomography: Screening covered annually for persons 55 through 80 years of age with a 30 pack per year history of smoking who are currently smoking or have quit within the past 15 years. Screening should be discontinued once the individual has not smoked for 15 years or develops a health problem significantly limiting either life expectancy or ability or willingness to undergo curative lung surgery. The effective date for coverage of lung cancer screening is December 31, 2013.	CPT ¹ code 71250.
Infectious Diseases:	Tuberculosis (TB) Screening: Screen annually, regardless of age, all individuals at high risk for tuberculosis (as defined by Centers for Disease Control and Prevention (CDC) using Mantoux tests.	CPT ¹ codes 86580 and 86585.
	Rubella Antibodies: Test females, once, between the ages of 12 and 18, unless documented history of adequate rubella vaccination with at least one dose of rubella vaccine on or after the first birthday is documented.	CPT ¹ code 86762.
	Hepatitis B Screening: Screen pregnant women for HBsAG during prenatal period.	CPT ¹ code 87340.
Cardiovascular Diseases:	Cholesterol Screening: Age-specific, periodic lipid panel as recommended by the National Heart, Lung, and Blood Institute (NHLBI). Refer to the NHLBI web site (http://www.nhlbi.nih.gov/guidelines) for current recommendations.	CPT ¹ code 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.	CPT ¹ code 76999.

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Clinical Preventive Services - TRICARE Prime

SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT PROCEDURE CODE
Other:	<p>Body Measurement: For children and adolescents: Height and weight typically is measured and Body Mass Index (BMI)-for-age calculated and plotted at each primary care visit using the CDC "Data Table of BMI-for-age Charts". Children/adolescents with a BMI value greater than the 85th percentile typically receive appropriate nutritional and physical activity counseling as part of the primary care visit. Head circumference typically is measured through age 24 months. For adults: Height and weight typically is measured and BMI calculated at each primary care visit. Individuals identified with a BMI of 25 or above typically receive appropriate nutritional and physical activity counseling as part of primary care visit.</p>	See appropriate level evaluation and management codes.
	<p>Vision Care: Pediatric vision screening at birth and approximately six months of age to include determination of vision on visual acuity, ocular alignment and red reflex, along with external examination of ocular abnormalities. Routine eye examination once every two years for 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.</p>	CPT ¹ codes 92002, 92004, 92012, 92014, 92015, 99172, and 99173.
	<p>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).</p>	
	<p>Hearing Screening: According to the American Academy of Pediatrics (AAP) and the Joint Committee on Infant Hearing (JCIH), all newborns should undergo hearing screening using evoked Otoacoustic Emissions (OAE) testing or automated Auditory Brainstem Response (ABR) testing before one month of age; preferably, before leaving the hospital. An infant who does not pass the hearing screening should undergo appropriate audiological and medical evaluations to confirm the presence of a hearing loss at no later than three months of age.</p> <p>A hearing evaluation should be a part of routine examinations for all children, and those with possible hearing impairment should be referred for appropriate testing.</p>	CPT ¹ codes 92551 and 92585 - 92588.

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Clinical Preventive Services - TRICARE Prime

SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT PROCEDURE CODE
Other (Continued):	Pediatric Blood Lead: Assessment of risk for lead exposure by structured questionnaire based on 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.	CPT ¹ code 83655.
	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.
	<p>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 for use in the United States.</p> <p>The effective date of coverage for immunizations recommended by the CDC is the date that the ACIP recommendations for a particular vaccine or immunization are published in CDC MMWR or October 6, 1997, whichever is later.</p> <p>Immunizations recommended specifically for travel outside the United States are NOT covered, EXCEPT for those 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.</p>	

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- END -

Eating Disorder Treatment

Issue Date: July 19, 1983

Authority: [32 CFR 199.4\(c\)\(3\)\(ix\)](#), [\(g\)\(3\)](#), [\(g\)\(28\)](#); and [32 CFR 199.6\(b\)](#) and [\(c\)](#)

1.0 DESCRIPTION

The following diagnoses are considered by the current edition of the **Diagnostic and Statistical Manual of Mental Disorders** (DSM) to be eating disorders:

- Binge Eating Disorder
- Anorexia Nervosa
- Bulimia Nervosa
- Avoidant/Restrictive Food Intake Disorder
- Pica
- Rumination Disorder
- Other Specified Eating Disorder
- Unspecified Eating Disorder

2.0 POLICY

2.1 A claim for treatment of an eating disorder diagnosis is to be adjudicated as a mental health claim.

2.2 Medically necessary and appropriate eating disorder treatment may be provided on an inpatient or outpatient basis. All eating disorder treatment, to include treatment provided in an "eating disorder program," must be rendered by a TRICARE-authorized provider listed in [32 CFR 199.6](#). Inpatient eating disorder care must be provided in a Residential Treatment Center (RTC), Partial Hospitalization Program (PHP) or other authorized institutional provider. Outpatient eating disorder care must be rendered by a TRICARE-authorized individual professional provider as listed in [32 CFR 199.6](#).

- END -

