



DEFENSE
HEALTH AGENCY

MB&RS

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

**CHANGE 155
6010.57-M
FEBRUARY 8, 2016**

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

The Defense Health Agency has authorized the following addition(s)/revision(s).

**CHANGE TITLE: NATIONAL DEFENSE AUTHORIZATION ACT FISCAL YEAR 2015 SECTION 703
ELIMINATION OF DAY LIMITS FOR INPATIENT MENTAL HEALTH CARE**

CONREQ: 17756

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

SUMMARY OF CHANGE(S): This change helps establish mental health parity with medical/surgical benefit in TRICARE. Specifically, TRICARE coverage is no longer subject to an annual limit on stays in inpatient mental health facilities of 30 days for adults and 45 days for children. In addition, TRICARE coverage is no longer subject to a 150-day annual limit for stays at Residential Treatment Centers for eligible beneficiaries.

EFFECTIVE DATE: December 19, 2014.

IMPLEMENTATION DATE: March 8, 2016.

**This change is made in conjunction with Feb 2008 TOM, Change No. 168 and Feb 2008 TRM,
Change No. 125.**

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

**ATTACHMENT(S): 108 PAGE(S)
DISTRIBUTION: 6010.57-M**

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

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Primary Care Managers (PCMs)

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

1.0 POLICY

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

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

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

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

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

2.0 EXCEPTIONS

PCM referral is not required for the following services:

2.1 Services provided directly by the PCM.

2.2 Emergency care.

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

2.4 The first eight outpatient mental health visits per beneficiary in a fiscal year do not require PCM or Health Care Finder (HCF) referral and do not require preauthorization. Mental health visits exceeding eight in a fiscal year require authorization, but do not require a referral. The authorization of outpatient mental health care after the first eight visits (visits nine forward) shall be in accordance with the MCSC's best practices. This does not apply to mental health care received by active duty personnel. Mental health care for active duty personnel requires preauthorization. See [Chapter 7, Section 3.8](#).

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

- END -

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

Issue Date: November 6, 2007
Authority:

1.0 HCPCS "C" AND "S" CODES

C1000 - C9999; S0000 - S9999

2.0 DESCRIPTION

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

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

3.0 POLICY

3.1 Upon implementation of TRICARE's Outpatient Prospective Payment System (OPPS), HCPCS "C" codes shall be paid according to OPPS guidelines as outlined in the TRICARE Reimbursement Manual (TRM), [Chapter 13](#). For Hospital Outpatient Department (HOPD) services provided on or before May 1, 2009 (implementation of TRICARE's OPPS), and thereafter, for services by exempt OPPS hospitals, the contractor shall allow payment of HCPCS "C" codes consistent with current policy as stated in the TRM, [Chapter 1, Section 24, paragraph 2.2](#).

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

3.2.1 S9122, S9123, S9124, and S8940 for the Extended Care Health Option (ECHO) respite care benefit and the ECHO Home Health Care (EHHC) benefit;

3.2.2 S0812, S1030, S1031, S1040, S2083, S2202, S2235, S2325, S2360, S2361, S2401 - S2405, S2411, S3620, S8030, S8185, S8265, S8270, and S9430 for all beneficiaries; and

3.2.3 S5108 for direct Educational Interventions for Autism Spectrum Disorders (EIA) services provided to TRICARE beneficiaries under the Department of Defense (DoD) Enhanced Access to Autism Services Demonstration. (See the TRICARE Operations Manual (TOM), [Chapter 18, Section 8](#).)

3.2.4 S2400 for prenatal surgical intervention of temporary tracheal occlusion of Congenital Diaphragmatic Hernia (CDH) for fetuses with prenatal diagnosis of CDH shall be determined on a

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

case-by-case basis, based on the Rare Disease policy, effective October 1, 2009. Procedural guidelines for review of rare disease are contained in [Section 3.1](#).

3.2.5 S0189 for testosterone pellets as provided in [Chapter 4, Section 5.1](#).

3.2.6 S8999 for resuscitation bag for use by the patient on artificial respiration during power failure or other catastrophic event. The bag must be U.S. Food and Drug Administration (FDA) approved, used in accordance with FDA indications, and must be prescribed by a physician.

3.2.7 S9900 for services rendered by an authorized Christian Science Practitioner as provided in [Chapter 11, Section 1.1](#).

3.2.8 S0190 and S0191 as provided in [Chapter 4, Section 18.3](#).

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

3.4 S2095 for the treatment of unresectable liver metastases from neuroendocrine tumors, as stated in [Chapter 1, Section 3.1](#).

3.5 S5110 and S5115 are covered as part of the Applied Behavior Analysis (ABA) benefit as outlined in [Chapter 7, Section 3.16](#). The end date is December 31, 2014.

3.6 S9480 as described in [Chapter 7, Section 3.4, paragraph 3.8](#) and [Chapter 7, Section 3.5, paragraph 3.3.1.2.3](#).

4.0 EXCLUSIONS

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

4.2 HCPCS S2066, S2067, and S2068 shall no longer be used. Current Procedural Terminology (CPT)¹ code 19364 is the more appropriate representation of these services.

- END -

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Medicine

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Chapter 7

Section 3.1

Acute Hospital Psychiatric Care: Preauthorization, Concurrent Review, and Payment Responsibility

Issue Date: March 13, 1992

Authority: [32 CFR 199.4\(b\)\(6\)\(iii\)](#) and [\(b\)\(9\)](#); and 10 USC 1079(a)

1.0 BACKGROUND

1.1 In the National Defense Authorization Act for Fiscal Year 1991 (NDAA FY 1991), Public Law (PL) 101-510 and the Defense Appropriations Act for 1991, PL 101-511, Congress firmly addressed the problem of spiraling costs for mental health services. Motivated by the desire to bring mental health care costs under control, Congress in both the Authorization and Appropriations Acts established certain benefit changes and management procedures. These statutes made two principal changes. First, they established new day limits for inpatient mental health services and secondly, they mandated prior authorization for all nonemergency inpatient mental health admissions, with required certification of emergency admissions within 72 hours.

1.2 The NDAA FY 2015, Section 703, signed into law on December 19, 2014, removed TRICARE statutory limitations on inpatient mental health services (30 days for adults, 45 days for children) and Residential Treatment Center (RTC) care for children (150 days), including the corresponding waiver provisions. The removal of inpatient days for mental health services, which placed quantitative limitations on mental health treatment that do not exist for medical or surgical care, is consistent with principles of mental health parity. Further, the Department believes these changes will reduce stigma and enhance access to care, which continue to be high priorities within the Department of Defense (DoD). As a result, inpatient mental health services, regardless of length/quantity, may be covered as long as the care is considered medically or psychologically necessary and appropriate.

2.0 POLICY

2.1 Effective December 19, 2014, day limits in any fiscal year are removed for TRICARE beneficiaries of all ages for the provision of acute inpatient mental health services. Criteria for medical and psychological necessity continue to apply for inpatient mental health services and take into account the level, intensity, and availability of the care needs of the patient.

2.2 Preadmission and continued stay authorization is required before nonemergency inpatient mental health services may be **provided and** cost-shared. Prompt continued stay authorization is required after emergency admissions. To avoid denial, requests for preadmission authorization on weekends and holidays are discouraged. The admission criteria shall not be considered satisfied unless the patient has been personally evaluated by a physician or other authorized health care professional with admitting privileges to the facility to which the patient is being admitted prior to the admission.

3.0 POLICY CONSIDERATIONS

Medical and psychological necessity will determine the Length-of-Stay (LOS) for treatment in an acute inpatient mental health care facility. The contractor shall use established criteria for preadmission, concurrent review, and continued stay decisions. If a case involves both Substance Use Disorder (SUD) and other **Diagnostic and Statistical Manual of Mental Disorders (DSM)** diagnoses, the 21-day limit would apply if the patient was admitted to a Diagnosis-Related Group (DRG) exempt SUD rehabilitation unit.

3.1 Treatment of Mental Disorders

In order to qualify for mental health benefits, the patient must be diagnosed by an authorized licensed, qualified mental health professional to be suffering from a mental disorder, according to the criteria listed in the current edition of the DSM. Benefits are limited for certain mental disorders, such as specific learning disorders. No benefits are payable for "Conditions Not Attributable to a Mental Disorder", or **International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) V codes**, or **International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) Z codes**. In order for treatment of a mental disorder to be medically or psychologically necessary, the patient must, as a result of a diagnosed mental disorder, be experiencing both physical or psychological distress and an impairment in his or her ability to function in appropriate occupational, educational or social roles. It is generally the degree to which the patient's ability to function is impaired that determines the level of care (if any) required to treat the patient's condition.

3.2 Criteria for Determining Medical or Psychological Necessity

In determining the medical or psychological necessity of acute inpatient mental health services, the evaluation conducted by the Deputy Director, **Defense Health Agency (DHA)** (or designee) shall consider the appropriate level of care for the patient, the intensity of services required by the patient, and the availability of that care. The purpose of such acute inpatient care is to stabilize a life-threatening or severely disabling condition within the context of a brief, intensive model of inpatient care in order to permit management of the patient's condition at a less intensive level of care. Such care is appropriate only if the patient requires services of an intensity and nature that are generally recognized as being effectively and safely provided only in an acute inpatient hospital setting. Acute inpatient care shall not be considered necessary unless the patient:

3.2.1 Needs to be observed and assessed on a 24-hour basis by skilled nursing staff, and/or

3.2.2 Requires continued intervention by a multidisciplinary treatment team; and in addition, at least one of the following criteria is determined to be met:

3.2.2.1 Patient poses a serious risk of harm to self and/or others.

3.2.2.2 Patient is in need of high dosage, intensive medication or somatic and/or psychological treatment, with potentially serious side effects.

3.2.2.3 Patient has acute disturbances of mood, behavior, or thinking.

3.3 Emergency Admissions

Admission to an acute inpatient hospital setting may be on an emergency or on a non-emergency basis. In order for an admission to qualify as an emergency, the following criteria, in addition to those in [paragraph 3.2](#) must be met:

3.3.1 The patient must be at immediate risk of serious harm to self and or others based on a psychiatric evaluation performed by a physician (or other qualified mental health professional with hospital admission authority); and

3.3.2 The patient requires immediate continuous skilled observation and treatment at the acute psychiatric level of care.

3.4 Preauthorization Requirements

All non-emergency admissions to an acute inpatient hospital level of care must be authorized prior to the admission. The criteria for preauthorization shall be those set forth in [paragraph 3.2](#). In applying those criteria in the context of preauthorization review, special emphasis is placed on the development of a specific individualized treatment plan, consistent with those criteria and reasonably expected to be effective, for that individual patient.

3.4.1 The timetable for development of the individualized treatment plan shall be as follows:

3.4.1.1 The development of the plan must begin immediately upon admission;

3.4.1.2 A preliminary treatment plan must be established within 24 hours of the admission;

3.4.1.3 A master treatment plan must be established within five calendar days of the admission.

3.4.2 The elements of the individualized treatment plan must include:

3.4.2.1 The diagnostic evaluation that establishes the necessity for the admission;

3.4.2.2 An assessment regarding the inappropriateness of services at a less intensive level of care;

3.4.2.3 A comprehensive biopsychosocial assessment and diagnostic formulation;

3.4.2.4 A specific individualized treatment plan that integrates measurable goals/objectives and their required level of care for each of the patient's problems that are a focus of treatment;

3.4.2.5 A specific plan for involvement of family members, unless therapeutically contraindicated; and

3.4.2.6 A discharge plan, including an objective of referring the patient to further services, if needed, at less intensive levels of care.

