



DEFENSE  
HEALTH AGENCY

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**CHANGE 145  
6010.57-M  
NOVEMBER 20, 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: CLARIFICATION ON DURABLE EQUIPMENT/DURABLE MEDICAL EQUIPMENT,  
ORDERING DURABLE EQUIPMENT/DURABLE MEDICAL EQUIPMENT, AND  
ASSISTIVE TECHNOLOGY DEVICES**

**CONREQ: 17374**

**PAGE CHANGE(S): See page 2.**

**SUMMARY OF CHANGE(S): This change adds a definition of assistive technology devices for purposes of benefits coverage under the Extended Care Health Option (ECHO) Program. The change also explains that durable medical equipment (DME), wheelchairs, hospital beds, iron lungs, and cardiorespiratory monitors (under conditions) are subsets of durable equipment (DE). Finally, this change clarify that a TRICARE authorized individual professional provider who may order or prescribe DE is a physician, a dentist, or any TRICARE-authorized allied health care professional as described in 32 CFR 199.6(c)(3)(ii), when acting within the scope of their license or certification.**

**EFFECTIVE DATE: January 30, 2015.**

**IMPLEMENTATION DATE: December 21, 2015.**

**This change is made in conjunction with Feb 2008 TOM, Change No. 155 and Feb 2008 TRM, Change No. 118.**

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**ATTACHMENT(S): 52 PAGE(S)  
DISTRIBUTION: 6010.57-M**

**REMOVE PAGE(S)**

**CHAPTER 7**

Section 23.1, pages 1 and 2

**CHAPTER 8**

Table of Contents, pages 1 and 2

Section 2.1, pages 1 through 4

Section 2.2, pages 1 and 2

Section 2.4, page 1

Section 5.4, page 3

Section 6.1, page 1

Section 10.1, page 1

Section 20.1, pages 1 and 2

**CHAPTER 9**

Table of Contents, page 1

Section 14.1, pages 1 and 2

★ ★ ★ ★ ★

Section 15.1, pages 5, 6, and 19 through 23

**CHAPTER 11**

Section 9.1, pages 1 and 2

Section 12.1, pages 1 through 6

**CHAPTER 12**

Section 1.1, pages 1 through 4

**APPENDIX A**

pages 3 through 8

**INDEX**

pages 1 and 2

**INSERT PAGE(S)**

Section 23.1, pages 1 and 2

Table of Contents, pages 1 and 2

Section 2.1, pages 1 through 6

Section 2.2, pages 1 and 2

Section 2.4, page 1

Section 5.4, page 3

Section 6.1, page 1

Section 10.1, page 1

Section 20.1, pages 1 and 2

Table of Contents, page 1

Section 14.1, pages 1 and 2

Section 14.2, pages 1 through 4

Section 15.1, pages 5, 6, and 19 through 23

Section 9.1, pages 1 and 2

Section 12.1, pages 1 through 6

Section 1.1, pages 1 through 4

pages 3 through 8

pages 1 and 2

## Augmentative Communication Devices (ACDs)

Issue Date: December 8, 2004

Authority: [32 CFR 199.4\(e\)\(23\)](#) and 10 USC 1077(e)(1)

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### 1.0 CPT<sup>1</sup> PROCEDURE CODES

92605, 92607, 92608, 97755, 97608

### 2.0 HCPCS PROCEDURE CODES

E2500 - E2599, and V5336

### 3.0 POLICY

**3.1** Augmentative Communication Devices (ACDs) (also referred to as Speech Generating Devices (SGDs) and medically necessary services and supplies that provide an individual who has a severe speech impairment with the ability to meet functional speaking needs are covered. ACDs/SGDs are characterized by:

**3.1.1** Being a dedicated speech device, used solely by the individual who has severe speech impairment;

**3.1.2** May have digitized speech output, using pre-recorded messages, less than or equal to eight minutes recording time;

**3.1.3** May have digitized speech output, using pre-recorded messages, greater than eight minutes recording time;

**3.1.4** May have synthesized speech output, which requires message formulation by spelling and device access by physical contact with the device-direct selection techniques;

**3.1.5** May have synthesized speech output, which permits multiple methods of message formulation and multiple methods of device access; or

**3.1.6** May be software that allows a laptop computer, desktop computer or personal digital assistant (PDA) to function as a speech generating device.

**3.2** ACDs and SGDs as defined in [32 CFR 199.2](#) are considered voice prostheses. The prosthesis provisions found at [Chapter 8, Section 4.1](#) apply.

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<sup>1</sup> CPT only © 2006 American Medical Association (or such other date of publication of CPT). All Rights Reserved.

#### 4.0 EXCLUSIONS

Examples of devices that do not meet the above definition and are excluded from coverage as ACDs/SGDs include, but are not limited to:

**4.1** Devices that are not dedicated speech devices, but are devices that are capable of running software for purposes other than for speech generation, e.g., devices that can also run a word processing package, an accounting program, or perform other non-medical functions.

**4.2** Laptop computers, desktop computers, or Personal Digital Assistants (PDAs), which may be programmed to perform the same function as a speech generating device, are non-covered since they are not primarily medical in nature and do not meet the definition of prosthetic, prosthetic device, prosthetic supply, or Durable Equipment (DE).

**4.3** Communication aids that do not generate speech are not covered. Communication aids that are not ACDs/SGDs are not considered prosthetics for speech. Examples of noncovered communication aids include the following: picture books; flashcards; Braille typewriters; Teletypewriter (TTY) devices; devices that allow the patient to communicate messages to others with writing (e.g., a display screen or printout) rather than with synthesized speech; and devices that allow the user to communicate with a computer rather than with another person. Although these devices may be useful, they do not meet the definition of an ACD/SGD, prosthetic, or DE.

**4.4** Altered auditory feedback devices are communication aids that are excluded because they are not augmentative communication devices/voice prostheses.

#### 5.0 EXCEPTION

Computer based and PDA based ACDs/SGDs are covered when they have been modified to run only ACD/SGD software.

#### 6.0 EFFECTIVE DATE

September 1, 2005.

- END -

## Chapter 8

### Other Services

Section/Addendum	Subject/Addendum Title
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1.1	Ambulance Service
2.1	Durable Equipment (DE): Basic Program
2.2	Infantile Apnea Cardiorespiratory Monitor
2.3	External And Implantable Infusion Pumps
2.4	Cold Therapy Devices For Home Use
2.5	Home Prothrombin Time (PT) International Normalized Ratio (INR) Monitor
2.6	Breast Pumps, Breast Pump Supplies, And Breastfeeding Counseling
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
5.3	Continuous Glucose Monitoring System (CGMS) Devices
5.4	Automated External Defibrillators (AEDs)
6.1	Medical Supplies And Dressings (Consumables)
7.1	Nutritional Therapy
7.2	Liquid Protein Diets
8.1	Diabetes Self-Management Training (DSMT) 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)

**TRICARE Policy Manual 6010.57-M, February 1, 2008**  
Chapter 8, Other Services

<b>Section/Addendum</b>	<b>Subject/Addendum Title</b>
16.1	Mucus Clearance Devices
17.1	Lymphedema
18.1	Continuous Passive Motion (CPM) Devices
19.1	Smoking Cessation Counseling
20.1	Infusion Drug Therapy Delivered In The Home

## Chapter 8

## Section 2.1

# Durable Equipment (DE): Basic Program

Issue Date: December 29, 1982

Authority: [32 CFR 199.2](#), [32 CFR 199.4\(d\)\(3\)\(ii\)](#), and [32 CFR 199.6\(c\)\(3\)\(i\)](#), [\(ii\)](#), and [\(iii\)](#)

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### 1.0 HCPCS PROCEDURE CODES

Level II Codes E0100 - E1900, K0001 - K0547

### 2.0 POLICY

**2.1** DE, which is a medically necessary and appropriate item, ordered by a TRICARE authorized individual professional provider for the specific use of the beneficiary, and which complies with the following DE definition and coverage criteria may be cost-shared. A TRICARE authorized individual professional provider who may order or prescribe DE is a physician, a dentist, or any TRICARE authorized allied health care professional as described in [32 CFR 199.6\(c\)\(3\)\(ii\)](#), when acting within the scope of their license or certification, including the following:

- Doctors of Podiatric Medicine (DPMs).
- Doctors of Optometry (ODs).
- Certified Physician Assistants (CPAs).
- Certified Clinical Nurse Specialists (CCNSs) when recognized by TRICARE as:
  - Certified Nurse Practitioners (CNPs),
  - Certified Nurse Midwives (CNMs), or
  - Certified Psychiatric Nurse Specialists (CPNSs).
- Certified Registered Nurse Anesthetists (CRNAs).
- Certified Psychiatric Nurse Specialists (CPNSs).

**2.2** Definition. As defined in the [32 CFR 199.2](#), DE is a medically necessary item that:

**2.2.1** Can withstand repeated use;

**2.2.2** Is primarily and customarily to serve a medical purpose; and

**2.2.3** Is generally not useful to an individual in the absence of an illness or injury.

### 3.0 COVERAGE CRITERIA

**3.1** Covered items that may be provided to a beneficiary as DE includes the following:

- Hospital beds.
- Iron lungs.

- Durable Medical Equipment (DME).
- Wheelchairs.
- Cardiorespiratory monitor under conditions specified in [Section 2.2](#) of this chapter.

**3.2** A covered DE shall be provided on a rental or purchase basis.

**3.2.1** Coverage of DE shall be based on the price most advantageous to the government, taking into consideration the anticipated duration of the medically necessary need for the equipment and current price information for the type of item.

**3.2.2** The cost analysis must include a comparison of the total price of the item as a monthly rental charge, a lease-purchase price, and a lump-sum purchase price and a provision for the time value of money at the rate determined by the U.S. Department of Treasury.

**3.3** A prescribed item of DE that provides the medically appropriate level of performance and quality for the beneficiary's medical condition present must be supported by adequate documentation, as defined in [32 CFR 199.2](#). Luxury, deluxe, immaterial, or non-essential features, which increase the cost of the item relative to a similar item without those features, based on industry standards for a particular item at the time the equipment is prescribed or replaced for a beneficiary, are not authorized. Only the "base" or "basic" model of equipment (or more cost-effective alternative equipment) shall be covered, except as authorized in [paragraphs 3.6, 3.7, or 4.1](#).

**3.4** The item of DE must be prescribed for a use consistent with required U.S. Food and Drug Administration (FDA) approved labeling for the item. When prescribed use of an item appears to be extraordinary, a signed statement from the manufacturer that a specific medical device is FDA approved for such a use is adequate evidence that the requirement of FDA approval is met.

**3.5** The item of DE must not be otherwise excluded by the regulation and policy (for example, those found in [32 CFR 199.4\(g\)](#)), to include communication devices other than those allowed in [Chapter 7, Section 23.1](#), eyeglasses, exercise/relaxation/comfort devices, comfort or convenience items, etc.).

**3.6** Durable Medical Equipment (DME) is DE (as defined in [paragraph 2.2](#)) that meets the following additional coverage criteria:

**3.6.1** It is medically appropriate to:

**3.6.1.1** Improve, restore, or maintain the function of a malformed, diseased, or injured body part, or can otherwise minimize or prevent the deterioration of the beneficiary's function or condition; or

**3.6.1.2** Maximize the beneficiary's function consistent with the beneficiary's physiological or medical needs.

**3.6.2** DME Customization. Customization of DME (equipment designed permanently to preclude the use of such equipment by another individual) owned by a beneficiary, and any

accessory or item of supply for any such equipment, may be covered as determined by the Director (or designee) to be essential for:

- Achieving therapeutic benefit for the patient;
- Making the equipment serviceable; or
- Otherwise assuring the proper functioning of the equipment.

**3.7** Wheelchairs, which otherwise meet the DE definition in [paragraph 2.2](#), are covered to provide medically appropriate basic mobility.