3.4.3 The request for preauthorization must be received by the reviewer designated by the Director, **DHA** prior to the planned admission. In general, the decision regarding preauthorization

Acute Hospital Psychiatric Care: Preauthorization, Concurrent Review, and Payment Responsibility

shall be made within one business day of receipt of a request for preauthorization, and shall be followed with written confirmation. In the case of an authorization issued after an admission resulting from approval of a request made prior to the admission, the effective date of the certification shall be the date of the receipt of the request. If the request on which the approved authorization is based was made after the admission (and the case was not an emergency admission), the effective date of the authorization shall still be the date of receipt of the request. If the care is found not medically necessary, however, and is not approved, the provider is liable for the services but has the right to appeal the "not medically necessary" determination. Only non-network providers may appeal as network providers are never appropriate appealing parties.

3.4.4 Authorization prior to admission is not required in the case of a psychiatric emergency requiring an inpatient acute level of care, but authorization for a continuation of services must be obtained promptly. Admissions resulting from a bona fide psychiatric emergency should be reported within 24 hours of the admission or the next business day after the admission, but must be reported to the Deputy Director, DHA or a designee, within 72 hours of the admission. In the case of an emergency admission authorization resulting from approval of a request made within 72 hours of the admission, the effective date of the authorization shall be the date of the admission. However, if it is determined that the case was not a bona fide psychiatric emergency admission (but the admission can be authorized as medically or psychologically necessary), the effective date of the authorization shall be the date of the receipt of the request.

3.4.5 Preadmission authorization is required even when the beneficiary has Other Health Insurance (OHI) because the statutory requirement is applicable to every case in which payment is sought, regardless of whether it is first payer or second payer basis.

3.5 Payment Responsibility

Any inpatient mental health care obtained without requesting preadmission authorization or rendered without following concurrent review requirements, in which the services are determined excluded by reason of being not medically necessary, is not the responsibility of the patient or the patient's family until:

3.5.1 Receipt of written notification by TRICARE or a TRICARE contractor that the services are not authorized; or

3.5.2 Signing of a written statement from the provider which specifically identifies the services which will not be reimbursed. The beneficiary must agree, in writing, to personally pay for the non-reimbursable services. General statements, such as those signed at admission, do not qualify.

3.6 Concurrent Review

Concurrent review of the necessity for continued stay will be conducted. The criteria for concurrent review shall be those set forth in paragraph 3.2. In applying those criteria in the context of concurrent review, special emphasis is placed on evaluating the progress being made in the active clinical treatment being provided and on developing/refining appropriate discharge plans. In general, the decision regarding concurrent review shall be made within one business day of the review, and shall be followed with written confirmation.

4.0 EXCEPTION

TRICARE's preadmission and continued stay authorization is not required for inpatient mental health care for Medicare-TRICARE dual eligibles for the period when Medicare is primary payer and has authorized the care. Once Medicare inpatient mental health benefits have been exhausted, TRICARE's preadmission and continued stay requirements apply.

5.0 EFFECTIVE DATES

5.1 Inpatient services provided on **or** after October 1, 1991.

5.2 **Removal of day limits in any fiscal year for TRICARE beneficiaries of all ages for the provision of acute inpatient mental health services on or after December 19, 2014.**

- END -

Chapter 7

Section 3.2

Residential Treatment Center (RTC) Care: Preauthorization and Concurrent Review

Issue Date: March 13, 1992

Authority: [32 CFR 199.4\(b\)\(4\)\(viii\) and \(b\)\(8\)](#); [32 CFR 199.6\(b\)\(4\)\(vii\)\(A\)\(1\)](#); and 10 USC 1079(a)

1.0 BACKGROUND

1.1 In the National Defense Authorization Act for Fiscal Year 1991 (NDAA FY 1991), Public Law (PL) 101-510 and the Defense Appropriations Act for 1991, PL 101-511, Congress firmly addressed the problem of spiraling costs for mental health services. Motivated by the desire to bring mental health care costs under control, Congress in both the Authorization and Appropriations Acts established certain benefit changes and management procedures. These statutes made two principal changes. First, they established new day limits for inpatient mental health services and secondly, they mandated prior authorization for all nonemergency inpatient mental health admissions, with required certification of emergency admissions within 72 hours.

1.2 The NDAA FY 2015, Section 703, signed into law on December 19, 2014, removed TRICARE statutory limitations on inpatient mental health services (30 days for adults, 45 days for children) and RTC care for children (150 days), including the corresponding waiver provisions. The removal of inpatient days for mental health services, which placed quantitative limitations on mental health treatment that do not exist for medical or surgical care, is consistent with principles of mental health parity. Further, the Department believes these changes will reduce stigma and enhance access to care, which continue to be high priorities within the Department of Defense (DoD). As a result, inpatient mental health services, regardless of length/quantity, may be covered as long as the care is considered medically or psychologically necessary and appropriate.

2.0 POLICY

Preadmission and continued stay authorization are required for care in an RTC. Admission to an RTC is considered elective and not of an emergency nature. For admissions to an RTC, a physician (M.D. or D.O.), psychiatrist, or clinical psychologist shall recommend admission and direct the treatment plan. Admission to an RTC primarily for substance abuse rehabilitation is not authorized.

3.0 POLICY CONSIDERATIONS

Medical and psychological necessity will determine the Length-of-Stay (LOS) for treatment in an RTC. The contractor shall use established criteria for preadmission, concurrent review, and continued stay decisions.

3.1 Treatment of Mental Disorders

In order to qualify for admission to an RTC, a physician (M.D. or D.O.), **psychiatrist, or clinical psychologist** shall recommend that the child be admitted to the RTC **and** direct the development of the child's treatment plan. The child must be diagnosed as suffering from a mental disorder, according to the criteria listed in the current edition of the **Diagnostic and Statistical Manual of Mental Disorders** (DSM). Benefits are limited for certain mental disorders, such as specific learning disorders (**see Section 3.6**). No benefits are payable for "Conditions Not Attributable to a Mental Disorder", or **International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) V codes, or International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) Z codes**. In order for treatment of a mental disorder to be medically or psychologically necessary, the patient must, as a result of a diagnosed mental disorder, be experiencing both physical or psychological distress **and** an impairment in his or her ability to function in appropriate occupational, educational or social roles. It is generally the degree to which the patient's ability to function is impaired that determines the level of care (if any) required to treat the patient's condition.

3.2 Criteria for Determining Medical or Psychological Necessity

In determining the medical or psychological necessity of services and supplies provided by RTCs, the evaluation conducted by the Deputy Director, **Defense Health Agency (DHA)** (or designee) shall consider the appropriate level of care for the patient, the intensity of services required by the patient, and the availability of that care. RTC services and supplies shall not be considered medically or psychologically necessary unless, at a minimum, **all** the following criteria are clinically determined in the evaluation to be fully met:

3.2.1 Patient has a diagnosable psychiatric disorder.

3.2.2 Patient exhibits patterns of disruptive behavior with evidence of disturbances in family functioning or social relationships and persistent psychological and/or emotional disturbances.

3.2.3 RTC services involve active clinical treatment under an individualized treatment plan that provides for:

3.2.3.1 Specific level of care, and measurable goals/objectives relevant to each of the problems identified;

3.2.3.2 Skilled interventions by qualified mental health professionals to assist the patient and/or family;

3.2.3.3 Time frames for achieving proposed outcomes; and

3.2.3.4 Evaluation of treatment progress to include timely reviews and updates as appropriate of the patient's treatment plan that reflects alterations in the treatment regimen, the measurable goals/objectives, and the level of care required for each of the patient's problems, and explanations of any failure to achieve the treatment goals/objectives.

3.2.4 Unless therapeutically contraindicated, the family and/or guardian must actively participate in the continuing care of the patient either through direct involvement at the facility or

geographically distant family therapy. (In the latter case, the treatment center must document that there has been collaboration with the family and/or guardian in all reviews.)

3.3 Preauthorization Requirements

All admissions to RTC care are elective and must be certified as medically/psychologically necessary prior to admission. The criteria for preauthorization shall be those set forth in [paragraph 3.2](#). In applying those criteria in the context of preadmission authorization review, special emphasis is placed on the development of a specific diagnosis/treatment plan, consistent with those criteria and reasonably expected to be effective, for that individual patient.

3.3.1 The timetable for development of the individualized treatment plan shall be as follows:

3.3.1.1 The plan must be under development at the time of the admission.

3.3.1.2 A preliminary treatment plan must be established within 24 hours of the admission.

3.3.1.3 A master treatment plan must be established within 10 calendar days of the admission.

3.3.2 The elements of the individualized treatment plan must include:

3.3.2.1 The diagnostic evaluation that establishes the necessity for the admission;

3.3.2.2 An assessment regarding the inappropriateness of services at a less intensive level of care;

3.3.2.3 A comprehensive, biopsychosocial assessment and diagnostic formulation;

3.3.2.4 A specific individualized treatment plan that integrates measurable goals/objectives and their required level of care for each of the patient's problems that are a focus of treatment;

3.3.2.5 A specific plan for involvement of family members, unless therapeutically contraindicated; and

3.3.2.6 A discharge plan, including an objective of referring the patient to further services, if needed, at less intensive levels of care.

3.3.3 Preauthorization requests should be made not less than two business days prior to the planned admission. In general, the decision regarding preauthorization shall be made within one business day of receipt of all information for a request for preauthorization, and shall be followed with written confirmation. Preauthorizations are valid for 90 days.

3.4 Services for which payment is disallowed for failure to obtain preauthorization may not be billed to the patient (or the patient's family).

3.5 Concurrent Review

Concurrent review of the necessity for continued stay **in an RTC** will be conducted no less frequently than every 30 days. The criteria for concurrent review shall be those set forth in

TRICARE Policy Manual 6010.57-M, February 1, 2008

Chapter 7, Section 3.2

Residential Treatment Center (RTC) Care: **Preauthorization and Concurrent Review**

paragraph 3.2. In applying those criteria in the context of concurrent review, special emphasis is placed on evaluating the progress being made in the active individualized clinical treatment being provided and on developing appropriate discharge plans. **In general, the decision and notification regarding concurrent review shall be made within three business days of the review.**

4.0 EFFECTIVE DATES

4.1 RTC services provided on or after October 1, 1991.

4.2 Removal of day limits in any fiscal year for TRICARE beneficiaries for the provision of RTC care on or after December 19, 2014.

- END -

Preauthorization Requirements For Substance Use Disorder (SUD) Detoxification And Rehabilitation

Issue Date: March 13, 1992

Authority: 32 CFR 199.4(b)(6)(iii), (e)(4)(ii)(A), and (e)(4)(v), and 10 USC 1079(a)

1.0 BACKGROUND

1.1 In the National Defense Authorization Act for Fiscal Year 1991 (NDAA FY 1991), Public Law 101-510 and the Defense Appropriations Act for 1991, Public Law 101-511, Congress firmly addressed the problem of spiraling costs for mental health services. Motivated by the desire to bring mental health care costs under control, Congress in both the Authorization and Appropriations Acts established certain benefit changes and management procedures. These statutes made two principal changes. First, they established new day limits for inpatient mental health services and secondly, they mandated prior authorization for all nonemergency inpatient mental health admissions, with required certification of emergency admissions within 72 hours.

1.2 The NDAA FY 2015, Section 703, signed into law on December 19, 2014, removed TRICARE statutory limitations on inpatient mental health services (30 days for adults, 45 days for children) and Residential Treatment Center (RTC) care for children (150 days), including the corresponding waiver provisions. The removal of inpatient days for mental health services, which placed quantitative limitations on mental health treatment that do not exist for medical or surgical care, is consistent with principles of mental health parity. Further, the Department believes these changes will reduce stigma and enhance access to care, which continue to be high priorities within the Department of Defense (DoD). As a result, inpatient mental health services, regardless of length/quantity, may be covered as long as the care is considered medically or psychologically necessary and appropriate.

1.3 The NDAA FY 2015 removed statutory day limits for inpatient mental health services and by extension the days of detoxification previously counted toward statutory day limits; however, the 21-day limit for SUD rehabilitation remains in place. Regulatory requirements for no more than seven days detoxification and 21 days residential treatment during a single benefit period have not changed; however, these day limits no longer count toward a statutory limitation of 30-days inpatient mental health services. The practical implication is that a beneficiary could have one or more acute inpatient psychiatric admissions during a single benefit period and one or more detoxification and rehabilitation admissions in the same year; even though the total number of inpatient days would exceed 30 days. Requirements have not changed for concurrent review of the necessity for continued stay and exceptions.

2.0 POLICY

Preadmission and continued stay authorization is required before services for SUDs may be

Preauthorization Requirements For Substance Use Disorder (SUD) Detoxification And Rehabilitation

cost-shared. Preadmission and continued stay authorization is required for both detoxification and rehabilitation services. To comply with the statutory requirements and to avoid denial, requests for preadmission authorization on weekends and holidays are discouraged. All admissions for rehabilitation are elective and must be certified as medically/psychologically necessary prior to admission. The admission criteria shall not be considered satisfied unless the patient has been personally evaluated by a physician or other authorized health care professional with admitting privileges to the facility to which the patient is being admitted prior to the admission.

3.0 POLICY CONSIDERATIONS

3.1 Treatment of Mental Disorders

In order to qualify for mental health benefits, the patient must be diagnosed by a licensed, qualified mental health professional to be suffering from a mental disorder, according to the criteria listed in the current edition of the **Diagnostic and Statistical Manual of Mental Disorders (DSM)** or a mental health diagnosis in International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) for diagnoses made before the mandated date, as directed by Health and Human Services (HHS), for the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) implementation, after which the ICD-10-CM **diagnoses** must be used. Benefits are limited for certain mental disorders, such as specific developmental disorders. No benefits are payable for "Conditions Not Attributable to a Mental Disorder," or ICD-9-CM **V codes**, or ICD-10-CM **Z codes**. In order for treatment of a mental disorder to be medically or psychologically necessary, the patient must, as a result of a diagnosed mental disorder, be experiencing both physical or psychological distress and an impairment in his or her ability to function in appropriate occupational, educational or social roles. It is generally the degree to which the patient's ability to function is impaired that determines the level of care (if any) required to treat the patient's condition.

3.2 Admissions occurring on or after October 1, 1991, to all facilities (includes Diagnosis Related Group (DRG) and non-DRG facilities).

3.2.1 Detoxification. Stays for detoxification are covered if preauthorized as medically/psychologically necessary. In determining the medical or psychological necessity of detoxification and rehabilitation for **SUD**, the evaluation conducted by the contractor shall consider the appropriate level of care for the patient and the intensity of services required by the patient. Emergency and inpatient hospital services are covered when medically necessary for the active medical stabilization, and for treatment of medical complications of **SUD**. Authorization prior to admission is not required in the case of an emergency requiring an inpatient acute level of care, but authorization for a continuation of services must be obtained promptly. Admissions resulting from a bona fide emergency **shall** be reported within 24 hours of the admission or the next business day after the admission to the contractor. Emergency and inpatient hospital services are considered medically necessary only when the patient's condition is such that the personnel and facilities of a hospital are required. Stays for detoxification in a **SUD** facility are limited to seven days unless the limit is waived by the contractor and must be provided under general medical supervision.

3.2.2 Rehabilitative care. The patient's condition must be such that rehabilitation for **SUD** must be provided in a hospital or in an organized inpatient **SUD** treatment program. Rehabilitation stays are covered if preauthorized as medically/psychologically necessary. Coverage during a single benefit period is limited to no more than one inpatient stay (prior to October 1, 2008, exclusive of

Preauthorization Requirements For Substance Use Disorder (SUD) Detoxification And Rehabilitation

stays classified in DRG 433; and on or after October 1, 2008, exclusive of stays classified in DRG 894) in hospitals subject to the DRG-based payment system or 21 days in a DRG-exempt facility for rehabilitative care unless the limit is waived by the contractor. The concept of an emergency admission does not apply to rehabilitative care.

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

3.2.3.1 Active treatment has taken place during the period of the benefit limit and substantial progress has been made according to the plan of treatment.

3.2.3.2 Further progress has been delayed due to the complexity of the illness.

3.2.3.3 Specific evidence has been presented to explain the factors that interfered with further treatment progress during the period of the benefit limit.

3.2.3.4 The waiver request includes specific time frames and a specific plan of treatment which will complete the course of treatment.

3.2.4 The request for preauthorization must be received by the contractor prior to the planned admission. In general, the decision regarding preauthorization shall be made within one business day of receipt of a request for preauthorization, and shall be followed with written confirmation. In the case of an authorization issued after an admission resulting from approval of a request made prior to the admission, the effective date of the certification shall be the date of the receipt of the request. If the request on which the approved authorization is based was made after the admission (and the case was not an emergency admission), the effective date of the authorization shall still be the date of receipt of the request. The contractor may grant an exception to the requirement for preauthorization if the services otherwise would be payable except for the failure to obtain preauthorization.

3.2.5 When the beneficiary has Other Health Insurance (OHI) that provides coverage, exception to the preauthorization requirements will apply as provided in Chapter 1, Section 7.1, paragraph 1.10. When the contractor is acting as a secondary payer, any medical necessity reviews shall be performed on a retrospective basis.

3.3 Payment Responsibility

3.3.1 Any inpatient mental health care obtained for SUD detoxification and rehabilitation without requesting preadmission authorization, without following concurrent review requirements, in which the services are determined excluded by reason of being not medically necessary, is not the responsibility of the patient or the patient's family until:

3.3.1.1 Receipt of written notification by a contractor that the services are not authorized; or

3.3.1.2 Signing of a written statement from the provider which specifically identifies the services which will not be reimbursed. The beneficiary must agree, in writing, to personally pay for the non-reimbursable services. General statements, such as those signed at admission, do not qualify.

Preauthorization Requirements For Substance Use Disorder (SUD) Detoxification And Rehabilitation

3.3.2 If a request for waiver is filed for Length-of-Stay (LOS) and the waiver is not granted by the contractor benefits will only be allowed for the period of care authorized.

3.4 Concurrent Review

Concurrent review of the necessity for continued stay will be conducted. For care provided under the DRG-based payment system, concurrent review will be conducted only when the care falls under the DRG long-stay outlier. The criteria for concurrent review shall be those set forth in paragraph 3.2. In applying those criteria in the context of concurrent review, special emphasis is placed on evaluating the progress being made in the active clinical treatment being provided and on developing/refining appropriate discharge plans. In general, the decision regarding concurrent review shall be made within one business day of the review, and shall be followed with written confirmation.

4.0 EXCEPTION

For Dual Eligible beneficiaries, these requirements apply when TRICARE is primary payer. As secondary payer, TRICARE will rely on and not replicate Medicare's determination of medical necessity and appropriateness in all circumstances where Medicare is primary payer. When the beneficiary has OHI that is primary to TRICARE, all double coverage provisions in the TRICARE Reimbursement Manual (TRM), Chapter 4, shall apply. In the event that TRICARE is primary payer for these services and preauthorization was not obtained, the contractor shall obtain the necessary information and perform a retrospective review.

- END -

Psychiatric Partial Hospitalization Programs (PHPs) - Preauthorization And Day Limits

Issue Date: July 14, 1993

Authority: [32 CFR 199.4\(a\)\(12\)](#) and [\(b\)\(10\)](#)

1.0 BACKGROUND

The Fiscal Year (FY) 1992 Defense Authorization Conference Report directed the Secretary of Defense to establish a partial hospitalization benefit. As a result, the partial hospitalization benefit, previously limited to treatment of alcoholism, was expanded to cover other mental health disorders. This added level of care improves the availability of mental health services. The intent is to provide a needed service at a lower cost than the full hospitalization rate, and to allow more efficient use of resources for needed mental health care.

2.0 DESCRIPTION

Psychiatric partial hospitalization is a treatment setting capable of providing an interdisciplinary program of medical therapeutic services at least three hours per day, five days per week, which may embrace day, evening, night and weekend treatment programs which employ an integrated, comprehensive and complementary schedule of recognized treatment approaches. To be approved, such programs must enter into a participation agreement, and be accredited and in substantial compliance with the Joint Commission's **Standards for Behavioral Health Care** (formerly **Consolidated Standards Manual**).

3.0 POLICY

3.1 Preadmission and continued stay authorization is required for all admissions to a psychiatric PHP without exception, as the concept of an emergency admission does not pertain to a partial hospitalization level of care. Preauthorization is required even if the facility is transferring a patient to a lower level of care within its own structure.

3.2 The admission criteria shall not be considered fulfilled unless the patient has been personally evaluated prior to the admission by a physician or other authorized health care professional with admitting privileges operating within the scope of his/her license.

3.3 Day Limits for Psychiatric Partial Hospitalization. The benefits for institutional services for psychiatric partial hospitalization are limited to 60 treatment days (whether a full day or partial day program) in a fiscal year or in an admission. This limit may be extended by waiver. The 60 treatment days are not offset by or counted toward the 30-45 day inpatient limit.

3.4 Criteria for determining medical or psychological necessity of psychiatric partial hospitalization services. Psychiatric partial hospitalization services will be considered necessary only if all of the following conditions are present:

3.4.1 The patient is suffering significant impairment from a mental disorder (as defined in [32 CFR 199.2](#)) which interferes with age appropriate functioning.

3.4.2 The patient is unable to maintain himself or herself in the community, with appropriate support, at a sufficient level of functioning to permit an adequate course of therapy exclusively on an outpatient basis (but is able, with appropriate support, to maintain a basic level of functioning to permit partial hospitalization services and presents no substantial imminent risk of harm to self or others).

3.4.3 The patient is in need of crisis stabilization, treatment of partially stabilized mental health disorder, or services as a transition from an inpatient program.

3.4.4 The admission into the PHP is based on the development of an individualized diagnosis and treatment plan expected to be effective for that patient and permit treatment at a less intensive level.

3.5 Claims for outpatient psychotherapy provided during the period a patient is participating in a PHP are to be denied as "noncovered services". Professional services provided by an attending physician that do not duplicate treatment provided in a PHP may be billed separately.

3.6 Outpatient psychotherapy services provided by a PHP after the patient's care has been denied or after the patient has been discharged, are not a benefit of the PHP. Partial hospitalization is an institutional benefit, not a professional services benefit. The PHP services provided by the institutional provider are covered by the all-inclusive per diem rate when authorized. If authorization is denied due to the PHP stay not being medically necessary or appropriate, none of the services related to that stay are payable regardless of how they are billed. Psychotherapy services provided by a PHP after a patient has been discharged from the PHP are not part of the partial hospitalization benefit nor is the PHP an authorized provider under TRICARE for these outpatient services.

3.7 Authorized PHPs have entered into participation agreements to provide multi-disciplinary programs in exchange for all-inclusive per diem reimbursement. Any attempt by a PHP to carve out certain services and bill on a fee-for-service basis would be considered a violation of that agreement.

3.8 PHPs may also provide a service they call "Intensive Outpatient Program" or IOP. Freestanding and hospital-based PHPs may provide partial hospitalization services, also referred to as IOP, provided less than five days per week, at least three hours per day but less than six hours per day, with reimbursement occurring at half-day PHP rate (i.e., three to five hours), in accordance with the TRICARE Reimbursement Manual (TRM), [Chapter 7, Section 2](#); TRM, [Chapter 7, Addendum B](#); and TRM, [Chapter 13, Section 2](#). IOPs must be provided by a TRICARE-certified PHP. All program policies that apply to TRICARE-certified PHPs shall also apply to the IOPs provided by PHPs.