**3.7.1** Electric wheelchairs. An electric wheelchair, or TRICARE approved alternative to an electric wheelchair (e.g., scooter), may be provided in lieu of a manual wheelchair to provide basic mobility. Benefits will not be extended for the use of both an electric-powered, cart-type vehicle and an electric wheelchair during the same period of time.

**3.7.2** Lifts. A vehicle lift, which otherwise meets the requirements of [paragraph 3.3](#) and all other applicable provisions of this policy, may be covered when necessary to transport an otherwise authorized wheelchair (or an approved alternative). Coverage is limited to the basic model lift and must be a temporary (non-permanent/transferrable) lift that transports the wheelchair itself (or an approved alternative).

**3.7.2.1** Labor charges may be allowed to cover only the installation of the allowable vehicle wheelchair lift.

**3.7.2.2** TRICARE does not cover transportation of beneficiaries, including to and from medical appointments, except for ambulances when medical care is provided to the individual in transit. A lift may be authorized solely to transport the wheelchair so that a traveling beneficiary may have "basic" mobility once at his or her destination.

**3.7.2.3** Vehicle conversions are excluded. That is conversions such as but not limited to, raising the roof, widening the door, or permanent attachments installed (e.g., items that are non-transferable to another vehicle). Purchases and (or) conversions of personal vehicles for a wheelchair bound beneficiary fall outside the scope of the TRICARE medical benefits and, therefore, are excluded.

**3.7.2.4** TRICARE's allowable charge is based on the basic (or standard) model lift and authorized installation fees. Lifts beyond the basic (or standard) model required for transport of an authorized wheelchair are excluded from TRICARE coverage and cannot be considered in determining the TRICARE allowable costs. Beneficiaries who choose a lift other than the basic (or standard) model (i.e., luxury/deluxe) are responsible for the costs above and beyond the allowable amount of the basic lift. In such a case, the beneficiary is responsible for submitting sufficient information regarding the otherwise authorized basic model lift and costs of installation along with the itemized costs of the luxury/deluxe model and installation costs.

**Note:** Refer to [paragraph 4.0](#) for TRICARE description of "any item of DE beyond the basic/standard model."

**3.7.3** Modifications of wheelchairs. Medically appropriate modifications (i.e., slight or small changes or alterations) to the wheelchair (or an approved alternative) to accommodate a particular

physiological or medical need may be covered if necessary to provide basic mobility and to allow proper use of the wheelchair. When an otherwise covered wheelchair requires substantial modification, or is uniquely built to meet the special needs of a beneficiary, for basic mobility and proper use of the wheelchair, coverage may be provided only under a lump-sum purchase or rental-purchase agreement resulting in the beneficiary owning the modified wheelchair.

**3.8 Repairs.** Benefits are allowed for repair of beneficiary-owned DE when necessary to make the equipment functional because of reasonable wear and usage and the manufacturer's warranty has expired, but only on the condition that the repair cost is less than the replacement cost. Coverage includes the use of a temporary replacement item provided during a reasonable period of repair.

**3.9 Replacements.** Benefits are allowed for replacement of beneficiary-owned DE with documentation that the DE is lost or stolen and not otherwise covered by another insurance (such as a homeowner's policy). Replacement of beneficiary-owned DE is also allowed when the item is not functional due to normal wear, accidental damage, a change in the beneficiary's condition, or the device has been declared adulterated by the FDA. (Exceptions exist for prosthetic devices; see [Section 4.1](#) for more information.)

**Note:** Replacement is subject to review of documentation supporting why the current DE item is no longer usable/repairable and that the replacement cost is less than the repair cost.

**Note:** Replacement equipment is allowed only upon a new order or prescription by a TRICARE authorized individual professional provider with an explanation of the medical need.

**3.9.1** When a rented item of DE is lost or stolen, the supplier is required to use modifier **RA** to notify the TRICARE contractor that the item has been lost or stolen, and a replacement item is being provided. Payment for the original rented item of DE that was lost or stolen is the contractual responsibility of the supplier.

**3.9.2** TRICARE will not continue to pay rental fees on equipment that has been lost or stolen. Once the medically necessary DE has been replaced by the supplier and provided to the beneficiary, rental fees for the replacement item shall resume based on the continuous use provision, if applicable.

**3.10** An item of DE which otherwise meets the DE benefits requirement that is essential to provide a fail-safe in-home life-support system, or that replace in-like-kind an item of equipment that is not serviceable because of normal wear, accidental damage, a change in the beneficiary's condition, has been declared adulterated by the FDA, or is being, or has been recalled by the manufacturer, is not considered duplicate and, therefore is covered.

**Note:** For the purpose of this policy, "duplicate" means an item of equipment that meets the definition of DE and serves the same purpose that is served by an item of DE previously cost-shared by TRICARE. For example, various models of a stationary oxygen concentrator with no significant differences are considered duplicates, whereas stationary and portable concentrators are not considered duplicates of each other because the latter is intended to provide a beneficiary with mobility outside the home. Also for example, an electric wheelchair, which otherwise meets the definition of DE would not be duplicative of a manual wheelchair previously cost-shared by TRICARE in that the electric wheelchair provides independent mobility not provided by the manual wheelchair.

## 4.0 POLICY CONSIDERATION

### 4.1 Upgraded DE (Deluxe, Luxury, or Immaterial Features)

**4.1.1** Medically Necessary Upgrades. An upgraded item of DE, which otherwise meets the DE benefit requirement and is medically necessary, is covered if the prescription specifically states the medical reason why an upgrade is necessary. For example, the beneficiary does not have the physical strength or balance required to lift a standard walker and, therefore, one with wheels is required. Equipment lacking documentation of medical necessity for the deluxe, luxury, or immaterial feature device may have the TRICARE allowed amount for the base model applied to the upgraded equipment, with the beneficiary responsible for the difference between the allowed amount for the base model and the provider's billed charges. **For a wheelchair, the upgrade must be required for the beneficiary to maintain basic mobility.** See the TRICARE Reimbursement Manual (TRM), [Chapter 1, Section 11](#) for pricing and payment policy.

**4.1.2** If the beneficiary prefers to upgrade an item of DE, which otherwise meets the DE benefit requirements, the beneficiary will be solely responsible for the cost that exceeds the cost of what the government would pay for the standard equipment. The upgraded item must be within the range of services that are appropriate for the beneficiary's medical condition (e.g., beneficiaries can upgrade from a standard manual wheelchair to a power wheelchair, when there is no medical objection from the physician, but not from a walker to a wheelchair).

### 4.2 Beneficiary Liability

**4.2.1** When the beneficiary prefers to upgrade an item of DE, which otherwise meets the DE benefit requirements, the provider may collect the charges that exceed the cost of what the government would pay for the standard equipment, only if the beneficiary were given written notice that the item has been (or may be) denied and agrees in writing, to be financially liable for the difference between the charges for the upgraded item, and the charges for the standard item. Should the provider fail to provide written notice and receive written agreement from the beneficiary of financial liability, for network providers, the beneficiary is "held harmless" in accordance with the TRICARE Operations Manual (TOM), [Chapter 5, Section 1, paragraph 2.5.1](#). For non-network providers, [Chapter 1, Section 4.1](#) of this manual applies.

**4.2.2** Beneficiaries are also liable for the repairs on the upgraded item/features.

**Note:** Deluxe, luxury, or immaterial features are items of DE that are more expensive than the item that is medically necessary. Deluxe items include comfort or convenience features that enhance standard DE equipment, but are not considered medically necessary. Comfort and convenience items are defined as those optional items, which the patient may elect at an additional charge, but are not medically necessary in the treatment of a patient's condition. These devices exceed what is medically necessary and increase the cost of the item to the government relative to a similar item without those features.

## 5.0 EXCLUSIONS

**5.1** DE for a beneficiary who is a patient in a type of facility that ordinarily provides the same type of DME item to its patients at no additional charge in the usual course of providing its services is excluded.

**TRICARE Policy Manual 6010.57-M, February 1, 2008**

Chapter 8, Section 2.1

Durable Equipment (DE): Basic Program

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**5.2** DE that is available to the beneficiary from a Uniformed Services Medical Treatment Facility (USMTF).

**5.3** An item of DE that has been lost or stolen (except as provided in [paragraph 3.9](#)), or for an item under warranty, or when a DE is damaged while using the equipment in a manner inconsistent with its common use.

**5.4** DE with luxury, deluxe, immaterial, or non-essential features, which increase the cost of the item relative to a similar item without those features, based on industry standards for a particular item at the time the equipment is prescribed or replaced for a beneficiary. (See [paragraph 4.0](#) for Policy Consideration.)

**5.5** Exercise, relaxation, comfort, sporting items, or sporting devices. Exercise equipment, to include wheelchairs and items primarily and customarily designed for use in sports or recreational activities, spas, whirlpools, hot tubs, swimming pools health club memberships or other such charges, or items.

**5.6** Repairs of deluxe, luxury, or immaterial features of DE (except as provided in [paragraph 3.8](#)).

**5.7** Repairs of DE damaged while using the equipment in a manner inconsistent with its common use.

**5.8** Maintenance agreement.

**5.9** Routine periodic servicing, such as testing, cleaning, regulating, and checking which the manufacturer does not require be performed by an authorized technician.

**5.10** Duplicate items of otherwise allowable DE to be used solely as a back-up to currently owned or rented equipment, except as provided in [paragraph 3.10](#).

**5.11** DE must be considered durable -- can withstand repeated use. Therefore, DE does not include expendable items such as incontinent pads, diapers, ace bandages, etc. Such items are excluded from DE coverage. Refer to [Section 6.1](#) for policy regarding supplies and dressings (consumables).

**5.12** Non-medical equipment (e.g., humidifier, electric air cleaners, exercycle, safety grab bars, training equipment, etc.). See [32 CFR 199.4](#).

**6.0 EFFECTIVE DATE**

September 1, 2005.

- END -

## Chapter 8

## Section 2.2

# Infantile Apnea Cardiorespiratory Monitor

Issue Date: December 4, 1987

Authority: [32 CFR 199.4\(d\)\(3\)\(ii\)](#), 10 United States Code (USC) Section 1079(a)(15)

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### 1.0 HCPCS PROCEDURE CODE

Level II Code E0608

### 2.0 DEFINITION

Apnea refers to abnormal cessation of air exchange. Infantile apnea is thought to be one of the pediatric disorders of respiratory control. Abnormalities that have been identified in infants with idiopathic apnea include prolonged episodes of apnea during sleep, often associated with bradycardia; an increased incidence of upper airway obstruction; a high density of short apneic episodes during sleep; excessive periodic breathing during sleep and diminished arousal and ventilatory responses to induced hypercapnia and hypoxemia.

### 3.0 POLICY

**3.1** Use of a cardiorespiratory monitor, with or without a trend-event recorder, may be covered for in-home diagnostic data-collection or in-home clinical management of a condition or suspected condition, which places the beneficiary at extraordinary risk of life threatening cardiorespiratory complications for which 24-hour per day observation would otherwise be clinically indicated.

**3.2** Associated services and items are covered in conjunction with a covered cardiorespiratory monitor.

**3.3** Other applicable policy. Equipment cost-share is subject to the provisions of the Durable Medical Equipment (DME)/**Durable Equipment (DE)** Basic Program.

### 4.0 EXCLUSIONS

**4.1** Screening Pneumogram. A 12- to 24-hour pneumogram (recordings of heart rate and thoracic impedance) accomplished solely as a predictive test for Sudden Infant Death Syndrome (SIDS) risk or life-threatening apnea risk.

**4.2** A back-up electrical system or any alteration to the beneficiary's living space.

**4.3** Any separate charge for the availability of medical, technical, or counseling assistance.

**TRICARE Policy Manual 6010.57-M, February 1, 2008**

Chapter 8, Section 2.2

Infantile Apnea Cardiorespiratory Monitor

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**4.4** Equipment which monitors only respiration or cardiac function.