4.0 POLICY CONSIDERATIONS

4.1 Payment Responsibility.

4.1.1 Any care in a psychiatric PHP obtained without requesting preadmission authorization or rendered in excess of the 60-day limit without following concurrent review requirements, in which the services are determined excluded by reason of being not medically necessary, is not the financial responsibility of the patient or the patient's family until:

4.1.1.1 Receipt of written notification from a contractor that the services are not authorized; or

4.1.1.2 Signing of a written statement from the provider which specifically identifies the services which will not be reimbursed. The beneficiary must agree, in writing, to personally pay for the non-reimbursable services. General statements, such as those signed at admission, do not qualify.

4.1.2 If a request for waiver is filed and the waiver is not granted, benefits will only be allowed for the period of care authorized by the contractor.

4.2 For purposes of counting day limits, a move from one facility to another facility can be considered a transfer when documentation establishes that coordination for the move existed between two like facilities for the purpose of ensuring continued treatment of the condition requiring the original admission. Under these circumstances, the admission to a new facility would be considered a continuous uninterrupted Episode of Care (EOC). If the documentation does not establish that coordination for the move existed between the two facilities, then the intent to transfer cannot be established and the move should be considered a discharge.

5.0 EXCEPTIONS

Waiver of the 60-day psychiatric partial hospitalization limit. The purpose of partial hospitalization is to provide an appropriate setting for crisis stabilization, treatment of partially stabilized mental health disorders, and as a transition from an inpatient program when medically necessary to avoid a serious deterioration in functioning within the context of a time-limited, ambulatory, active treatment program that offers therapeutically intensive, coordinated, and structured clinical services within a stable therapeutic environment. There is a regulatory presumption against the appropriateness of partial hospitalization in excess of 60 days. However, a waiver may be authorized through the contractor and payment allowed for care beyond the 60-day limit in certain circumstances.

5.1 The criteria for waiver are set forth in [paragraph 3.0](#). In applying these criteria in the context of a waiver request review, special emphasis is placed on determining whether additional days of partial hospitalization are medically/psychologically necessary to complete essential elements of the treatment plan prior to discharge. Consideration is also given in cases in which a patient exhibits well-documented new symptoms or maladaptive behaviors which have appeared in the partial hospitalization setting requiring significant revisions to the treatment plan.

5.2 The clinician responsible for the patient's care is responsible for documenting the need for additional days and must establish an estimated Length-of-Stay (LOS) beyond the date of the 60-day limit. There must be evidence of a coherent and specific plan for assessment, intervention and

reassessment that reasonably can be accomplished within the time frame of the additional days of coverage requested under the waiver provisions.

5.3 For patients in care at the time the PHP limit is reached, a waiver must be granted prior to the limit. The contractor will handle the waiver requirement by asking for additional information during continued stay reviews. For patients being readmitted after having received 60 days in the fiscal year, the waiver review will be conducted at the time of the preadmission authorization.

6.0 EXCEPTION

Effective October 1, 2003, TRICARE's preadmission and continued stay authorization is not required for inpatient mental health care for Medicare-TRICARE dual eligibles for the period when Medicare is primary payer and has authorized the care. In the event that TRICARE is primary payer for these services and preauthorization was not obtained, the contractor shall obtain the necessary information and perform a retrospective review.

7.0 EXCLUSION

IOP services rendered by a provider that is not TRICARE-authorized (i.e., IOPs that are not TRICARE-authorized hospital-based or freestanding PHPs).

- END -

Chapter 7

Section 3.5

Substance Use Disorders (SUDs)

Issue Date: June 26, 1995

Authority: [32 CFR 199.4\(c\)\(3\)\(ix\)\(A\)](#), (e)(4), and (h)

1.0 DESCRIPTION

Complication of alcohol and/or drug use or dependency and detoxification.

2.0 POLICY

Coverage may be extended for the treatment of SUDs including detoxification, rehabilitation, and outpatient care provided in authorized Substance Use Disorder Rehabilitation Facilities (SUDRFs) in accordance with [paragraph 3.0](#).

3.0 POLICY CONSIDERATIONS

3.1 Emergency And Inpatient Hospital Services

3.1.1 Emergency and inpatient hospital services are covered when medically necessary for the active medical treatment of the acute phases of substance use withdrawal (detoxification), for stabilization, and for treatment of medical complications of SUDs.

3.1.2 Emergency and inpatient hospital services are considered medically necessary only when the patient's condition is such that the personnel and facilities of a hospital are required.

3.1.3 Stays provided for SUD rehabilitation in a hospital-based facility are covered when provided as outlined in [paragraph 3.2](#).

3.1.4 Inpatient hospital services are subject to the statutory requirement for preauthorization.

3.2 Authorized SUD Treatment

3.2.1 Only those services provided by an authorized institutional providers are covered. Such a provider must be either an authorized hospital, or an organized SUD treatment program in an authorized freestanding or hospital-based SUDRF.

3.2.2 A qualified mental health provider (physicians, clinical psychologists, Certified Clinical Social Workers (CCSWs), and Certified Psychiatric Nurse Specialists (CPNSs)) shall prescribe the particular level of treatment.

3.2.3 Each beneficiary is entitled to three SUD treatment benefit periods in his or her lifetime. A waiver may be extended in accordance with the criteria in [paragraph 3.5](#).

3.2.3.1 A benefit period begins with the first date of covered treatment and ends 365 days later, regardless of the total services actually used within the benefit period.

3.2.3.2 Emergency and inpatient hospital services as described under [paragraph 3.1.1](#), do not constitute substance use treatment for the purposes of establishing the beginning of a benefit period.

3.2.3.3 Unused benefits cannot be carried over to subsequent benefit periods.

3.3 Covered Services

3.3.1 Rehabilitative care in an authorized hospital or SUDRF, whether freestanding or hospital-based, is covered on either a residential or partial care (day, evening or weekend) basis.

3.3.1.1 Residential Care is subject to the following:

3.3.1.1.1 Care must be preauthorized.

3.3.1.1.2 Coverage during a single benefit period is limited to no more than one inpatient stay (prior to October 1, 2008, exclusive of stays classified in Diagnosis Related Group (DRG) 433; and on or after October 1, 2008, exclusive of stays classified in DRG 894) in hospitals subject to DRG-based payment system or 21 days in a DRG-exempt facility for rehabilitation care, unless the limit is waived in accordance with the criteria in [paragraph 3.5](#).

3.3.1.1.3 If the patient is medically in need of chemical detoxification, but does not require the personnel or facilities of a general hospital setting, detoxification services are covered in addition to rehabilitative care, but in a DRG-exempt facility detoxification services are limited to seven days, unless the limit is waived in accordance with the criteria in [paragraph 3.5](#).

3.3.1.1.4 The medical and psychological necessity of the detoxification must be documented. Any detoxification services provided in the SUDRF must be under general medical supervision.

3.3.1.2 Partial care is subject to the following:

3.3.1.2.1 Care must be preauthorized.

3.3.1.2.2 Coverage during a single benefit period is limited to 21 days unless the limit is waived in accordance with the criteria in [paragraph 3.5](#).

3.3.1.2.3 TRICARE authorized SUDRFs may also provide a service they call "Intensive Outpatient Program" or IOP. SUDRFs may provide partial SUD services, also referred to as IOP, provided less than five days per week, at least three hours per day but less than six hours per day, with reimbursement occurring at the half-day PHP rate (i.e., three to five hours), TRICARE Reimbursement Manual (TRM), [Chapter 7, Section 2](#); TRM, [Chapter 7, Addendum B](#); and TRM, [Chapter 13, Section 2](#). IOPs shall be provided by a TRICARE-certified SUDRF. All program policies that apply to TRICARE-certified SUDRFs also apply to the IOPs provided by SUDRFs.

3.3.2 Outpatient care is subject to the following:

3.3.2.1 Outpatient care (SUD) must be provided by an approved SUDRF, whether freestanding or hospital-based. Certified addiction rehabilitation counselors or certified alcohol counselors employed by an authorized hospital or a SUDRF may provide the care.

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

3.3.2.3 Coverage is up to 60 visits in a benefit period unless the limit is waived in accordance with the criteria in [paragraph 3.5](#).

3.3.2.4 Outpatient care is covered in both individual and group settings, in an authorized hospital or freestanding or hospital-based SUDRF. For patients with a primary diagnosis of mental disorder (**Diagnostic and Statistical Manual of Mental Disorders** (DSM)) that coexists with an alcohol and other SUD see [Section 3.11](#).

3.3.2.5 Opioid Replacement Treatment

Effective November 21, 2013, opioid replacement treatment is covered for the treatment of SUDs. Opioid replacement treatment involves the substitution of a therapeutic drug with addictive potential for a drug of addiction. Benefit limits stated in [paragraph 3.3.1.2](#) or [paragraph 3.3.2.3](#) apply unless waived in accordance with [Section 3.3](#).

3.3.3 Family Therapy.

3.3.3.1 Family therapy provided on an outpatient basis by an approved SUDRF, whether freestanding or hospital-based, is covered beginning with the completion of the patient's rehabilitative care as outlined in [paragraph 3.3.1](#). The family therapy is covered for up to 15 visits in a benefit period unless the limit is waived in accordance with the criteria in [paragraph 3.5](#). Services provided on an outpatient basis will be reimbursed under the appropriate allowable charge for the procedure code(s) billed.

3.3.3.2 Family therapy must be provided by a qualified mental health provider (psychiatrists or other physicians, clinical psychologists, CPNSs, CCSWs, TRICARE certified mental health counselors, certified marriage and family therapists; and pastoral and supervised mental health counselors, under a physician's supervision).

3.4 Coverage Limitations

3.4.1 Detoxification. Admissions to all facilities (includes DRG and non-DRG facilities) for detoxification are covered if preauthorized as medically/psychologically necessary.

3.4.2 Rehabilitation. Rehabilitation stays are subject to a limit of three benefit periods in a lifetime unless this limit is waived. Preadmission and continued stay authorization is required for SUD detoxification and rehabilitation. Rehabilitation stays are covered if preauthorized as medically/psychologically necessary. The concept of an emergency admission does not apply to rehabilitative care.

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

3.5 Waiver Of Benefit Limits

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

3.5.1 Active treatment has taken place during the period of the benefit limit and substantial progress has been made according to the plan of treatment.

3.5.2 Further progress has been delayed due to the complexity of the illness.

3.5.3 Specific evidence has been presented to explain the factors that interfered with further treatment progress during the period of the benefit limit.

3.5.4 The waiver request includes specific time frames and a specific plan of treatment which will complete the course of treatment.

3.6 Payment Responsibility

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

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

3.8 Confidentiality

Release of any patient identifying information, including that required to adjudicate a claim, must comply with the provisions of section 544 of the Public Health Service Act, as amended (42 United States Code (USC) 290dd-2), which governs the release of medical and other information from the records of patients undergoing treatment of SUD. If the patient refuses to authorize the release of medical records which are, in the opinion of the contractor necessary to determine benefits on a claim for treatment of SUD the claim will be denied.

4.0 EXCEPTIONS

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

4.2 Domiciliary settings. Domiciliary facilities, generally referred to as halfway or quarterway houses, are not authorized providers. Charges for services provided by these facilities are not covered.

5.0 EXCLUSION

IOP services rendered by a provider that is not TRICARE-authorized (i.e., IOPs that are not TRICARE-authorized hospital-based or freestanding SUDRFs).

- END -

Chapter 7

Section 3.6

Specific Learning Disorders

Issue Date: December 5, 1984

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

1.0 DESCRIPTION

Specific Learning Disorders are diagnosed when the individual's achievement on individually administered, standardized tests in reading, mathematics, or written expression is substantially below that expected for age, schooling and level of intelligence. The learning problems significantly interfere with academic achievement or activities of daily living that require reading, mathematical, or writing skills. The learning disorders recognized by the current edition of the **Diagnostic and Statistical Manual of Mental Disorders (DSM)** are: **Specific Learning Disorder, With impairment in reading; Specific Learning Disorder, With impairment in written expression; and Specific Learning Disorder, With impairment in mathematics**. A condition is not considered a specific learning disorder if it is a result of or is associated with such conditions as mental retardation, infantile autism or pervasive developmental disorder, visual or hearing impairments, acquired aphasia (normal language followed by onset of language disorder often associated with head trauma, seizures, or Electroencephalogram (EEG) abnormalities) or dysarthria (abnormal articulation due to disorders of the oral speech mechanisms or documented neurological abnormalities).

2.0 POLICY

2.1 Diagnostic, evaluation, and treatment services and supplies, including special education services, provided in conjunction with a learning disorder may not be cost-shared.

2.2 Learning disorders, individually and collectively, are not qualifying conditions for eligibility under the Extended Care Health Option (ECHO). (See [Chapter 9, Sections 2.1 to 2.4](#)).

- END -

Attention-Deficit/Hyperactivity Disorder

Issue Date: December 5, 1984

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

1.0 DESCRIPTION

The current edition of the **Diagnostic and Statistical Manual of Mental Disorders** (DSM) indicates that the essential feature of Attention Deficit/Hyperactivity Disorder is a persistent pattern of inattention and/or hyperactivity-impulsivity that is more frequent and severe than is typically observed in individuals at a comparable level of development.

2.0 POLICY

Otherwise allowable services that are necessary to diagnose and treat attention deficit/hyperactivity disorder may be cost-shared.

3.0 EXCLUSIONS

Services and supplies related to general or special education.

- END -

Treatment Of Mental Disorders

Issue Date: December 5, 1984

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

1.0 CPT¹ PROCEDURE CODE RANGES

90801 - 90899 for care provided through December 31, 2012.

90785 - 90899 for care provided on or after January 1, 2013.

2.0 POLICY

Benefits are payable for services and supplies that are medically or psychologically necessary for the treatment of mental disorders when:

2.1 The services are rendered by persons who meet the criteria of [32 CFR 199.6](#) for their respective disciplines (whether the person is an individual professional provider or is employed by another authorized provider), and

2.2 The mental disorder is one of those listed in the current edition of the **Diagnostic and Statistical Manual of Mental Disorders** (DSM) and is of a severity not only to cause the patient distress but also to interfere with the patient's ability to carry out his or her usual activities.

3.0 POLICY CONSIDERATIONS

3.1 Professional and Institutional Providers of Mental Health Services

3.1.1 List of authorized providers. Only the types of providers listed below are considered qualified providers of mental health services. The person providing the care must meet the criteria of [32 CFR 199.6](#), whether that person is an individual, professional provider or is employed by another authorized provider.

- Psychiatrists and other physicians;
- Clinical psychologists;
- Certified Psychiatric Nurse Specialists (CPNSs);
- Certified Clinical Social Workers (CCSWs);
- TRICARE Certified Mental Health Counselors (TCMHCs);
- Certified marriage and family therapists;
- Pastoral counselors; and
- Supervised Mental Health Counselors (SMHCs).

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3.1.2 Professional staff of institutions providing mental health services. For those types of institutional providers that are certified by **Defense Health Agency (DHA)**, reviewers may assume that all professional staff meet regulatory criteria. Any evidence to the contrary is to be brought to the attention of **DHA Special Contracts and Operations Office (SCOO)**, immediately. Contractors shall notify institutional providers within their jurisdictions that payment is authorized only for professional services provided by employees meeting the program requirements. In any situation where the contractor obtains evidence that an institution is billing for professional services of unqualified staff, the case is to be submitted to the **DHA Office of Program Integrity (PI)**.

3.2 Review of Claims for Treatment of Mental Disorders

All claims for treatment of mental disorders are subject to review in accordance with claims processing procedures contained in the TRICARE Operations Manual (TOM).

3.2.1 Psychotropic drugs. All patients receiving psychotropic drugs must be under the care of a qualified mental health provider authorized by state licensure to prescribe drugs. That provider need not be the attending provider, but there must be evidence in the treatment plan of coordination between the various providers.

3.2.2 Electroconvulsive treatment (CPT² procedure codes 90870 and 90871). Electroconvulsive treatment is covered when medically or psychologically appropriate and when rendered by qualified providers. However, the use of electric shock as negative reinforcement (aversion therapy) is excluded.

3.2.3 Ancillary therapies (no code, as separate reimbursement is not permitted). Includes art, music, dance, occupational, and other ancillary therapies, when included by the attending provider in an approved inpatient treatment plan and under the clinical supervision of a licensed doctoral level mental health professional. These ancillary therapies are not separately reimbursed professional services but are included within the institutional reimbursement.

3.2.4 Services by non-medical providers. With the exception of pastoral counselors and supervised mental health counselors, approved categories of non-medical providers may render covered services independent of physician referral and supervision. All providers, however, are expected to consult with, or refer patients to, a physician for evaluation and treatment of physical conditions that may co-exist with or contribute to a mental disorder. Failure to do so will result in denial of the non-physician provider's services on quality-of-care grounds. Questionable cases will be referred to peer review.

3.3 The first eight outpatient mental health visits per beneficiary in a fiscal year require no Primary Care Manager (PCM) or Health Care Finder (HCF) referral, nor is a preauthorization required (see [Chapter 1, Section 8.1](#) and the TOM, [Chapter 7, Section 2](#)). This applies to outpatient mental health visits identified by CPT² codes 90801 - 90857 for services provided through December 31, 2012; and, CPT² codes 90791 - 90853 for services provided on or after January 1, 2013.

4.0 EXCLUSIONS

4.1 Sexual dysfunctions, paraphilias, and gender identity disorders.

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4.2 Drug maintenance programs when one addictive drug is substituted for another on a maintenance basis, except as otherwise authorized in [Section 3.5](#).

4.3 Specific developmental disorders.

4.4 Microcurrent Electrical Therapy (MET), Cranial Electrotherapy Stimulation (CES), or any therapy that uses the non-invasive application of low levels of microcurrent stimulation to the head by means of external electrodes for the treatment of anxiety, depression or insomnia, and electrical stimulation devices used to apply this therapy.

4.5 Transcranial Magnetic Stimulation (TMS) (also referred to as repetitive TMS (rTMS)) for the treatment of major depressive disorder (CPT³ procedure codes 90867 and 90868), is unproven.

5.0 EFFECTIVE DATE

November 13, 1984.

- END -

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Ancillary Inpatient Mental Health Services

Issue Date: December 29, 1982

Authority: [32 CFR 199.4\(b\)\(1\)](#), [\(b\)\(6\)](#), and [\(c\)\(3\)\(ix\)\(B\)\(2\)](#)

1.0 POLICY

1.1 Itemized mental health services, other than individual and group therapy, which are provided as an incidental part of an inpatient treatment plan may be covered. This would include miscellaneous ancillary therapy modalities such as recreational therapy, and art therapy.

1.2 Other therapy sessions such as family therapy, social services group therapy, adapt groups and occupational therapy may be covered when rendered as part of treatment related to an otherwise covered inpatient stay and when provided by an authorized individual provider.

Note: Under [32 CFR 199.4\(c\)\(3\)\(ix\)](#) individual and group psychotherapy provided by a qualified professional (psychologist, psychiatrist, etc.) is generally limited to no more than five one-hour therapy sessions in any seven day period. Additional sessions can be covered based upon a finding of medical or psychological necessity.

1.3 Initial evaluations are considered as other medical services and may be authorized. They must be directly related to the diagnosis and/or definitive set of symptoms and rendered by a member of the institution's medical and/or professional staff (either salaried or contractual) and billed for by the hospital.

1.4 Other ancillary services such as pharmacy, x-rays, and laboratory charges are payable and customarily billed separately on the institutional claim form.

Note: Therapeutic programs or regimens, which may include those services outlined in the policy section above, when provided by authorized individual providers who are employees of the institution, are not subject to the Regulation limitations for inpatient psychotherapy.

2.0 EXCLUSION

Leisure time programs, outings, and movies.

- END -

Psychological Testing

Issue Date: March 13, 1992

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

1.0 CPT¹ PROCEDURE CODES

96101-96103, 96118-96120

2.0 DESCRIPTION

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

3.0 POLICY

3.1 Psychological testing and assessment is a covered benefit when medically or psychologically necessary and is provided in conjunction with otherwise covered psychotherapy or as a required part of the assessment and reassessment process for Applied Behavior Analysis (ABA) under the Comprehensive Autism Care Demonstration. Testing and assessment is generally limited to six hours in a fiscal year. Testing or assessment in excess of these limits requires review for medical necessity.

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

Note: Psychological tests are considered diagnostic services and are not counted against the two psychotherapy visits per week or against the number of weekly hours for ABA under the Comprehensive Autism Care Demonstration.

4.0 EXCLUSIONS

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

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

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

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Psychological Testing

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

4.5 Teacher and parental referrals for psychological testing.

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

4.7 Testing for a patient in a Residential Treatment Center (RTC) or Partial Hospitalization Program (PHP) is included in the per diem rate and cannot be separately reimbursed. Also, payment billed by an individual professional provider not employed by or under contract with the RTC or PHP is included in the per diem rate.

- END -

Psychotherapy

Issue Date: December 5, 1984

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

1.0 CPT¹ PROCEDURE CODE RANGES

90804 - 90857 for care provided through December 31, 2012.

90832 - 90853 for care provided on or after January 1, 2013.

2.0 DESCRIPTION

Psychotherapy is the treatment for mental illness and behavioral disturbances in which the clinician establishes a professional contact with the patient and, through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development.

3.0 POLICY

3.1 Benefits are available for inpatient and outpatient psychotherapy that is medically or psychologically necessary to treat a covered mental disorder.

3.2 Individual psychotherapy for patients with a mental disorder (**Diagnostic and Statistical Manual of Mental Disorders** (DSM)) that coexists with an alcohol and other **Substance Use Disorder (SUD)** is a covered benefit.

3.3 Charges for outpatient psychotherapy are not covered when the patient is an inpatient in an institution. Claims for outpatient psychotherapy must be denied for the entire period during which the beneficiary is an inpatient in the institution.

3.4 Employees of institutional providers are not authorized to bill for services rendered as part of that employment. Such services billed by the employee must be denied.

3.5 Eye Movement Desensitization and Reprocessing (EMDR) is covered for the treatment of Post-Traumatic Stress Disorder (PTSD) in adults.

3.6 Psychotherapy is not a Health and Behavior Assessment/Intervention. See [Section 16.2](#).

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4.0 POLICY CONSIDERATIONS

4.1 Maximum duration of psychotherapy sessions for care provided through December 31, 2012:

4.1.1 Inpatient or outpatient individual psychotherapy (CPT² procedure codes 90806, 90807, 90818, 90819) approximately 45 to 50 minutes; or (CPT² procedure codes 90804, 90805, 90816, 90817) approximately 20 to 30 minutes.

4.1.2 Inpatient or outpatient group, conjoint or family psychotherapy: 90 minutes (CPT² procedure codes):

90846 - FAMILY PSYTX W/O PATIENT
90847 - FAMILY PSYTX W/ PATIENT
90849 - MULTIPLE FAMILY GROUP PSYTX
90853 - GROUP PSYCHOTHERAPY

4.1.3 Crisis intervention (CPT² procedure codes):

90808 - PSYTX, OFFICE, 75-80 MIN
90809 - PSYTX, OFF, 75-80, W/E&M
90821 - PSYTX, HOSP, 75-80 MIN
90822 - PSYTX, HOSP, 75-80 MIN W/E&M

4.2 Maximum duration of psychotherapy sessions for care provided on or after January 1, 2013:

4.2.1 Inpatient or outpatient individual psychotherapy: 30 minutes (CPT² procedure codes 90832 and 90833); 45 minutes (CPT² procedure codes 90834 and 90836); or 60 minutes (CPT² procedure codes 90837 and 90838).