- END -

## Chapter 8

## Section 2.4

# Cold Therapy Devices For Home Use

Issue Date: April 19, 1983

Authority: [32 CFR 199.2](#), [32 CFR 199.4\(d\)\(3\)\(ii\)](#), [\(g\)\(1\)](#), [\(g\)\(64\)](#), and [32 CFR 199.5\(d\)\(7\)](#)

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### 1.0 DESCRIPTION

Cold therapy devices generally consist of a picnic-type chest cooler in which is placed a quantity of ice and water and into which is submerged a low voltage submersible pump with an in-line thermometer and flow control valve. Water is circulated by way of a plastic tube to a hollow rubber pad, which is placed on the affected body part, and back to the water chest. The device is sold under various trade names such as: Aqua K<sup>®</sup> pad, polar care device, cryo-cuff or other similar designations.

### 2.0 POLICY

Cold therapy devices are excluded from coverage as:

- **Durable Equipment (DE) and** Durable Medical Equipment (DME) with deluxe, luxury, or immaterial features; and
- Comfort and convenience item.

They are not primarily medical in nature, even though used to control pain, do not preclude the use of analgesics in conjunction with the cold therapy, and ultimately, except for the convenience of the commercial devices, ice packs have been shown to serve the same purpose.

- END -



**TRICARE Policy Manual 6010.57-M, February 1, 2008**

Chapter 8, Section 5.4

Automated External Defibrillators (AEDs)

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same purpose only one type (wearable OR non-wearable) may be cost-shared. Please reference [Section 2.1, paragraph 3.10](#), concerning duplicate equipment.

- END -



## Chapter 8

## Section 6.1

# Medical Supplies And Dressings (Consumables)

Issue Date: October 25, 1993

Authority: [32 CFR 199.4\(d\)\(3\)\(iii\)](#)

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### 1.0 DESCRIPTION

Medical supplies and dressings (consumables) are those that do not withstand prolonged, repeated use.

### 2.0 POLICY

**2.1** Medical supplies and dressings (consumables) are covered when related directly to a covered medical condition and obtained from a medical supply company, a pharmacy, or authorized institutional provider. Examples of covered medical supplies and dressings include disposable syringes for diabetics, colostomy sets, irrigation sets, elastic bandages, TED<sup>®</sup> hose, and external surgical garments designed for use following a mastectomy.

**2.2** Generally, the allowable charge of a medical supply item will be under \$100. Any item over this amount must be reviewed to determine whether it would not qualify as a Durable Equipment (DE) item. If it is, in fact, a medical supply item and does not represent an excessive charge, it can be considered for benefits under this policy.

### 3.0 EXCLUSION

Diapers.

- END -



## Oxygen And Oxygen Supplies

Issue Date: February 14, 1984

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

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### 1.0 HCPCS PROCEDURE CODES

Level II Codes A4611 - A4629, E0424 - E0480, E1353 - E1399, E1400 - E1406

### 2.0 POLICY

**2.1** Oxygen is a prescription medication and the following benefits may be cost-shared:

**2.1.1** Oxygen and the supplies and equipment related to its administration;

**2.1.2** Oxygen in gas (to include oxygen concentrators) and liquid form;

**2.1.3** Stationary and/or portable oxygen units; and

**2.1.4** Oxygen therapy for migraine and/or cluster headaches.

**2.2** Oxygen concentrators may be purchased or cost-shared on a rental basis. If oxygen concentrators are rented, the **Durable Equipment (DE)/Durable Medical Equipment (DME)** cost-sharing policy will not apply even though the purchase price for this equipment has been reached. Cost-sharing on a rental basis is necessary, as oxygen concentrators require frequent periodic maintenance and frequent checks to ensure that the liter flow setting of the oxygen concentrator has not been altered.

**2.3** If the initial prescription shows an indefinite or lifetime need for oxygen, a new prescription is not required as long as the diagnosis substantiates its continued use.

### 3.0 EXCLUSIONS

The following are not covered:

**3.1** Oxygen (95%) and carbon dioxide (5%) inhalation therapy for inner ear disease. The therapeutic benefit derived from this procedure is not established.

**3.2** The purchasing of maintenance agreements for oxygen equipment.

- END -



## Infusion Drug Therapy Delivered In The Home

Issue Date: September 7, 2011

Authority: [32 CFR 199.2](#) and [32 CFR 199.6\(f\)](#)

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### 1.0 CPT<sup>1</sup> PROCEDURE CODES

99601, 99602

### 2.0 HCPCS CODE

S9430

### 3.0 BACKGROUND

#### 3.1 [32 CFR 199.2](#) defines appropriate medical care as:

- Services performed in connection with the diagnosis or treatment of disease or injury, pregnancy, mental disorder, or well-baby care which are in keeping with the generally accepted norms for medical practice in the United States;
- The authorized individual professional provider rendering the medical care is qualified to perform such medical services by reason of his or her training and education and is licensed or certified by the state where the service is rendered or appropriate national organization or otherwise meets CHAMPUS standards; and
- The services are furnished economically. For purposes of this part, "economically" means that the services are furnished in the least expensive level of care or medical environment adequate to provide the required medical care regardless of whether or not that level of care is covered by CHAMPUS.

#### 3.2 [32 CFR 199.2](#) defines homebound as:

- A beneficiary's condition is such that there exists a normal inability to leave home and, consequently, leaving home would require considerable and taxing effort. Any absence of an individual from the home attributable to the need to receive health care treatment--including regular absences for the purpose of participating in therapeutic, psychosocial, or medical treatment in an adult day-care program that is licensed or certified by a state, or accredited to furnish adult day-care services in the--state shall not disqualify an individual from being considered to be confined to his home. Any other absence of an individual from the home shall not disqualify an individual if the absence is infrequent or

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of relatively short duration. For purposes of the preceding sentence, any absence for the purpose of attending a religious service shall be deemed to be an absence of infrequent or short duration. Also, absences from the home for non-medical purposes, such as an occasional trip to the barber, a walk around the block or a drive, would not necessarily negate the beneficiary's homebound status if the absences are undertaken on an infrequent basis and are of relatively short duration. An exception is made to the above homebound definitional criteria for beneficiaries under the age of 18 and those receiving maternity care. The only homebound criteria for these special beneficiary categories are written certification from a physician attesting to the fact that leaving the home would place the beneficiary at medical risk. In addition to the above, absences, whether regular or infrequent, from the beneficiary's primary residence for the purpose of attending an educational program in a public or private school that is licensed and/or certified by a state, shall not negate the beneficiary's homebound status.

**3.3** In addition to infusion therapy provided in the home, infusion therapy may also be provided in alternative settings, which include hospital outpatient departments, ambulatory infusion suites, physician's offices, or in inpatient settings.

#### **4.0 DESCRIPTION**

Infusion therapy delivered in the home may include:

- Skilled nursing services to administer the drug;
- The drug and associated compounding services; and
- Medical supplies and Durable Equipment (DE).

#### **5.0 POLICY**

Coverage may be extended for infusion therapy delivered in the home when preauthorized by the Managed Care Support Contractor (MCSC). Preauthorization shall be required when:

##### **5.1 Homebound Beneficiaries**

Contractors shall ensure the following criteria are met for homebound beneficiaries receiving Home Health Care (HHC) under a Plan of Care (POC) as described in the TRICARE Reimbursement Manual (TRM), [Chapter 12](#):

**5.1.1** Homebound beneficiaries who require skilled services (e.g., skilled nursing) for administration of a home infusion drug must receive those skilled services from a Home Health Agency (HHA), in accordance with the policy described in the TRM, [Chapter 12](#). See TRM, [Chapter 2, Addendum A](#) for beneficiary cost shares for HHC services. See TRM, [Chapter 12, Section 2, Figure 12.2-1](#) for beneficiary cost-shares for services reimbursed outside the Home Health Agency Prospective Payment System (HHA PPS) when receiving home health services under a POC.

**5.1.2** Homebound beneficiaries who desire to self-administer (or have a caregiver administer) an infusion drug obtained from a TRICARE authorized pharmacy under the TPharm contract may

## Chapter 9

### Extended Care Health Option (ECHO)

Section/Addendum	Subject/Addendum Title
1.1	General
2.1	Eligibility - General
2.2	Eligibility - Qualifying Condition: Mental Retardation
2.3	Eligibility - Qualifying Condition: Serious Physical Disability
2.4	Eligibility - Qualifying Condition: Other
3.1	Registration
4.1	Benefit Authorization
5.1	Public Facility Use Certification
6.1	Diagnostic Services
7.1	Treatment
8.1	Training
9.1	Special Education And Other Services
10.1	Institutional Care
11.1	Transportation
12.1	Extended Care Health Option (ECHO) Respite Care
13.1	Other Extended Care Health Option (ECHO) Benefits
13.2	Other Extended Care Health Option (ECHO) Benefits - Hippotherapy
14.1	Durable Equipment (DE) <b>Prior To January 30, 2015</b>
14.2	<b>Durable Equipment (DE) And Assistive Technology (AT) Devices On Or After January 30, 2015: Extended Care Health Option (ECHO) Program</b>
15.1	ECHO Home Health Care (EHC)
16.1	Cost-Share Liability
17.1	Providers
18.1	Claims



## Durable Equipment (DE) Prior To January 30, 2015

Issue Date: December 29, 1982

Authority: [32 CFR 199.2\(b\)](#), [32 CFR 199.5\(c\)\(2\)](#), [\(d\)\(7\)](#), and [\(g\)\(2\)](#)

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### 1.0 HCPCS CODES

All valid codes.

### 2.0 DESCRIPTION

Prior to January 30, 2015, Durable Equipment (DE) was defined in [32 CFR 199.2\(b\)](#) as a device or apparatus, which does not qualify as Durable Medical Equipment (DME) under the TRICARE Basic Program but which is essential to the efficient arrest or reduction of functional loss resulting from, or the disabling effects of a qualifying condition as provided in [Sections 2.2](#) through [2.4](#). Examples of DE, at the time, were special computer peripheral devices (keyboard, mouse, etc.) or software that makes a computer functional to an Extended Care Health Option (ECHO) beneficiary with a qualifying condition that would otherwise limit or prohibit the beneficiary's ability to use the computer; or an electrical/mechanical lifting device that raises an ECHO beneficiary in a wheelchair from ground level to first floor level of the beneficiary's residence.

### 3.0 POLICY

3.1 DE may be cost-shared when:

3.1.1 A physician has certified that the item is necessary for the treatment, habilitation, or rehabilitation of the beneficiary or to reduce the disabling effects of the qualifying condition.

3.1.2 A written authorization to purchase the item has been issued by the appropriate Managed Care Support Contractor (MCSC) or the Director, TRICARE Area Office (TAO) prior to the purchase.

3.2 Customization of ECHO-authorized DE and any accessory or item of supply for any DE may be provided if such customization, accessory, or supply item is essential for:

3.2.1 Achieving therapeutic benefit for the beneficiary; or

3.2.2 Making the equipment usable; or

3.2.3 Otherwise assuring the proper functioning of the equipment; and

3.2.4 Is not otherwise excluded from coverage by regulation or policy.

**3.3** Installation of authorized DE may also be cost-shared through the ECHO, however, alterations, such as those made to living spaces or vehicles to accommodate installation of such equipment, **cannot** be cost-shared through the ECHO.

**3.4** A sponsor/beneficiary cost-share, as described in [Section 16.1](#), is required in the month in which the item is purchased.

**3.5** Reasonable repairs and maintenance on authorized beneficiary-owned DE may be cost-shared.

#### **4.0 EXCLUSIONS**

**4.1** Purchase or rental of DE is excluded when:

**4.1.1** 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

**4.1.2** The item is available from a local Uniformed Service Medical Treatment Facility (USMTF); or

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

**4.1.4** When the item is duplicate equipment, as defined in [32 CFR 199.2](#). This does not preclude the purchase of a replacement for an item that is no longer usable.