4.2.2 Inpatient or outpatient group, conjoint or family psychotherapy (CPT² procedure codes):

90846 - FAMILY PSYTX W/O PATIENT
90847 - FAMILY PSYTX W/ PATIENT
90849 - MULTIPLE FAMILY GROUP PSYTX
90853 - GROUP PSYCHOTHERAPY

4.2.3 Crisis intervention (CPT² procedure codes):

90839 - PSYTX FOR CRISIS, FIRST 60 MIN
90840 - PSYTX FOR CRISIS, EACH ADDL 30 MIN

4.3 Frequency of psychotherapy sessions.

Note: Beginning October 1, 1993, the mental health benefit year is changed from a calendar year to fiscal year. A patient is not automatically entitled to a designated number of sessions, and review can be more frequent when determined necessary.

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4.3.1 The frequency limitations on outpatient psychotherapy apply to any psychotherapy performed on an outpatient basis, whether by an individual professional provider or by staff members of an institutional provider.

4.3.2 Treatment sessions may not be combined, i.e., 30 minutes on one day added to 20 minutes on another day and counted as one session, to allow reimbursement and circumvent the frequency limitation criteria.

4.3.3 Multiple sessions the same day: If the multiple sessions are of the same type--two individual psychotherapy sessions or two group therapy sessions--payment may be made only if the circumstances represent crisis intervention and only according to the restrictions applicable to crisis intervention. A collateral session not involving the identified patient on the same day the patient receives a therapy session does not require review.

4.3.4 Collateral visits (CPT³ procedure code 90887). Collateral visits are payable when medically or psychologically necessary for treatment of the identified patient. A collateral visit is considered to be a psychotherapy session for purposes of reviewing the duration or frequency of psychotherapy.

4.3.5 Psychoanalysis (CPT³ procedure code 90845). Psychoanalysis is covered when provided by a graduate or candidate of a psychoanalytic training institution recognized by the American Psychoanalytic Association and when preauthorized by the contractor.

4.3.6 Play therapy. Play therapy is a form of individual psychotherapy which is utilized in the diagnosis and treatment of children with psychiatric disorders. Play therapy is a benefit, subject to the regular points of review and frequency limitations applicable to individual psychotherapy.

4.3.7 Marathon therapy. Marathon therapy is a form of group therapy in which the therapy sessions last for an extended period of time, usually one or more days. Marathon therapy is not covered since it is not medically necessary or appropriate.

4.3.8 Inpatient psychotherapy and medical care. The allowable charge for inpatient psychotherapy includes medical management of the patient. A separate charge for hospital visits rendered by the provider on the same day as he/she is rendering psychotherapy is not covered. Payment is authorized only for medically necessary hospital visits billed on a day that psychotherapy was not rendered. If the provider who is primarily responsible for treatment of the mental disorder is not a physician, charges for medical management services by a physician are coverable, but only if the physician is rendering services that the non-physician provider is prohibited from providing. Concurrent inpatient care by providers of the same or different disciplines is covered only if second or third level review determines that the patient's condition requires the skills of multiple providers.

4.3.9 Physical examination. A physical examination is an essential component of the work up of the psychiatric patient, and for all admissions should be performed either by the attending psychiatrist or by another physician. The examination may lead to confirmation of a known psychiatric diagnosis or consideration of other unsuspected psychiatric or medical illness. When not performed by the attending psychiatrist, payment may be made to another physician for

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performance of the initial physical examination. Any additional concurrent care provided by a physician other than the attending psychiatrist may be covered only if it meets the criteria under inpatient concurrent care.

5.0 EFFECTIVE DATES

5.1 November 13, 1984.

5.2 April 16, 2007, for EMDR for the treatment of PTSD in adults.

- END -

Family Therapy

Issue Date: August 31, 1987

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

1.0 CPT¹ PROCEDURE CODES

90846, 90847, 90849

2.0 DESCRIPTION

Family Therapy Defined. Family therapy is a form of psychotherapy directed toward the family as a unit, instead of toward a single individual. Family therapy is based on the assumption that the mental or emotional illness and the functional impairment of the identified-patient is related to family interactions and, therefore, the family is the unit that should be treated. Problems and dysfunctional behaviors are dealt with as responsibilities of all family members and are not necessarily focused on any one individual. Family therapy may involve the complete or partially available family unit and normally would involve the same therapist or treatment team. When geographical distance necessitates therapy be given to partial family units at separate locations, collaboration between treating therapists is acceptable. For the purposes of coverage, the family generally would include the husband or wife of the patient, his or her children or, in the case of child patients, the parents, stepparents and siblings. When determined appropriate, other family members residing in the same household could also be included.

3.0 POLICY

Family therapy can be cost-shared when rendered in conjunction with otherwise covered treatment of a beneficiary suffering a diagnosed mental disorder.

4.0 POLICY CONSIDERATIONS

4.1 Frequency. Professional review of the medical or psychological necessity is required for therapy in excess of the parameters indicated below.

4.1.1 Outpatient psychotherapy is limited to a maximum of two psychotherapy sessions per week in any combination of individual, family, collateral, or group sessions.

4.1.2 Inpatient psychotherapy is limited to five sessions per week in any combination of individual, family, collateral, or group sessions.

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Note: Two consecutive family therapy sessions with the same family members present is considered to be a single session and not two distinct sessions with a different focus (e.g., a different child being the focus of each). In such cases, the reimbursement will be treated as if the therapy had occurred at a single session.

4.2 Telephone calls, therapeutic leaves and visits among family members are not a substitute for family therapy, although they can be important adjuncts to a child's treatment. Multi-family group therapy does not meet the family therapy requirement. A collateral visit, a session between an authorized provider and a significant person in the identified-patient's life, is primarily for the purpose of information gathering and does not constitute a family therapy session, although such visits do count toward the psychotherapy limits.

4.3 Special Considerations Involving Partial Hospitalization and Residential Treatment Center (RTC) Care.

4.3.1 Family Therapy involving Partial Hospitalization and RTC Admissions. In accordance with the appropriate medical care standard, discharge planning should start with the day of admission. The goal should be to restore the patient's ability to function in one or more major life activities. In the case of a child under age 21, the environment to which the patient is to be discharged is a major consideration. To be authorized, RTCs and partial hospitalization programs are required to address the feasibility of family therapy as part of the treatment plan.

4.3.1.1 Standards. A compliance requirement of the RTC standards (see [32 CFR 199.4\(b\)\(4\)\(vii\)](#)) and the partial hospitalization standards is that the admission process must include the family's (or responsible relative's or legal guardian's) understanding of residential or partial hospitalization treatment and of their involvement in treatment as well as the probable length-of-stay (LOS) of the patient. The RTC standards dictate that if the patient is not returning to the family, appropriate documentation in the clinical record should indicate the type of preparation made with other persons who will be involved with the patient upon discharge. The RTC and partial hospitalization standards require that all specific therapeutic modalities be spelled out in the treatment plan, including family therapy.

4.3.1.2 Joint Commission's **Standards for Behavioral Health Care** (formerly **Consolidated Standards Manual**). Under the **Standards for Behavioral Health Care**, the Joint Commission requires a specific plan for involving the family in the treatment plan, when indicated. There is also a requirement that the patient's record shall contain documentation of family members involvement in the patient's treatment program. If appropriate, a separate record may need to be maintained on each family member involved in the patient's treatment program.

4.3.2 Detailed Description of Family Therapy in Treatment Plan. Family therapy is an integral part of the treatment of children and adolescents and should be included in all mental health treatment plans unless circumstances exist which make such treatment contraindicated. Treatment plans must include a detailed description of the plans for family therapy (name and qualifications of therapist, frequency, length of sessions) or provide rationale for why such therapy is not being provided. In all cases, this is an issue subject to medical review, dependent on the needs of the individual patient.

4.3.3 Family is Geographically Distant from the Child. If the family is not in the area, the patient may not be a candidate for partial care as individuals in this program return to their home setting

daily, and effective family interaction is essential. If an RTC accepts a child for admission whose parents are geographically distant, the facility must document its plans for including the family in therapy, in accord with RTC standards and the appropriate medical care standard. If one or both parents reside a minimum of 250 miles from the RTC, the RTC has the flexibility of setting up therapy with the parents at the distant locality, while the child is in treatment in the RTC. The parent's therapist and child's therapist must collaborate in all cases. Collaboration between therapists is the responsibility of the RTC and must be documented in the medical records.

4.3.4 Geographical distance of the patient's family is not considered an appropriate reason to exclude the family from the treatment plan. By accepting a child for admission, the RTC or **Partial Hospitalization Program (PHP)** is acknowledging that it can provide the specific treatment appropriate to the individual child's needs and is responsible for taking only those children whom it feels it can help through the development of an appropriate treatment program designed to maximize the patient's ability to function in one or more major life activities.

4.3.5 Circumstances Where Family Therapy is Inappropriate. If family therapy is inappropriate due to the particular circumstances of the case, supporting documentation and rationale must be provided in the treatment plan. An example of such circumstances might include not returning to the family unit following treatment. Authorization shall be denied for partial hospitalization and RTC care if the patient's treatment plan does not address the provision of family therapy. The contractor shall notify the **Defense Health Agency (DHA) Special Contracts and Operations Office (SCOO)** if it finds that a facility's treatment planning demonstrates a pattern of failure to provide for family therapy, as this constitutes a violation of the standards and may reflect domiciliary care.

- END -

Psychotropic Pharmacologic Management

Issue Date: December 5, 1984

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

1.0 DESCRIPTION

Pharmacologic management, including prescription and review of medication, when performed with or without psychotherapy services.

2.0 POLICY

2.1 In 2013, the American Medical Association (AMA) made significant revisions to the Current Procedural Terminology (CPT) codes regarding behavioral health services. Beginning January 1, 2013, psychotropic pharmacologic management services can be billed in one of two ways depending on the type of provider and the services being rendered:

2.1.1 Physicians and certified psychiatric nurse specialists permitted to utilize Evaluation and Management (E&M) codes providing psychotropic pharmacologic management with or without psychotherapy services should use the appropriate E&M code as described in the current CPT manual.

Note: Office visits for psychotropic pharmacologic management provided without psychotherapy are routine medical services and do not count against the two visits per week or the initial eight visits for psychotherapy.

2.1.2 Prescribing psychologists providing psychotropic pharmacologic management in conjunction with psychotherapy services (when the psychologist is authorized to prescribe in their state; for example, New Mexico and Louisiana) should use CPT¹ code 90863 as an add-on code to the primary psychotherapy service as described in the current CPT manual. Other providers (i.e., physicians or Certified Psychiatric Nurse Specialists [CPNSs]) should not utilize this CPT code. See also [Chapter 11, Section 3.7](#), regarding TRICARE's definition of CPNS.

2.2 The allowable charge for psychotropic pharmacologic management shall be based on the CHAMPUS Maximum Allowable Charge (CMAC) methodology.

3.0 EFFECTIVE DATE

January 1, 2013.

- END -

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Collateral Visits

Issue Date: December 5, 1984

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

1.0 CPT¹ PROCEDURE CODE

90887

2.0 DESCRIPTION

Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient.

3.0 POLICY

3.1 Collateral visits that are medically or psychologically necessary for the treatment of the patient are covered. It is not a therapy session, a treatment planning session, or a discussion with the milieu staff. It is conducted for the purpose of information gathering and implementing treatment goals. A responsible person is generally a parent, the husband, wife, or siblings. Other individuals also may qualify for collateral visits for both the adult and the child or adolescent patient provided it can be demonstrated that the individual is, in fact, a significant person in the life of the identified patient.

3.2 A collateral visit does not involve treatment of the collateral person(s). It is for purposes of information exchange regarding the patient or implementing treatment goals for the patient. Collateral visits are considered as services rendered on behalf of the patient, are billed in the name of the patient, and are counted as individual psychotherapy sessions for purposes of utilization review. Duration up to 60 minutes is allowed.

4.0 EXCLUSIONS

4.1 Group visits. A group collateral visit is when the therapist meets with a group of parents of the children he/she sees in group therapy. The focus of the sessions is on improving parenting techniques and fostering better implementation goals.

4.2 A collateral visit rendered on the same day that the patient receives individual or group psychotherapy is coverable. Collateral visits do not count toward crisis intervention sessions.

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5.0 EFFECTIVE DATE

October 1, 1980.

- END -

Eating Disorder Treatment

Issue Date: July 19, 1983

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

1.0 DESCRIPTION

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

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

2.0 POLICY

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

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

- END -

Applied Behavior Analysis (ABA)

Issue Date: August 10, 2012

Authority: 10 USC 1079(a), and [32 CFR 199.4\(c\)](#)

1.0 CPT¹ PROCEDURE CODES

90887, 99080

2.0 HCPCS CODE

S5108

3.0 DESCRIPTION

Applied Behavior Analysis (ABA) is covered under the TRICARE Basic Program as an interim benefit until December 31, 2014.

4.0 POLICY

4.1 TRICARE covers ABA services for all eligible beneficiaries, including retirees and their dependent family members, with a diagnosis of Autism Spectrum Disorder (ASD). ABA reinforcement is covered separately for Active Duty Family Members (ADFM) under the Autism Demonstration and for Non-Active Duty Family Members (NADFM) under the ABA Pilot.

4.2 Autism Spectrum Disorder (ASD)

4.2.1 The covered ASD diagnoses are described under the Neurodevelopmental Disorders category of the most current edition of the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V). The DSM-V was released in May 2013. The DSM-V diagnostic code for ASD (299.00) is equivalent to the corresponding codes for Autistic Disorder (299.0) in the currently used edition of the International Classification of Diseases, Clinical Modification manual (currently International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)) used for claims processing under TRICARE for services provided before the mandated date, as directed by Health and Human Services (HHS), for International Classification of Diseases, 10th Revision (ICD-10) implementation.

4.2.2 The Military Health System (MHS) and mental health community has transitioned to the DSM-V (released May 2013). This transition resulted in the five covered diagnoses for an ASD (ASD, Rett's Disorder, Childhood Disintegrative Disorder (CDD), Asperger's Disorder, and Pervasive Developmental Disorder (PDDNOS)) under the DSM, Fourth Edition, Text Revision (DSM-IV-TR)

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falling under the one diagnosis of ASD (299.00) in the DSM-V. The corresponding ICD-9-CM code is Autistic Disorder (299.0) and the corresponding ICD-10-CM code is Autistic Disorder (F84.0).

Note: The DSM-IV-TR and the ICD-9-CM use the same numeric diagnosis codes for three of the five ASD Diagnoses found in the DSM-IV-TR (Autistic Disorder (299.00 & 299.0), CDD (299.10 & 299.1), and Asperger's (299.80 & 299.8)). The DSM-IV-TR uses one code 299.80 to refer to Rett's Disorder, PDD, and Asperger's Disorder whereas the ICD-9-CM designates a unique code for each diagnosis.

4.2.3 The DoD and the rest of the United States will transition to ICD-10-CM on the mandated date, as directed by Health and Human Services (HHS), for ICD-10 implementation. Those beneficiaries diagnosed with one of the five ASD diagnoses under the DSM-IV-TR (ASD, Rett's Disorder, CDD, Asperger's Disorder, and PDDNOS) are given the single diagnosis of ASD (299.00) under the DSM-V (released in May 2013). The corresponding ICD-10-CM code is Autistic Disorder (F84.0).

4.3 Payable services include:

4.3.1 An initial beneficiary assessment;

4.3.2 Development of a treatment plan;

4.3.3 One-on-one ABA interventions with an eligible beneficiary, training of immediate family members to provide services in accordance with the treatment plan; and

4.3.4 Monitoring of the beneficiary's progress toward treatment goals.

4.4 ABA services will be provided only for those beneficiaries with an ASD diagnosis rendered by a TRICARE-authorized Primary Care Provider (PCP) or by a specialized ASD provider defined as:

4.4.1 Physician board-certified or board-eligible in behavioral developmental pediatrics, neurodevelopmental pediatrics, pediatric neurology or child psychiatry; or

4.4.2 Ph.D. or Psy.D. clinical psychologist working primarily with children.

5.0 REIMBURSEMENT

5.1 Claims for ABA services will be submitted by an authorized provider on Centers for Medicare and Medicaid Services (CMS) 1500 Claim Form as follows:

5.1.1 Functional Behavioral Assessment and Analysis.

5.1.1.1 The Functional Behavioral Assessment and Analysis and initial treatment plan will be billed using Healthcare Common Procedure Coding System (HCPCS) code S5108, "Home care training to home care client, per 15 minutes".

5.1.1.2 Reimbursement for the Functional Behavioral Assessment and Analysis includes the intellectual work and diagnostic evaluation required to establish the initial treatment plan.

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Applied Behavior Analysis (ABA)

5.1.2 ABA services rendered by an authorized provider, in-person, will be billed using HCPCS code S5108, "Home care training to home care client, per 15 minutes".

5.1.3 Development of an updated treatment plan will be billed using Current Procedural Terminology² (CPT) procedure code 99080, "Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form".

5.1.4 Conducting progress meetings will be billed using CPT2 procedure code 90887, "Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible person, or advising them how to assist patient".

5.2 Reimbursement of claims will be the lesser of:

5.2.1 The CHAMPUS Maximum Allowable Charge (CMAC);

5.2.2 One hundred and twenty-five dollars (\$125) per hour for services provided by the authorized provider;

5.2.3 The negotiated rate; or

5.2.4 The billed charge. For care provided outside the 50 United States, the District of Columbia, and the U.S. Territories, billed charges will be paid.

6.0 EXCLUSIONS

6.1 ABA services provided in a group format are not a covered service.

6.2 Services rendered by an unauthorized TRICARE provider.

7.0 PROVIDERS

For services provided in conjunction with ABA under the TRICARE Basic benefit, the following are TRICARE-authorized providers when referred by and working under the supervision of those identified in [paragraph 4.4](#):

7.1 Have a current state license to provide ABA services; or

7.2 Are currently state-certified as an Applied Behavioral Analyst; or

7.3 Where such state license or certification is not available, are certified by the Behavioral Analyst Certification Board (BACB) as a Board Certified Behavior Analyst (BCBA); and

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

Note: Individuals certified by the BACB as a Board Certified Assistant Behavior Analyst (BCaBA) **are not** TRICARE-authorized ABA providers under the TRICARE Basic Program.

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8.0 EFFECTIVE DATE

February 16, 2010, except for services overseas which is February 16, 2008.

- END -

Applied Behavior Analysis (ABA) For Non- Active Duty Family Members (NADFM) Who Participate In The ABA Pilot

Issue Date: August 10, 2012

Authority: 10 USC 1079(a), 10 USC 1092, [32 CFR 199.4\(c\)](#), and [32 CFR 199.6](#)

1.0 CPT¹ PROCEDURE CODES

1181F, 1450F

2.0 HCPCS CODE

S5110, S5115, G8539, G8542, G9165 - G9167

3.0 DESCRIPTION

3.1 ABA is covered under the TRICARE Basic Program as an interim benefit until December 31, 2014. TRICARE-eligible NADFM with Autism Spectrum Disorder (ASD) may continue to receive ABA services under the Basic Program guidelines without seeking additional ABA reinforcement services under the Department of Defense (DoD) Applied Behavior Analysis Pilot (ABA Pilot).

3.2 The requirements of this section apply ONLY to NADFM who seek ABA reinforcement in addition to ABA, and elect to participate in the ABA Pilot, referred to as the ABA Pilot, outlined in the TRICARE Operations Manual (TOM), [Chapter 18, Section 15](#). ABA is covered under the TRICARE Basic Program as interim benefit until December 31, 2014.

3.3 The Behavioral Analyst Certification Board (BACB) explains that ABA has established standards for practice and distinct methods of service by providers with recognized experience and educational requirements for practice. Information regarding the content of ABA is contained in the BACB Behavior Analysis Task List, available at: <http://www.bacb.com/Downloadfiles/AutismTaskList/708AutismTaskListF.pdf>.

4.0 DEFINITIONS

4.1 Applied Behavior Analysis (ABA). According to the BACB Practice Guidelines (2012), ABA is “the design, implementation, and evaluation of environmental modifications to produce socially significant improvement in human behavior. ABA includes the use of direct observation, measurement, and functional analysis of the relations between environment and behavior. ABA uses changes in environmental events, including antecedent stimuli and consequences, to produce practical and significant changes in behavior. Direct observation, measurement and recording of

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behavior are defining characteristics of ABA" (p. 4). For TRICARE program purposes, ABA has a component covered as an interim benefit under the TRICARE Basic Program and a reinforcement component covered under the authority of 10 United States Code (USC) 1092.

4.2 Autism Spectrum Disorder (ASD) Diagnosis. The diagnosis of a condition limited to those conditions listed in [paragraph 5.2](#) by an ASD diagnosing provider listed in [paragraph 5.6](#).

4.3 ABA Assessment by the Behavior Analyst. A developmentally appropriate assessment process that is used for formulating an individualized ABA Treatment Plan (TP) conducted by a Board Certified Behavior Analyst (BCBA), or Board Certified Behavior Analyst - Doctoral (BCBA-D) or other TRICARE authorized ABA providers practicing within the scope of their state license or state certification. For TRICARE purposes, an ABA assessment includes data obtained from multiple methods to include direct observation and the measurement and recording of beneficiary behavior. A functional assessment that may include a functional analysis (see [paragraph 4.5](#)) shall be required to address problematic behaviors. Data gathered from the parent/caregiver interview and parent report rating scales is also required. The ABA assessment by the BCBA, BCBA-D, or other TRICARE authorized ABA providers practicing within the scope of their state license or state certification is required prior to starting all ABA reinforcement under the ABA Pilot.

4.4 Standardized Psychometric Testing. Standardized psychometric tests are measures developed by the social sciences that have been researched to ensure validity and reliability. A reliable measure is one that measures a construct consistently across time, individuals, and situations. A valid measure is one that measures what it is intended to measure. Reliability is necessary, but not sufficient, for validity. For TRICARE purposes, per [paragraph 5.7.3](#), specific standardized psychometric tests are required to be administered by a qualified clinician in order to establish baseline measurement of the impairments of an ASD prior to the start of all ABA. This prerequisite requirement must be obtained prior to beginning ABA reinforcement under the ABA Pilot. Repeat testing is required at specified intervals per [paragraph 5.7.5](#) for all NADFM receiving ABA reinforcement under the ABA Pilot.

4.5 Functional Behavior Analysis. The process of identifying the variables that reliably predict and maintain problem behaviors which typically involves: identifying the problem behavior(s); developing hypotheses about the antecedents and consequences likely to trigger or support the problem behavior; and, performing an analysis of the function of the behavior by testing the hypotheses.