**4.2** Exercise equipment, spas, whirlpools, hot tubs, swimming pools, health club membership, electronic devices used to locate or monitor the location of a beneficiary, and other similar charges or items are not considered DE.

**4.3** Rental of equipment is excluded unless it can be shown to be more cost-effective than purchase.

**4.4** DME that is available under the TRICARE Basic Program is not eligible to be cost-shared under this issuance.

#### **5.0 EFFECTIVE DATE**

September 1, 2005.

- END -

## Durable Equipment (DE) And Assistive Technology (AT) Devices On Or After January 30, 2015: Extended Care Health Option (ECHO) Program

Issue Date: November 20, 2015

Authority: 32 CFR 199.2(b), 32 CFR 199.5(c)(2), (c)(8)(ii), (iii), (d)(3), (d)(7)(i), (iv), (v), and (d)(8)

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### 1.0 HCPCS CODES

All valid codes.

### 2.0 DESCRIPTION

**2.1** Durable Equipment (DE), which does not otherwise qualify for coverage under the TRICARE Basic Program (Chapter 8, Section 2.1) but has been certified by an authorized TRICARE individual professional provider, as essential to the efficient arrest or reduction of functional loss resulting from the disabling effects of a qualifying condition of an eligible beneficiary, may be provided under the TRICARE Extended Care Health Option (ECHO) under 32 CFR 199.5.

**2.2** Assistive Technology (AT) devices are defined in 32 CFR 199.2(b) as equipment that generally does not treat an underlying injury, illness, disease or their symptoms. AT devices are authorized only under the ECHO. AT devices help an ECHO beneficiary overcome or remove a disability and are used to increase, maintain, or improve the functional capabilities of an individual. AT devices may include non-medical devices, but do not include any structural alterations (e.g., permanent structure of wheelchair ramps or alterations to street curbs), service animals (e.g., Seeing Eye dogs, hearing/handicapped assistance animals, etc.), or specialized equipment and devices whose primary purpose is to enable the individual to engage in sports or recreational events. AT devices are authorized only under coverage criteria determined by the Director, Defense Health Agency (DHA) (formerly TRICARE Management Activity (TMA)) to assist in the reduction of the disabling effects of a qualifying condition for individuals eligible to receive benefits under the ECHO program, as provided in 32 CFR 199.5.

### 3.0 POLICY

**3.1** A DE or AT device shall only be covered under ECHO if it is not otherwise covered by TRICARE as DE, a prosthetic, augmentation communication device, or other benefits under the Basic Program.

**3.2** DE and AT devices may be cost-shared and provided in the beneficiary's home or another environment, as appropriate.

**TRICARE Policy Manual 6010.57-M, February 1, 2008**

Chapter 9, Section 14.2

Durable Equipment (DE) And Assistive Technology (AT) Devices On Or After January 30, 2015:  
Extended Care Health Option (ECHO) Program

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**3.3** AT devices may include an educational learning device and may be cost-shared when:

**3.3.1** A TRICARE authorized provider has certified that an AT device is necessary to assist in the reduction of the disabling effects of a qualifying condition.

**3.3.2** It is recommended in the beneficiary's Individual Educational Program (IEP) and is not otherwise provided by State or local government programs; or

**3.3.3** The beneficiary is not eligible for an IEP, in this case, the AT device;

**3.3.3.1** Shall be authorized as if directly related to the beneficiary's qualifying condition;

**3.3.3.2** Must be an educational learning device normally included in an IEP; and

**3.3.3.3** Must be preauthorized under ECHO as an integral component of the beneficiary's individual comprehensive health care services plan (including rehabilitation), as prescribed by a TRICARE authorized provider.

**3.4** Benefits allowed for AT electronic learning devices include the hardware and software as appropriate. The Director, DHA, or designee, shall determine the types and (or) platforms of electronic devices.

**3.5** Training. When training is required to allow the use of an AT device, see [Section 8.1](#).

**3.6** Equipment Adaptation. ECHO-authorized equipment and an AT device purchase shall include such services and modifications to the equipment that is essential to make the equipment usable for a particular ECHO beneficiary.

**3.7** Equipment Maintenance and Repairs. Reasonable repairs and maintenance on the beneficiary owned AT device or DE shall be cost-share while the beneficiary is registered in the ECHO Program.

**3.8** Upgrades and Replacement.

**3.8.1** The Director, DHA, or designee, shall determine replacement lifecycles of the hardware (and its supporting software).

**3.8.2** All upgrades or replacements shall require a recommendation from the individual's IEP or the individual's comprehensive health care services plan.

**3.8.3** A beneficiary owned AT device damaged through improper use of the device may not be replaced until the device would next be eligible for a lifecycle replacement.

**3.8.4** Benefits are allowed for replacement of a beneficiary-owned AT device or DE with documentation that the AT device or DE is lost or stolen and not otherwise covered by another insurance (such as a homeowner's policy). A new order or prescription by a TRICARE authorized

**TRICARE Policy Manual 6010.57-M, February 1, 2008**

Chapter 9, Section 14.2

Durable Equipment (DE) And Assistive Technology (AT) Devices On Or After January 30, 2015:  
Extended Care Health Option (ECHO) Program

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provider is required to reaffirm that the AT device or DE is necessary to assist in the reduction of the disabling effects of a qualifying condition.

**3.9 Cost-share and Allowable Amount:**

**3.9.1** The TRICARE allowable amount for AT devices or DE shall be calculated in the same manner as Durable Medical Equipment (DME) allowable as addressed in [32 CFR 199.4](#), and accrues to the fiscal year benefits limit specified in [Section 16.1](#).

**3.9.2** A sponsor/beneficiary cost-share, as described in [Section 16.1](#), is required in the month in which the item is purchased.

**3.9.3** A sponsor/beneficiary is not required to pay more than one cost-share, regardless of the number of benefits the sponsor's dependents receive under the ECHO Program.

**4.0 EXCEPTIONS**

**4.1** A second platform may be obtained if the beneficiary's IEP recommends one platform such as a computer for the majority of the learning objectives, but there exists another objective, which cannot be performed on that platform. In these limited circumstances, the beneficiary shall submit a request with the above justification to the Director, DHA, or designee, who may authorize a second device.

**4.2** When one or more electronic platform, such as a desktop computer, laptop, notebook or tablet, can perform the same functions in relation to the teaching or educational objective directly related to the qualifying condition, it is the intent of this policy to allow the beneficiary to choose only one electronic platform.

**5.0 EXCLUSIONS**

**5.1** Purchase or rental of AT devices and DE is excluded when:

**5.1.1** 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

**5.1.2** The item is available from a local Uniformed Service Medical Treatment Facility (USMTF); or

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

**5.1.4** The item is duplicate equipment, as defined in [32 CFR 199.2](#). However, this does not preclude the purchase of a replacement for an item that is no longer usable; or

**5.1.5** The hardware platform is a duplicate or redundant, except as provided in [paragraphs 4.1](#) and [4.2](#) of this policy issuance; or

**TRICARE Policy Manual 6010.57-M, February 1, 2008**

Chapter 9, Section 14.2

Durable Equipment (DE) And Assistive Technology (AT) Devices On Or After January 30, 2015:  
Extended Care Health Option (ECHO) Program

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**5.1.6** The item is not necessary to operate the system and is unrelated to the system or software components (e.g., printer or wireless Internet access devices); or

**5.1.7** The rental equipment is damaged while using the item in a manner inconsistent with its common use or has been lost or stolen. See [paragraph 3.8.4](#) of this policy issuance for beneficiary owned equipment; or

**5.1.8** The item (or a charge for access to such items through health club membership or other activities) is exercise equipment including an item primarily and customarily designed for use in sports or recreational activities, spas, whirlpools, hot tubs, swimming pools, or electronic devices used to locate or monitor the location of a beneficiary or other similar charges, or item charges.

**5.2** Service animals (e.g., Seeing Eye dogs, hearing and handicapped assistance animals, etc.) are excluded.

**5.3** Alterations to living space and permanent fixtures attached thereto, including alterations necessary to accommodate installation of equipment or AT devices to facilitate entrance or exit is excluded.

**5.4** Repairs and maintenance of deluxe, luxury, or immaterial features of AT device or DE.

**5.5** Maintenance agreements for beneficiary-owned or rented equipment or AT devices are excluded.

**5.6** DE that is available under the TRICARE Basic Program and an AT device that is also available under the TRICARE Basic Program as DE, a prosthetic, augmentation communication device, or other benefit are excluded.

**6.0 EFFECTIVE DATE**

January 30, 2015.

- END -

**6.1.5** Participating TRICARE-authorized HHA. A HHA that meets the requirements of [32 CFR 199.6\(b\)\(4\)\(xv\)](#) and has a valid participation agreement in effect at the time the EHC services are rendered.

## **6.2 Authorization**

All EHC services must be included in the beneficiary's POC and authorized by the Managed Care Support Contractor (MCSC) or Director, TRICARE Area Office (TAO) prior to those services being rendered.

## **6.3 Beneficiary Assessment**

**6.3.1** For the purpose of the EHC benefit, the beneficiary's attending physician or primary care manager is responsible for determining the required medically necessary skilled services. This includes, but is not limited to the scope, frequency and duration of such services, and is the basis for the POC.

**6.3.2** The EHC benefit is not subject to the HHA PPS, therefore, the MCSCs are not required to use the Outcome and Assessment Information Set (OASIS) nor the Centers for Medicare and Medicaid Services (CMS) Form 485 when developing the multidisciplinary POC.

## **6.4 POC**

**6.4.1** Scope. A multidisciplinary POC will be developed by the beneficiary's attending physician, or designee, together with the assistance of the HHA. At a minimum, the plan must include:

**6.4.1.1** All pertinent diagnoses and qualifying condition(s), including the beneficiary's mental status;

**6.4.1.2** The type, frequency, and duration of services and supplies, including any medically necessary treatments;

**6.4.1.3** Assessment of the beneficiary's functional limitations and activities permitted;

**6.4.1.4** The potential for rehabilitation or prevention of deterioration of the beneficiary's condition;

**6.4.1.5** Nutritional requirements, including but not limited to enteral and parenteral nutritional therapy and other special dietary requirements and restrictions;

**6.4.1.6** Dosage and administration of all medications;

**6.4.1.7** Safety measures to protect the beneficiary and the provider against injury;

**6.4.1.8** Instructions for timely discharge or completion of a treatment and referral for other skilled services;

**6.4.1.9** Those services to be taught to the primary caregiver(s) as discussed in [paragraph 6.1.4](#).

**TRICARE Policy Manual 6010.57-M, February 1, 2008**

Chapter 9, Section 15.1

ECHO Home Health Care (EHC)

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**6.4.1.10** The professional level of provider expected to render the specified services;

**6.4.1.11** Although paid under the TRICARE Basic Program and not included in the EHC fiscal year benefit cap, the following shall also be included in the beneficiary's POC:

**6.4.1.11.1** Required Durable Equipment (DE) to be rented or purchased;

**6.4.1.11.2** U. S. Food and Drug Administration (FDA)-approved injectable drugs for osteoporosis;

**6.4.1.11.3** Pneumococcal pneumonia, influenza virus and hepatitis B vaccines;

**6.4.1.11.4** Oral cancer drugs and antiemetics;

**6.4.1.11.5** Orthotics and prosthetics;

**6.4.1.11.6** Ambulance services operated by the HHA;

**6.4.1.11.7** Enteral and parenteral supplies and equipment; and

**6.4.1.11.8** Other drugs and biologicals administered by other than oral method.

**6.4.1.12** Although paid under the ECHO, the POC shall also include required **Assistive Technology (AT) devices** to be rented or purchased.

**6.4.1.13** Any other information the beneficiary's attending physician or primary care manager, the MCSC case manager, and the HHA believe necessary in order to provide the beneficiary with the appropriate level of services.

**6.4.2** Plan Certification. Upon completion, the following certifications will be provided by signature on the POC:

**6.4.2.1** The beneficiary's attending physician or primary care manager will certify that:

**6.4.2.1.1** The beneficiary is homebound; and

**6.4.2.1.2** The beneficiary requires medically necessary skilled services that exceed the HHA PPS under the TRICARE Basic Program; and/or

**6.4.2.1.3** The beneficiary requires frequent interventions, as defined in [paragraph 6.1.4](#), such that respite care services are needed in order to allow the primary caregiver(s) the opportunity to rest or sleep; and

**6.4.2.1.4** The services are allowable TRICARE benefits through the ECHO.

**6.4.2.2** The HHA will certify that:

**6.4.2.2.1** The agency has an agreement to participate in the TRICARE program and will continue such agreement for the duration of the plan; and

**6.5.5.4** Items that generally serve a routine hygienic purpose, for example soaps and shampoos, and items that generally serve as skin conditioners such as baby lotion, baby oil, skin softeners, powders, and other skin care lotions, are not considered medical supplies unless the particular item is recognized as serving a specific purpose in the physician's prescribed management of the beneficiary's qualifying condition.

**6.5.5.5** Limited amounts of medical supplies may be left in the home between visits where repeated applications are required and rendered by the beneficiary or other caregiver. These items must be part of the POC in which the home health staff is actively involved. For example, in the case of a beneficiary who requires a nutritional therapy enteral or parenteral feeding when HHA personnel are not present, it would be appropriate for the agency to leave reasonable quantities of the nutritional therapy product in the beneficiary's home for administration by other caregivers. Items such as needles, syringes, and catheters that require administration by a nurse should not be left in the home between visits.

**6.5.6** **AT Devices.** As defined in 32 CFR 199.2, AT devices are equipment that generally does not treat an underlying injury, illness, disease or their symptoms. AT devices are authorized only under the ECHO. AT devices help an ECHO beneficiary overcome or remove a disability and are used to increase, maintain, or improve the functional capabilities of an individual. AT devices may include non-medical devices (e.g., computer peripheral devices, keyboard, mouse, etc., or software that makes a computer functional to an ECHO beneficiary with a qualifying condition that would otherwise limit or prohibit the beneficiary's ability to use the computer) but do not include any structural alterations (e.g., permanent structure of wheelchair ramps or alterations to street curbs), service animals (e.g., Seeing Eye dogs, hearing/handicapped assistance animals, etc.), or specialized equipment and devices whose primary purpose is to enable the individual to engage in sports or recreational events. AT devices are authorized only under coverage criteria determined by the Director, Defense Health Agency (DHA) (formerly TRICARE Management Activity (TMA)) to assist in the reduction of the disabling effects of a qualifying condition for individuals eligible to receive benefits under the ECHO program, as provided in 32 CFR 199.5. For AT devices coverage criteria, see Section 14.2.

**6.5.7** **DE. Durable Medical Equipment (DME) (a subset of DE),** although included in the POC and provided by a HHA, is not part of the EHC benefit; it will be cost-shared only through the TRICARE Basic Program.

## **6.6 Authorized Providers**

**6.6.1** All EHC and respite care services will be provided only by TRICARE-authorized HHAs who have in effect at the time of services a valid agreement to participate in the TRICARE program;

**6.6.1.1** In order to receive payment for HHC services provided in accordance with this issuance, HHAs must be Medicare or Medicaid certified and meet all applicable Medicare or Medicaid conditions of participation.

**6.6.1.2** HHAs for which Medicare or Medicaid certification is not available due to the specialized categories of individuals they serve, for example, individuals that are under the age of 18 or who are receiving maternity care, must meet the qualifying conditions for corporate services provider status as specified in Chapter 11, Section 12.1.

**6.6.2** HHAs, whether or not they are Medicare or Medicaid certified, will be responsible for assuring that all individuals rendering EHC services and respite care services meet all applicable qualification standards. The MCSCs are not responsible for certification of individuals employed by or contracted with a HHA.

**6.6.3** Reimbursement for all EHC services provided by Medicare or Medicaid certified and non-Medicare or non-Medicaid certified HHAs will be as discussed in [paragraph 6.7](#) and [6.8](#).

## **6.7 Claims**

**6.7.1** Billing. HHAs will use itemized billing for EHC services, including those items that will be cost-shared under the TRICARE Basic Program, that are identified on the beneficiary's POC

**6.7.2** Primary Agency. When necessary, multiple HHAs may be involved in providing the services indicated in the beneficiary's POC. When such is the case, the MCSC will designate one such agency as the Primary Agency. In addition to being responsible for providing the services in the plan, the primary agency is also responsible for:

**6.7.2.1** Negotiating the reimbursement rate with the MCSC having jurisdiction where the beneficiary lives;

**6.7.2.2** Arranging for the services to be provided by other HHAs;

**6.7.2.3** Insuring the qualifications of the other HHAs;

**6.7.2.4** Insuring that services provided by other HHAs are in accordance with the POC; and

**6.7.2.5** Reimbursing the other HHAs that provide services.

**6.7.3** The MCSCs will deny claims from other than the primary agency for services and items provided as described herein.

**6.7.4** The EHC and respite care benefits will not use the "Requests for Anticipated Payment."

**6.7.5** All claims for EHC services or items will be submitted only after such services or items are provided.

**6.7.6** EHC and respite care services will be coded using the appropriate procedure codes shown in [paragraph 1.0](#).

**6.7.7** The EHC and respite care benefits will operate on the platform of existing TRICARE claims processing systems.

**6.7.8** Hours of services provided in accordance with the beneficiary's POC will become the unit of reimbursement and tracking in the claims processing systems. The EHC and respite care benefits require that services be recorded in **one** hour increments.

**6.7.9** HHAs providing EHC services will submit claims using the CMS 1500 Claim Form, either in paper form or electronic version.

**6.7.9.1** Frequency of submitting claims is at the discretion of the MCSC, that is, the HHA may be required by the MCSC to submit claims weekly, monthly, or at such other intervals as the MCSC determines is appropriate.

**6.7.9.2** The monthly (or other billing period as specified by the MCSC) claim will indicate the total hours for each type of service, that is, skilled services, skilled therapy services, home health aide services, and medical social services, will be grouped according to the professional level of the individuals providing such services. The totals will be entered on separate lines of the CMS 1500 Claim Form.

**6.7.10** The following, although required to be included in the POC and when provided by the HHA, will be itemized billed separately from the allowed HHC services and will be cost-shared through the TRICARE Basic Program or the ECHO as appropriate. The amount reimbursed for these items do not accrue to the EHC fiscal year benefit cap established under [paragraph 6.8](#).

- Rental or purchase of **AT devices** and **DE**;
- FDA-approved injectable drugs for osteoporosis;
- Pneumococcal pneumonia, influenza virus and hepatitis B vaccines;
- Oral cancer drugs and antiemetics;
- Orthotics and prosthetics;
- Ambulance services operated by the HHA;
- Enteral and parenteral supplies and equipment; and
- Other drugs and biologicals administered by other than oral method.

## **6.8 Reimbursement**

Reimbursement for the services described in this issuance will be made on the basis of allowable charges or negotiated rates between the MCSCs and the HHAs.

**6.8.1** Benefit cap. Coverage for the EHC benefit is capped on a fiscal year basis.

**6.8.2** Basis of the cap. The purpose of the EHC benefit is to assist eligible beneficiaries in remaining at their primary residence rather than being confined to institutional facilities, such as a SNF or other acute care facility. Therefore, TRICARE has determined that the appropriate EHC benefit cap is equivalent to what TRICARE would reimburse if the beneficiary was in a SNF.

**6.8.2.1** Annually, the MCSCs will calculate the EHC cap for each beneficiary's area of primary residence as follows:

**6.8.2.1.1** Obtain the annual notice, published in the **Federal Register**, of the CMS PPS and Consolidated Billing for SNFs--Update for the upcoming fiscal year. (From time to time the update notice may be known by another name but will contain the same information.)

**Note:** Although CMS periodically publishes updates to the SNF rates during any given fiscal year, those will not be used to calculate the EHC cap. Only the SNF reimbursement rates in effect on October 1 of each year will be used to calculate the EHC cap for the fiscal year beginning on that date.

**6.8.2.1.2** From the "RUG-IV Case-Mix Adjusted Federal Rates for Urban SNFs by Labor and Non-Labor Component", determine the highest cost RUG-IV category;

**6.8.2.1.3** Multiply the labor component obtained in [paragraph 6.8.2.1.2](#) by the "FY 2015 Wage Index for Urban Areas Based on CBSA Labor Market Areas" value corresponding to the beneficiary's location;

**6.8.2.1.4** Sum the non-labor component from [paragraph 6.8.2.1.2](#) and the adjusted labor component from [paragraph 6.8.2.1.3](#); the result is the beneficiary's EHC per diem in that location;

**6.8.2.1.5** Multiply the per diem obtained in [paragraph 6.8.2.1.4](#) by 365 (366 in leap year); the result is the beneficiary's fiscal year cap for EHC in that location.

**6.8.2.1.6** For beneficiary's residing in rural areas, use "RUG-IV Case-Mix Adjusted Federal Rates for Rural SNFs by Labor and Non-Labor Component" and "FY 2015 Wage Index Based on CBSA Labor Market Areas for Rural Areas" and adjust similarly to [paragraphs 6.8.2.1.3](#) through [6.8.2.1.5](#) to determine the EHC for beneficiaries residing in rural areas.

**6.8.2.2** Beneficiaries who seek EHC at any time during the fiscal year will have their cap calculated as above and prorated by month for the remaining portion of that fiscal year.

**6.8.2.3** The maximum amount reimbursed in any month for EHC services is the amount authorized in accordance with the approved POC and based on the actual number of hours of HHC provided and billed at the allowable charge or the negotiated rate. In no case will the amount reimbursed for any month of EHC exceed one-twelfth (1/12) of the annual fiscal year cap established under [paragraph 6.8.2.1](#) and as adjusted for the actual number of days in the month during which the services were provided.

**6.8.2.4** Beneficiaries who move will have their cap recalculated to reflect the wage index for their new location. The maximum amount reimbursed in the remaining months of that fiscal year for EHC services will reflect the re-calculated EHC cap.

**6.8.2.5** The cost for EHC services does not accrue to the maximum monthly or fiscal year Government cost-shares indicated in [Section 16.1](#).

**6.8.3** The sponsor's cost-share for EHC services will be as indicated in [Section 16.1](#).

## **7.0 EXCLUSIONS**

**7.1** Basic program and the ECHO Respite Care benefit (see [Section 12.1](#)).

**7.2** EHC services will not be provided outside the beneficiary's primary residence.

**7.3** EHC services and EHC respite care services are not available for the purpose of covering primary caregiver(s) absences due to deployment, employment, seeking employment, or to pursue education. Except for those excluded activities, this exclusion does not otherwise restrict or prohibit the primary caregiver(s) from engaging in other activities they choose, including those outside the beneficiary's primary residence.

**TRICARE Policy Manual 6010.57-M, February 1, 2008**

Chapter 9, Section 15.1

ECHO Home Health Care (EHC)

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**7.4** EHC services and supplies can be provided only to the eligible beneficiary, that is, such services will not be provided to or on behalf of other members of the beneficiary's family nor other individuals who reside in or are visiting in the beneficiary's primary residence.

**7.5** EHC services and supplies are excluded from those who are being provided continuing coverage of HHC as participants of the former Individual Case Management Program for Persons with Extraordinary Conditions (ICMP-PEC) or previous case management demonstrations.

**8.0 EFFECTIVE DATE**

September 1, 2005.

- END -



## Chapter 11

## Section 9.1

### Other Provider Certification

Issue Date: June 20, 1988  
Authority: [32 CFR 199.6\(d\)](#)

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#### 1.0 ISSUE

How are other providers certified such as ambulance companies, laboratories, pharmacies, etc.?

#### 2.0 POLICY

**2.1** Certifying authority. Each contractor is the certifying authority for the following categories of ancillary service or supply providers located within their geographical jurisdiction:

- Ambulance company.
- Independent laboratory.
- Medical equipment firm.
- Medical supply firm.
- Pharmacy.
- Portable x-ray service.
- Mammography suppliers.
- State Vaccine Programs or State Vaccine Program entities (SVPs) as suppliers of vaccines (see [Chapter 11, Section 9.2](#)).

**2.2** Vendors of medical supplies, vaccines, Durable Equipment (DE), or **Durable Medical Equipment (DME)** are covered as a Basic Program **benefit** or **Assistive Technology (AT)**, which is covered as an Extended Care Health Option (ECHO) benefit.

**2.2.1** The types of vendors which may be approved for medical supplies, vaccines, **DE**, **DME**, or **AT** includes, but are not limited to, the following:

**2.2.1.1** Any firm, supplier, or provider that is authorized under Medicare.

**2.2.1.2** Any commissary under the jurisdiction of the Defense Commissary Agency.

**2.2.1.3** Any Post Exchange, Base Exchange, or Station Exchange under the jurisdiction of:

- The Army/Air Force Exchange Service (AAFES); or
- The Department of the Navy; or
- The United States Marine Corps; or
- The United States Coast Guard.

**TRICARE Policy Manual 6010.57-M, February 1, 2008**

Chapter 11, Section 9.1

Other Provider Certification

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**2.2.1.4** Any civilian retail store.

**2.2.1.5** Any civilian retail pharmacy.

**2.2.1.6** An SVP that meets the requirements of Chapter 11, Section 9.2.

**2.2.2** A photocopy of a printed receipt which identifies the vendor as an allowable type of vendor is sufficient evidence of provider status for those listed that are not Medicare-authorized.

**2.3** Ambulance company. An ambulance company may be approved as a provider when:

**2.3.1** The company meets the requirements of state and local laws in the jurisdiction in which the ambulance firm is licensed.

**2.3.2** The company provides:

**2.3.2.1** A photocopy of the company's current license to provide ambulance services, or

**2.3.2.2** A signed and dated statement on letterhead by an official of the organization operating the ambulance service stating that:

- There is no license requirement for the operation of an ambulance service within the geographic area served by the ambulance service; or
- That the organization is exempt from a license requirement for the operation of an ambulance service with an explanation of the legal basis for exemption.

- END -

## Corporate Services Provider Class

Issue Date:

Authority: [32 CFR 199.2](#) and [32 CFR 199.6\(f\)](#)

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### 1.0 ISSUE

A general overview of the coverage and reimbursement of services provided by a Corporate Services Provider.

### 2.0 POLICY

#### 2.1 Regulatory Background

TRICARE supplements the availability of health care in military hospitals and clinics. Services and items allowable as TRICARE benefits must be obtained from TRICARE-authorized civilian providers to be considered for payment. The Code of Federal Regulations (CFR), [32 CFR 199.6](#), along with the TRICARE Policy Manual (TPM), establishes the specific requirements for institutional and professional providers recognized for payment under the program. These requirements have been used to ensure that providers possess licensing/credentials and/or meet recognized standards unique to their provider status, profession, or field of medicine. In the past, TRICARE has only recognized three classes of providers; i.e., 1) an institutional provider class consisting of hospitals and other categories of similar facilities; 2) an individual professional provider class including physicians and other categories of licensed individuals who render professional services independently, and certain allied health and extra medical providers that must function under physician orders and supervision; and 3) a class of providers consisting of suppliers of items and supplies of an ancillary or supplemental nature, such as **Durable Equipment (DE)/Durable Medical Equipment (DME)**. However, since the CFR and policy provisions were first established, the manner in which medical services are delivered has changed. TRICARE beneficiaries, like other health care consumers, now have access to a wide array of health care delivery systems that were not initially recognized or reimbursed under the Program. As a result, a fourth class of TRICARE provider has been established consisting of freestanding corporations and foundations that render principally professional, ambulatory or in-home care and technical diagnostic procedures. The addition of the corporate class recognizes the current range of providers with today's health care delivery structure, and gives beneficiaries access to another segment of the health care delivery industry.

#### 2.2 Scope of Coverage/Reimbursement

**2.2.1** Out-of-System/Non-Network Reimbursement. The intent of this provider class expansion (recognition of Corporate Services Providers as authorized providers under TRICARE) is not to create additional benefits that ordinarily would not be covered under TRICARE if provided by a more traditional health care delivery system (i.e., care traditionally offered in a hospital setting), but

## TRICARE Policy Manual 6010.57-M, February 1, 2008

### Chapter 11, Section 12.1

#### Corporate Services Provider Class

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rather to allow those services which would otherwise be allowed except for an individual provider's affiliation with a freestanding corporate entity. A provider qualifying for corporate services provider status under TRICARE would be allowed payment for the following services and supplies:

**2.2.1.1** Otherwise covered professional services provided by TRICARE-authorized individual providers employed by or under contract with a freestanding corporate entity will be paid under the CHAMPUS Maximum Allowable Charge (CMAC) reimbursement system, subject to any restrictions and limitations as may be prescribed under existing TRICARE policy.

**2.2.1.2** Payment will also be allowed for supplies used by a TRICARE authorized individual provider employed by or contracted with a corporate services provider in the direct treatment of a TRICARE eligible beneficiary. Allowable supplies will be reimbursed in accordance with TRICARE allowable charge methodology as described in TRICARE Reimbursement Manual (TRM), [Chapter 5, Section 1](#).

**2.2.1.3** Reimbursement of covered professional services and supplies will be made directly to the TRICARE authorized corporate services provider under its own tax identification number.

**2.2.1.4** Payment will be allowable for services rendered in the authorized corporate services provider's place of business, or in the beneficiary's home, under such circumstances as the contractor determines to be necessary for the efficient delivery of such in-home services.

**2.2.2** Alternative Network (In-System/Network) Reimbursement Systems. There are regulatory and contractual provisions currently in place that grant contractors the authority to establish alternative network reimbursement systems as long as they don't exceed what would have otherwise been allowed under Standard TRICARE payment methodologies as described in the TRM.

**2.2.2.1** Establishment of alternative reimbursement systems for Corporate Services Providers will allow contractors and TRICARE beneficiaries access to a wide source of competitive ambulatory and in-home services while at the same time maintaining budget neutrality; i.e., there should be no increases in benefit costs since the services would have otherwise been provided in an institutional setting on either an inpatient or outpatient basis.

**2.2.2.2** Since it is assumed that ambulatory services will be less expensive than when provided in an institutional setting, it is expected that contractors will be able to establish rates which will result in significant savings to the government. For example, under non-network (out-of-system) reimbursement methodologies, freestanding bone marrow transplant centers will be restricted solely to payment of professional services and related supplies which account for only 10% to 20% of the total program charges for autologous bone marrow transplants. The remaining 70% to 80% of the charges will be attributable to technical and/or facilities fees. The services will include but are not limited to: 1) laboratory charges; 2) pre-conditioning chemotherapy; 3) growth factor; 4) home health; 5) catheter placement; 6) blood products; and 7) recovery post discharge. Under the above alternative reimbursement provisions, contractors will be given the flexibility of negotiating with network providers (i.e., freestanding outpatient bone marrow transplant centers who agree to become network providers) for outpatient bone marrow transplants at rates below those performed in a hospital setting, which would include CMAC rates for professional fees plus the Diagnostic Related Group (DRG) amount.

**2.2.2.3** The following minimal requirements should be adhered to in the establishment of alternative reimbursement methodologies for in-system/network corporate services providers in order to ensure quality of care and fiscal accountability:

**2.2.2.3.1** Alternative reimbursement methodologies may include and/or be a combination of fee schedules, discounts from usual and customary fees or CMAC, flat fee arrangements (negotiated all inclusive rates), capitation arrangements, discounts off of DRGs, per diems; or such other method as is mutually agreed upon, provided such alternative payments do not exceed what would have otherwise been allowed under Standard TRICARE payment methodologies in another setting (e.g., comparable services rendered in a hospital inpatient or outpatient setting).

**2.2.2.3.2** Payments in full (e.g., negotiated flat fees, all-inclusive global fees, capitation arrangements, discounts off of DRGs and per diems) are prospective reimbursement systems which may include items related or incidental to the treatment of the patient but for which coverage is not normally extended under TRICARE. These incidental services are to be included in the negotiated prospective payment rate; i.e., they can neither be billed to the beneficiary or deducted from the negotiated global rate.

**2.2.3** All billing for Corporate Services Providers should be submitted on a Centers for Medicare and Medicaid Services (CMS) 1500 Claim Form. **Defense Health Agency (DHA)** will assign pricing rate codes (e.g., assigning a pricing rate code "GP" for non-institutional per diem rates) to accommodate approved alternative reimbursement systems. The contractor should designate the coding that it wants to use as part of the alternative reimbursement request submitted to the Deputy Director, **DHA** or designee for review and approval.

**2.2.4** The contractor will determine the appropriate procedural category of a qualified organization and may change the category based upon the provider's TRICARE claim characteristics. The category determination is conclusive and may not be appealed.

**2.2.5** The corporate entity will not be allowed additional facility charges that are not already incorporated into the professional services fee structure (i.e., facility charges that are not already included in the overhead and malpractice cost indices used in establishing locally-adjusted CMAC rates).

**2.2.6** While the expanded provider category will allow coverage of professional services for corporate entities qualifying for provider authorization status under the provisions of this policy, it will at the same time restrict coverage of professional services for those corporate entities which cannot meet the criteria for corporate services provider status under TRICARE.

### **2.3 Conditions for Coverage/Authorization**

**2.3.1** Be a corporation or a foundation, but not a professional corporation or professional association;

**2.3.2** Be institution-affiliated or freestanding;

**2.3.3** Provide services and related supplies of a type rendered by TRICARE individual professional providers employed directly or contractually by a corporation, or diagnostic technical services and related supplies of a type which requires direct patient contact and a technologist

who is licensed by the state in which the procedure is rendered or who is certified by a Qualified Accreditation Organization;

**2.3.4** Provide the level of care that does not necessitate that the beneficiary be provided with on-site sleeping accommodations and food in conjunction with the delivery of the services except for sleep disorder diagnostic centers in which on-site sleeping accommodations are an integral part of the diagnostic evaluation process.

**2.3.5** Render services for which direct or indirect payment is expected to be made by TRICARE only after obtaining written authorization (i.e., comply with applicable TRICARE authorization requirements before rendering designated services or items for which TRICARE cost-share/copayment may be expected);

**2.3.6** Comply with all applicable organizational and individual licensing or certification requirements that exist in the state, county, municipality, or other political jurisdiction in which the corporate entity provides services;

**2.3.7** Maintain Medicare approval for payment when the contractor determines that a category, or type, of provider is substantially comparable to a provider or supplier for which Medicare has regulatory conditions of participation or conditions of coverage, or when Medicare approved status is not required, be accredited by a qualified accreditation organization, as defined in [Section 12.2](#); and

**2.3.8** Has entered into a negotiated provider contract with a network provider or a participation agreement with a non-network provider which at least complies with the minimum participation agreement requirements set forth in [Section 12.3](#). The participation agreement will accompany the application form (Application for TRICARE-Provider Status: CORPORATE SERVICES PROVIDER) sent out as part of the initial authorization process for non-network providers as described below.

## **2.4 Application Process**

**2.4.1** The information collected on the "Application for TRICARE-Provider Status: CORPORATE SERVICES PROVIDERS" (i.e., the information collection form for which the provider is seeking TRICARE authorization status) will be used by the contractor in determining whether the provider meets the criteria for authorization as a corporate services provider under the TRICARE program (refer to [Addendum D](#) for a copy of the corporate services provider application form).

**2.4.2** The application will be sent out and information collected when a:

**2.4.2.1** Provider requests permission to become a TRICARE provider;

**2.4.2.2** Claim is filed for care received from a provider who is not listed on the contractor's provider file; or

**2.4.2.3** Formerly TRICARE authorized provider requests reinstatement.

**2.4.3** The contractor will verify that the provider meets TRICARE authorization criteria through the collection and review of applicable Medicare, Joint Commission, and state and national board certificates/licenses requests on the corporate services provider application form.

**2.4.4** The authorization process is streamlined (simplified) in that the individual authorization of professional providers employed by or under contract with a corporate entity will not be required as part of the authorization process.

**2.4.4.1** Instead, the responsibility for ensuring all individuals meet TRICARE requirements is placed on the corporate entity itself.

**2.4.4.2** This assurance is further strengthened by requiring Medicare approval for payment as a condition of authorization under TRICARE, since Medicare also relies on the delegation of certification of individual professional and allied health care providers to the corporate entity.

**2.4.4.3** Although the actual provider of care will still have to be identified on the claim form, verification of the qualifications of employed and contracted individual providers will not be required by the contractors. In the case where the individual (e.g., technician) providing the service does not have a National Provider Identifier (NPI), the NPI of the ordering/supervising physician, non-physician practitioner, or billing entity is required on the claim form.

**2.4.4.4** Reliance on Medicare approval for payment - or when Medicare approved status is not required, accreditation by a qualified accrediting organization - is administratively expeditious and cost effective for both TRICARE and providers qualifying for authorization under the new provider category.

**2.4.5** The effective date of authorization will be the date the provider met the "Conditions for Coverage/Authorization" as prescribed in [paragraph 2.3](#) or June 8, 1999, whichever is later. Retroactive authorization will apply to both network providers (providers that have entered into negotiated network contracts) and non-network providers (those providers authorized under the application process) subject to the effective date of June 8, 1999, appearing in the Corporate Services Provider Final Rule published in the **Federal Register** on March 10, 1999.

## **2.5 Approval Process For New Provider Categories Seeking Authorization Under the Corporate Services Provider class**

**2.5.1** While contractors will use the "Conditions for Coverage/Authorization" under [paragraph 2.3](#) for initial review/screening of all new provider categories seeking authorization status under the Corporate Services Provider class, final approval will be reserved for **DHA**.

**2.5.2** The contractors should only submit those provider categories who on initial analysis appear to meet the criteria for inclusion under the Corporate Services Provider class. The submission should include all supporting documentation, along with the contractor's rationale for recommending authorization status under the Corporate Services Provider class.

**2.5.3** If **DHA** concurs with the contractor's recommendation, a new provider specialty code will be added.

**TRICARE Policy Manual 6010.57-M, February 1, 2008**

Chapter 11, Section 12.1

Corporate Services Provider Class

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**2.5.4** A notice of the agency's determination, along with supporting documentation (a copy of the package seeking final approval status of the provider category), will be sent out to all the regional contractors for appropriate action.

**2.5.5** Requests for final approval status should be submitted to **DHA** through the contractor's Contracting Officer Representative (COR).

- END -

## Chapter 12

## Section 1.1

# TRICARE Overseas Program (TOP)

Issue Date:

Authority: [32 CFR 199.17\(u\)](#)

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### 1.0 GENERAL

**1.1** The TRICARE Overseas Program (TOP) is the Department of Defense's (DoD's) program for the delivery of health care support services overseas (all locations outside of the 50 United States and the District of Columbia). The delivery of health care services overseas represents a unique situation that cannot be effectively addressed by applying all of the standards that apply in the 50 United States and the District of Columbia. TOP blends many of the features of the TRICARE program in the United States (U.S.) while allowing for significant cultural differences unique to health care practices and services in foreign countries.

**1.2** TOP provides health care coverage for all overseas beneficiaries, including Active Duty Service Members (ADSMs), eligible Reserve Component (RC) personnel, Active Duty Family Members (ADFMs) (including family members of eligible RC personnel), retired military and their respective family members, and transitional survivors. This coverage applies regardless of where the services are received. TOP also provides health care coverage for stateside beneficiaries residing in the 50 United States or the District of Columbia (excluding beneficiaries enrolled to the Uniformed Services Family Health Plan (USFHP) and the Continued Health Care Benefit Program (CHCBP)) who receive health care in an overseas location. TOP coverage includes dental care for ADSMs **permanently assigned to remote overseas location, and only urgent and emergency dental care for ADSMs who are** Temporary Duty/Temporary Additional Duty (TDY/TAD), in an authorized leave status, **deployed or deployed on liberty** in remote overseas locations. Specific TOP program eligibility and health care coverage is based upon beneficiary status, location, and enrollment elections. All beneficiaries must be eligible for TRICARE as verified via the Defense Enrollment Eligibility Reporting System (DEERS).

**Note:** USFHP enrollees must be authorized to receive care by their USFHP Primary Care Manager (PCM), regardless of where the care is rendered. Claims for overseas care rendered to USFHP enrollees shall be sent to the USFHP for processing and payment. Claims for overseas care rendered to CHCBP enrollees shall be sent to the CHCBP contractor for processing and payment.

**1.3** TOP health care services are provided by Military Treatment Facilities (MTFs), MTF Partnership Providers, and a complement of network- and non-network host nation providers and institutions.

**1.4** Three geographic regions have been identified for the oversight of health care delivery overseas: TRICARE Eurasia-Africa (including the European continent, the Middle East, and Africa), TRICARE Pacific (including Asia, Australia, and the islands of the Pacific and Indian Oceans), and TRICARE Latin America and Canada (TLAC) (including Puerto Rico, the Caribbean basin, Latin

America, South America, and Canada). Three TRICARE Area Offices (TAOs) have been established for these geographic regions to provide management and oversight of TOP health care delivery for eligible TRICARE beneficiaries. The TAO Directors, working in concert with the MTFs and their respective services, are responsible for organizing and managing health care delivery in their respective region. A single TRICARE Overseas health care support contractor (hereinafter referred to as the "TOP contractor") supports the TAOs, MTFs, services, beneficiaries, and host nation providers by providing or arranging for the delivery of health care services, claims processing services, and a variety of health care administrative services.

## 2.0 TRICARE PROGRAMS/SERVICES IN OVERSEAS LOCATIONS

**2.1** The following TRICARE programs or services are available under the TOP contract: TOP Prime, TOP Prime Remote, TOP Standard, TOP TRICARE for Life (TFL), TRICARE Reserve Select (TRS), TRICARE Plus, the Extended Care Health Option (ECHO), TRICARE Young Adult (TYA), and the Transitional Assistance Management Program (TAMP).

**2.2** The following TRICARE programs or services may be available in certain overseas locations, but are not administered under the TOP contract: TRICARE Dental Program (TDP), TRICARE Retiree Dental Program (TRDP), TFL, TRICARE Pharmacy (TPharm) Program, TRICARE Active Duty Dental Program (ADDP), and the CHCBP.

**2.3** TRICARE Extra is not available outside the 50 United States and the District of Columbia.

## 3.0 TOP BENEFIT POLICY

**3.1** TOP benefit policy applies to the scope of services and items which may be considered for coverage by TRICARE within the intent of [32 CFR 199.4](#) and [32 CFR 199.5](#). Specifically, TRICARE may cost-share a procedure that is determined to be appropriate medical care, is medically or psychologically necessary, is not unproven as defined in [32 CFR 199.2](#), and the service or supply is not specifically limited in coverage or explicitly excluded by statute, regulation, or policy.

**3.2** While "appropriate medical care" references the norm for medical practice in the U.S., TOP gives consideration to the significant cultural differences unique to foreign countries. The TOP contractor shall exercise reasonable judgment to accommodate cultural differences relevant to the practices and delivery of host nation health care services. Services and supplies which otherwise fall within the range of TRICARE benefits (including, but not limited to, clinical preventive services, prescription drugs, and **Durable Equipment (DE)/Durable Medical Equipment (DME)**) may be eligible for coverage under TOP when the diagnosis or description of illness supports the reasonableness of the procedure, service, or supply and is commonly accepted practice in a host country or overseas region. Services and supplies, which are specifically excluded from TRICARE coverage cannot be covered under TOP simply because of cultural differences. A specific waiver is required if the service or supply would not normally be considered a TRICARE benefit. Refer to [Section 1.2](#) for a list of authorized benefit variations for TOP.

**3.3** Cultural differences may apply to things like location of care (provider comes to the patient's home) or the manner in which care is provided (services commonly done by a provider class in the U.S. may be performed by a provider assistant or physician overseas, depending on the country). Cultural differences may also apply to the manner in which claims are submitted to TRICARE. For example, certain countries may require a separate delineation of charges for health care delivery

and administrative practices that are attendant to the delivery of health care. These charges may be payable under TRICARE if they are determined to be reasonable and customary for a particular overseas location. Also, due to cultural differences, host nation providers may, and frequently do submit claims containing narrative summaries in lieu of diagnostic and/or procedural codes. These claims may be payable under TRICARE; however, the TOP contractor shall establish processes to ensure that narrative claims are converted to codes that accurately describe the services rendered and billed by the host nation provider. Fees for transplant donor searches in Germany may be reimbursed on a global flat fee basis since the German government does not permit health care facilities to itemize such charges. Itemized fees for supplies that are related or incidental to inpatient treatment in Japanese hospitals (e.g., hospital gowns) may be reimbursed if similar supplies would be covered under reimbursement methodologies used within the U.S. The TOP contractor shall implement internal management controls to ensure that payments are reasonable and customary for the location.

**3.4** The TOP benefit package includes pharmacy services through the TOP contractor for drugs dispensed by host nation pharmacies, institutions, and providers. TOP beneficiaries may also receive limited services through the TPharm contract, to include retail network pharmacy services (in U.S. territories) and mail order pharmacy (MOP) services. The TPharm MOP may be used by all TOP beneficiaries provided certain criteria are met, such as a U.S. credentialed provider to write the prescription and a U.S. zip coded address to ship to (Army Post Office (APO), Fleet Post Office (FPO), or Diplomatic Pouch Mail). Additionally, ADSMs or ADFMs assigned to U.S. Embassies/State Departments may also use TPharm MOP services. TOP beneficiaries who are covered by Other Health Insurance (OHI) with a prescription drug benefit may not use TPharm MOP services unless the OHI plan does not cover the medication needed, or the OHI coverage limit has been met. The TPharm MOP cannot ship drugs which must be refrigerated (e.g., insulin) to an address outside the 50 United States and the District of Columbia.

**Note:** The TPharm retail network pharmacy benefit is available in the 50 United States, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, American Samoa, and the Northern Mariana Islands.

#### **4.0 APPLICABILITY OF TRICARE REQUIREMENTS**

**4.1** All TRICARE requirements set forth in the TPM, the TRICARE Reimbursement Manual (TRM), TRICARE Operations Manual (TOM), and the TRICARE Systems Manual (TSM) apply to the TOP, unless specifically waived or superseded by the TOP contract, this chapter, or the TOM, [Chapter 24](#).

**4.2** For purposes of TOP implementation, any applicable manual language that refers to "TRICARE Prime" and "TRICARE Prime Remote" shall apply to TOP Prime and TOP Prime Remote, language that refers to "Regional Directors" shall apply to TAO Directors, language that refers to "TRICARE Standard" shall apply to TOP Standard, and language that refers to "Managed Care Support Contractor(s)" (MCSC(s)) shall apply to the TOP contractor.

**4.3** Waiver of rigid application of the requirements for processing/review of claims has been granted by the **Defense Health Agency (DHA)** Director to overcome variations between U.S. standards of health care practice and standards of health care practice in foreign countries. Examples of these variations are:

- TOP host nation providers, network and non-network are not required to meet all

TRICARE provider certification requirements to become a TOP host nation authorized provider; or

- Charges for taxi companies for driving physicians to accidents or private residences.

## **5.0 CONTRACTOR RESPONSIBILITIES**

The TOP contractor shall support the best value in the coordination and delivery of health care services in overseas locations for ADSM, ADFMs, and other TRICARE-eligible beneficiaries. This includes all health care services provided in an overseas location, regardless of the beneficiary's enrollment location or residence address. Contractor responsibilities under this contract include (but are not limited to) enrollment processing, host nation provider certification, network development and maintenance, Beneficiary and Provider Services (BPS) (including education and marketing), MTF optimization, medical management, fraud and abuse prevention and detection, medically-necessary patient evacuations and transfers, active duty dental care in remote overseas locations (except for U.S. territories), and claims processing. The TOP contractor is responsible for the processing of overseas claims for overseas Prime, Standard, TOP TFL, and pharmacy claims in non-Medicare overseas areas for beneficiaries considered to be within the TOP contractor's jurisdictional responsibility. The contractor shall provide a designated Point of Contact (POC) to assist the TAO Directors or designee(s). Additionally, every stateside regional MCSC shall offer traveling TOP beneficiaries use of existing toll free Health Care Finders (HCFs) numbers/services to locate a stateside TRICARE network provider. Specific contractor responsibilities are addressed in the TRICARE Manuals and in the TRICARE Overseas health care support contract. Refer to the TOM, [Chapter 24](#) for additional TOP program instructions.

- END -

# TRICARE Policy Manual 6010.57-M, February 1, 2008

## Appendix A

### Acronyms And Abbreviations

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AML	Acute Myelogenous [Myeloid] Leukemia
ANSI	American National Standards Institute
AOA	American Osteopathic Association
APA	American Psychiatric Association American Podiatry Association
APC	Adenomatous Polyposis Coli Ambulatory Payment Classification
API	Application Program Interface
APN	Assigned Provider Number
APO	Army Post Office
ARB	Angiotensin Receptor Blocker
ARCIS	Archives and Records Centers Information System
ART	Assisted Reproductive Technology
ARU	Automated Response Unit
ARVC	Arrhythmogenic Right Ventricular Cardiomyopathy
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
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
ASRM	American Society for Reproductive Medicine
<b>AT</b>	<b>Assistive Technology</b>
ATA	American Telemedicine Association
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
BAA	Business Associate Agreement
BACB	Behavior Analyst Certification Board
BART	BRAC Analysis Large Rearrangement Test

## TRICARE Policy Manual 6010.57-M, February 1, 2008

### Appendix A

#### Acronyms And Abbreviations

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BBA	Balanced Budget Act
BBP	Bloodborne Pathogen
BBRA	Balanced Budget Refinement Act
BC	Birth Center
BCaBA	Board Certified Assistant Behavior Analyst
BCAC	Beneficiary Counseling and Assistance Coordinator
BCBA	Board Certified Behavior Analyst
BCBA-D	Board Certified Behavior Analyst - Doctoral
BCBS	Blue Cross [and] Blue Shield
BCBSA	Blue Cross [and] Blue Shield Association
BCC	Biostatistics Center
BE&SD	Beneficiary Education and Support Division
BH	Behavioral Health
BI	Background Investigation
BIA	Bureau of Indian Affairs
BIPA	Benefits Improvement Protection Act
BL	Black Lung
BLS	Basic Life Support
BMI	Body Mass Index
BMT	Bone Marrow Transplantation
BNAF	Budget Neutrality Adjustment Factor
BOS	Bronchiolitis Obliterans Syndrome
BP	Behavioral Plan
BPPV	Benign Paroxysmal Positional Vertigo
BPC	Beneficiary Publication Committee
BRAC	Base Realignment and Closure
BRCA	BReast CAncer (genetic testing)
BRCA1/2	BReast CAncer Gene 1/2
BS	Bachelor of Science
BSGI	Breast-Specific Gamma Imaging
BSID	Bayley Scales of Infant Development
BSR	Beneficiary Service Representative
BT	Behavior Technician
BWE	Beneficiary Web Enrollment
C&A	Certification and Accreditation
C&P	Compensation and Pension
C/S	Client/Server
CA	Care Authorization
CA/NAS	Care Authorization/Non-Availability Statement
CABG	Coronary Artery Bypass Graft
CAC	Common Access Card
CACREP	Council for Accreditation of Counseling and Related Educational Programs

## TRICARE Policy Manual 6010.57-M, February 1, 2008

### Appendix A

#### Acronyms And Abbreviations

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CAD	Coronary Artery Disease
CAF	Central Adjudication Facility
CAH	Critical Access Hospital
CAMBHC	Comprehensive Accreditation Manual for Behavioral Health Care
CAP	Competitive Acquisition Program
CAP/DME	Capital and Direct Medical Education
CAPD	Continuous Ambulatory Peritoneal Dialysis
CAPP	Controlled Access Protection Profile
CAQH	Council for Affordable Quality Health
CARC	Claim Adjustment Reason Code
CAS	Carotid Artery Stenosis
CAT	Computerized Axial Tomography
CB	Consolidated Billing
CBC	Cypher Block Chaining
CBE	Clinical Breast Examination
CBHCO	Community-Based Health Care Organizations
CBL	Commercial Bill of Lading
CBP	Competitive Bidding Program
CBSA	Core Based Statistical Area
CC	Common Criteria Convenience Clinic Criminal Control (Act)
CC&D	Catastrophic Cap and Deductible
CCCT	Clomiphene Citrate Challenge Test
CCD	Corporate Credit or Debit
CCDD	Catastrophic Cap and Deductible Data
CCEP	Comprehensive Clinical Evaluation Program
CCN	Case Control Number
CCPD	Continuous Cycling Peritoneal Dialysis
CCR	Cost-To-Charge Ratio
CCTP	Custodial Care Transitional Policy
CD	Compact 9Disc
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
CEA	Carotid Endarterectomy

**TRICARE Policy Manual 6010.57-M, February 1, 2008**

Appendix A

Acronyms And Abbreviations

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CEIS	Corporate Executive Information System
CEO	Chief Executive Officer
CEOB	CHAMPUS Explanation of Benefits
CES	Cranial Electrotherapy Stimulation
CF	Conversion Factor Cystic Fibrosis
CFO	Chief Financial Officer
CFR	Code of Federal Regulations
CFRD	Cystic Fibrosis-Related Diabetes
CFS	Chronic Fatigue Syndrome
CGMS	Continuous Glucose Monitoring System
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CHAMPVA	Civilian Health and Medical Program of the Department of Veteran Affairs
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
CID	Central Institute for the Deaf
CIF	Central Issuing Facility Common Intermediate Format
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
CMR	Cardiovascular Magnetic Resonance
CMS	Centers for Medicare and Medicaid Services

# TRICARE Policy Manual 6010.57-M, February 1, 2008

## Appendix A

### Acronyms And Abbreviations

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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
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
COR	Contracting Officer's Representative
CORE	Committee on Operating Rules for Information Exchange
CORF	Comprehensive Outpatient Rehabilitation Facility
CORPA	Commission on Recognition of Postsecondary Accreditation
COTS	Commercial-off-the-shelf
CP	Cerebral Palsy
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
CQM	Clinical Quality Management
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
CRP	Canalith Repositioning Procedure
CRS	Cytoreductive Surgery
CRSC	Combat-Related Special Compensation
CRT	Computer Remote Terminal
CSA	Clinical Support Agreement
CSE	Communications Security Establishment (of the Government of Canada)

# TRICARE Policy Manual 6010.57-M, February 1, 2008

## Appendix A

### Acronyms And Abbreviations

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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
CTA	Composite Tissue Allotransplantation Computerized Tomography Angiography
CTC	Computed Tomographic Colonography
CTCL	Cutaneous T-Cell Lymphoma
CTEP	Cancer Therapy Evaluation Program
CTLN1	Citrullinemia Type 1
CTX	Corporate Trade Exchange
CUC	Chronic Ulcerative Colitis
CVAC	CHAMPVA Center
CVS	Contractor Verification System
CY	Calendar Year
DAA	Designated Approving Authority
DAO	Defense Attache Offices
DBA	Doing Business As
DBN	DoD Benefits Number
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 Investigative Service Ductal Carcinoma In Situ
DCN	Document Control Number
DCP	Data Collection Period
DCPE	Disability Compensation and Pension Examination
DCR	Developed Character Reference
DCS	Duplicate Claims System
DCSI	Defense Central Security Index
DCWS	DEERS Claims Web Service
DD (Form)	Department of Defense (Form)
DDAS	DCII Disclosure Accounting System
DDD	Degenerative Disc Disease
DDP	Dependent Dental Plan
DDS	DEERS Dependent Suffix
DE	Durable Equipment

# Index

A	Chap	Sec/Add
Abortions	4	18.3
Accreditation	11	3.3
Acronyms And Abbreviations		Appendix A
Adjunctive Dental Care	8	13.1
Allergy Testing And Treatment	7	14.1
Ambulance Service	8	1.1
Ambulatory Surgery	11	6.1
Ancillary Inpatient Mental Health Services	7	3.11
Anesthesia	3	1.1
Dental	8	13.2
Anesthesiologist Assistant (AA)	11	3.5
Antepartum Services	4	18.2
Anticoagulant Management	2	5.2
Application Form For Corporate Services Providers	11	D
Applied Behavior Analysis (ABA)	7	3.18
For Non-Active Duty Family Members (NADFM) Who Participate In The ABA Pilot	7	3.19
Assistant Surgeons	4	4.1
Attention-Deficit/Hyperactivity Disorder	7	3.9
Audiology Service	7	8.1
Auditory System	4	22.1
Augmentative Communication Devices (ACDs)	7	23.1
Automated External Defibrillators (AEDs)	8	5.4

B	Chap	Sec/Add
Biofeedback	7	4.1
Birthing Centers		
Accreditation	11	11.1
Certification Process	11	11.2
Birthing Centers	11	2.3
Bone Density Studies	5	1.1
Bone Density Studies	5	2.1
Bone Density Studies	5	4.1
Botulinum Toxin Injections	7	27.1
Brachytherapy	5	3.2
Breast Prostheses	4	5.2
Breast Pumps, Breast Pump Supplies, And Breastfeeding Counseling	8	2.6
Breast Reconstruction As A Result Of A Congenital Anomaly	4	5.6

C	Chap	Sec/Add
Cancer Clinical Trials	7	24.1
Cardiac Rehabilitation	7	11.1
Cardiovascular System	4	9.1
Cardiovascular Therapeutic Services	7	6.3
Category II Codes - Performance Measurement	1	11.1
Category III Codes	1	12.1
Central Nervous System (CNS) Assessments/Tests	7	16.1
Certification Of Organ Transplant Centers	11	7.1
Certified Clinical Social Worker (CSW)	11	3.6
Certified Marriage And Family Therapist		
Certification Process	11	11.3
Certified Marriage And Family Therapist	11	3.9
Certified Nurse Midwife (CNM)	11	3.12
Certified Physician Assistant	11	3.13
Certified Psychiatric Nurse Specialist (CPNS)	11	3.7
Cervical Cancer Screening	7	2.4
Cesarean Sections	4	18.4
Chelation Therapy	7	2.7
Chemotherapy Administration	7	16.3
Chest X-Rays	5	1.1
Chiropractic Manipulative Treatment (CMT)	7	18.5
Chronic Care Management Services	1	15.2
Chronic Fatigue Syndrome (CFS)	7	21.1
Clinical Preventive Services		
TRICARE Prime	7	2.2
TRICARE Standard	7	2.1
Clinical Psychologist	11	3.8
Cochlear Implantation	4	22.2
Cold Therapy Devices For Home Use	8	2.4
Collateral Visits	7	3.16
Combined Heart-Kidney Transplant (CHKT)	4	24.3
Combined Liver-Kidney Transplant (CLKT)	4	24.6
Combined Small Intestine-Liver (SI/L) Transplant	4	24.4
Complications (Unfortunate Sequelae) Resulting From Noncovered Surgery Or Treatment	4	1.1
Computerized Axial Tomography (CAT)	5	1.1
Computerized Tomography (CT)	5	1.1
Conscious Sedation	3	1.2