4.6 ABA Treatment Plan (TP). A written document outlining the ABA plan of care for the individual, including the expected progression of ABA. For TRICARE purposes, the ABA TP consists of: (a) an "initial ABA Treatment Plan" based on the initial ABA assessment; and, (b) the "ABA Treatment Plan Update" that is the revised and updated ABA TP based on periodic reassessment of beneficiary progress toward the objectives and goals. Components of the ABA TP include: the identified behavioral targets for improvement, the ABA specialized interventions to achieve improvement, ABA TP objectives, and the ABA TP short and long-term goals that are defined below.

4.7 ABA Specialized Interventions. ABA specialized interventions are ABA methods designed to improve the functioning of a specific ASD target deficit in a core area affected by the ASD such as social interaction, communication or behavior. The ABA provider delivers ABA to the beneficiary

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through direct administration of the ABA specialized interventions during one-on-one (i.e., face-to-face) interactions.

4.8 ABA Treatment Plan Objectives. ABA TP objectives are the short, simple, measurable steps that must be accomplished in order to reach the short-term and long-term goals of ABA.

4.9 ABA Treatment Plan Goals. These are the broad spectrum, complex short-term and long-term desired outcomes of ABA.

4.10 ABA includes: an initial ABA assessment, the initial ABA TP, the delivery of ABA specialized interventions delivered by the BCBA or BCBA-D, TRICARE eligible parent/caregiver ABA training, repeat ABA assessments, and ABA TP updates. "ABA reinforcement" refers to supplemental services provided by Board Certified Assistant Behavior Analysts (BCaBAs) and ABA Tutors to assist with the practice and execution of the ABA TP when under the supervision of a BCBA or BCBA-D.

4.11 Referral and Supervision. "Referral and supervision" means that the TRICARE authorized provider who refers the beneficiary for ABA must actually see the beneficiary to evaluate the qualifying ASD condition to be treated prior to referring the beneficiary for ABA; the referring provider also provides ongoing oversight of the course of referral-related ABA throughout the period during which the beneficiary is receiving ABA in response to the referral. Only those providers listed under [paragraph 5.6.1](#) may refer beneficiaries for ABA in accordance with [paragraph 5.7.1](#).

5.0 POLICY

5.1 TRICARE covers ABA as a TRICARE Basic Program benefit for eligible NADFM with a diagnosis of any of the five listed diagnoses of a Pervasive Developmental Disorder (PDD), also known as ASD, defined in [paragraph 5.2](#). ABA reinforcement is covered for eligible NADFM under this section as part of the ABA Pilot.

5.2 Autism Spectrum Disorder (ASD)

5.2.1 The covered ASD diagnoses are described under the Neurodevelopmental Disorders category of the most current edition of the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V). The DSM-V was released in May 2013. The DSM-V diagnostic code for ASD (299.00) is equivalent to the corresponding codes for Autistic Disorder (299.0) in the currently used edition of the International Classification of Diseases, Clinical Modification manual (currently International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)) used for claims processing under TRICARE for services provided before the mandated date, as directed by Health and Human Services (HHS), for International Classification of Diseases, 10th Revision (ICD-10) implementation.

5.2.2 The Military Health System (MHS) and mental health community has transitioned to the DSM-V (released May 2013). This transition resulted in the five covered diagnoses for an ASD (ASD, Rett's Disorder, Childhood Disintegrative Disorder (CDD), Asperger's Disorder, and Pervasive Developmental Disorder (PDDNOS)) under the DSM, Fourth Edition, Text Revision (DSM-IV-TR)

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falling under the one diagnosis of ASD (299.00) in the DSM-V. The corresponding ICD-9-CM code is Autistic Disorder (299.0) and the corresponding ICD-10-CM code is Autistic Disorder (F84.0).

Note: The DSM-IV-TR and the ICD-9-CM use the same numeric diagnosis codes for three of the five ASD Diagnoses found in the DSM-IV-TR (Autistic Disorder (299.00 and 299.0), CDD (299.10 and 299.1), and Asperger's (299.80 and 299.8)). The DSM-IV-TR uses one code 299.80 to refer to Rett's Disorder, PDD, and Asperger's Disorder whereas the ICD-9-CM designates a unique code for each diagnosis.

5.2.3 The DoD and the rest of the United States will transition to ICD-10-CM on the mandated date, as directed by Health and Human Services (HHS), for ICD-10 implementation. Those beneficiaries diagnosed with one of the five ASD diagnoses under the DSM-IV-TR (ASD, Rett's Disorder, CDD, Asperger's Disorder, and PDDNOS) are given the single diagnosis of ASD (299.00) under the DSM-V (released in May 2013). The corresponding ICD-10-CM code is Autistic Disorder (F84.0).

5.3 ABA under the TRICARE Basic Program refers to ABA provided one-to-one, in person to the NADFM beneficiary by TRICARE authorized ABA providers (described in [paragraphs 5.4](#) and [5.8](#)) to improve social interaction, communication and behavior as related to the core deficits and symptoms of an ASD. ABA reinforcement provided by BCaBAs and ABA tutors is covered separately under the ABA Pilot for NADFM.

5.4 ABA is a specialized intervention administered by an authorized provider described in [paragraph 5.8](#) who is a professional with advanced formal training in behavior analysis, to include at least a master's degree and several hundred hours of graduate level instruction, or mentored or supervised experience with another BCBA. The only providers qualified to deliver ABA under the TRICARE Basic Program are masters-level BCBAs or BCBA-Ds certified by the BACB or other TRICARE authorized ABA providers practicing within the scope of their state license or state certification. In accordance with qualifications of other TRICARE-authorized individual providers of behavioral health care (see [32 CFR 199.6\(c\)\(2\)](#)), these providers possess the education, required experience and supervision, and scope of practice consistent with TRICARE Basic Program regulations. Qualifications for individuals providing ABA reinforcement under the ABA Pilot are set forth in the TOM, [Chapter 18, Section 15](#).

5.5 The requirements of this section apply ONLY to NADFM who elect to participate in the ABA reinforcement covered separately under the ABA Pilot.

5.6 ASD Diagnosing Providers

5.6.1 Diagnosis of ASD shall be rendered by a TRICARE-authorized Physician Primary Care Managers (P-PCM) or by a specialized ASD provider:

5.6.1.1 For the purposes of the diagnosis of ASD, TRICARE authorized P-PCMs include: TRICARE authorized family practice, internal medicine and pediatric physicians whether they work in the Purchased Care or Direct Care (DC) system. In cases where the beneficiary does not have a P-PCM (as is sometimes the case for beneficiaries with TRICARE Prime Remote (TPR)), the diagnosis may be rendered by a TRICARE authorized physician in any of the disciplines described above under P-PCM,

or by a TRICARE authorized specialty ASD provider as described in [paragraph 5.6.1.2](#).

5.6.1.2 Authorized specialty ASD providers include: TRICARE authorized physicians board-certified or board-eligible in behavioral developmental pediatrics, neurodevelopmental pediatrics, pediatric neurology or child psychiatry; or Ph.D. or Psy.D. licensed clinical psychologists.

5.6.2 Other PCMs, including a Nurse Practitioner (NP) and a Physician Assistant (PA) or other providers not having the qualifications described in [paragraph 5.6.1](#), are not ASD diagnosing providers for TRICARE coverage purposes.

5.7 Referring Providers, Referrals and Prior Authorization

5.7.1 For those NADFM with ASD who elect to participate in the ABA Pilot in order to receive ABA reinforcement in addition to ABA, the following requirements apply:

- A referral by a provider listed under [paragraph 5.6.1](#) who is authorized to diagnose an ASD and refer to specialty care, and
- Authorization by the appropriate Managed Care Support Contractor (MCSC) prior to either initiation of the ABA assessment or beginning ABA (see [Chapter 1, Section 7.1](#), and the TOM, [Chapter 7, Section 2](#), and TOM, [Chapter 8, Section 5](#) for details concerning referrals and authorization requirements). Referral for ABA assessment will precede referral for ABA which is contingent upon the results of the ABA assessment. Each authorization period for ABA shall be for one year. A new referral is required for each period of authorized care (see the TOM, [Chapter 8, Section 5](#)).

5.7.2 Other PCMs, including an NP and a PA or other providers not having the qualifications described in [paragraph 5.6.1](#), may not refer beneficiaries for ABA assessment or ABA for ABA Pilot participant coverage purposes.

5.7.3 Authorization of ABA for NADFM who elect to participate in the ABA Pilot first requires a referral for a comprehensive ABA assessment by a BCBA, BCBA-D, or other TRICARE authorized ABA provider practicing within the scope of their state license or state certification. In addition to the essential ABA assessment elements recommended in the Guidelines of the BACB, the ABA assessment will include baseline psychometric testing using standardized assessment measures. The required baseline psychometrics that must be included as part of the initial ABA assessment for NADFM who elect to participate in the ABA Pilot are:

- Autism Diagnostic Observation Schedule, Second Edition (ADOS-2) (Lord, C., et.al., 2012); and,
- Vineland Adaptive Behavioral Scale II (VABS-II) (Sparrows, 2005) to include the Maladaptive Behavior Scale.

If the ABA provider conducting the initial ABA assessment is not qualified to administer these standardized assessment measures, then the TRICARE authorized referring provider must refer the beneficiary to a TRICARE authorized provider who possesses the requisite training (e.g., a

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licensed clinical psychologist) to provide this psychometric testing to establish baseline impairment across the core domains impacted by the ASD. Alternatively, the TRICARE authorized referring provider may administer the standardized psychometric assessment measures listed above, but only if qualified. Regardless of which qualified provider conducts the required standardized testing, it is the responsibility of the ABA provider conducting the ABA assessment to ensure that the results of the required testing are incorporated into the initial ABA assessment. The ADOS-2 and Vineland II reports will be accepted from the school system if done within one year of the referral for ABA.

5.7.4 Based on the results of the initial ABA assessment, the referring provider will submit a referral to the MCSC for authorization for NADFM who elect to participate in the ABA Pilot for ABA for one year, if indicated, and a new referral for reauthorization annually. The referral must contain:

- The ASD diagnosis rendered by a TRICARE authorized ASD diagnosing provider and confirmed by the ABA assessment and standardized testing.
- A description of why ABA is appropriate (“appropriate care” is defined for the purposes of ABA coverage under TRICARE in [paragraph 5.9](#)). The description shall include:
 - The functional impairments and the degree of impairment in each domain (social interaction, communication, behavior);
 - A description of how ABA is expected to improve each domain affected by the ASD (social interaction, communication and behavior);
 - An assessment of each TRICARE eligible family member/caregiver’s ability to reinforce ABA interventions at home;
 - A brief summary of the baseline psychometric testing results. The repeat psychometric testing should show progress consistent with the progress reported on the ABA TP update by the BCBA, BCBA-D, or other TRICARE authorized ABA provider practicing within the scope of his/her state license or state certification. A brief summary of this information shall be included in the referral for continued ABA; and
 - A recommendation for the number of weekly hours of ABA under the TRICARE Basic Program and the number of weekly hours of ABA reinforcement under either the Autism Demonstration or the ABA Pilot.

If the results of the ABA assessment indicate the beneficiary does not meet current criteria for diagnosis of an ASD, then a course of ABA is not authorized and the beneficiary should not be referred for ABA.

5.7.5 Repeat standardized psychometric testing utilizing the Vineland II (to include the Maladaptive Behavior Scale) is required every 180 days for NADFM who elect to participate in the ABA Pilot to assess progress as noted in [paragraph 5.7.3](#). This follow-up testing will require a referral

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to a qualified TRICARE authorized provider to administer the test unless the referring provider or the ABA provider is qualified to administer the Vineland II. The results of all testing shall be included in each reauthorization referral for ABA for NADFM who elect to participate in the ABA Pilot. Objective progress on the required standardized psychometric test is one critical factor for continued authorization.

5.7.6 The TRICARE authorized provider qualified to conduct the standardized psychometric testing will submit the baseline and every 180 day psychometric testing report to the referring provider (unless the testing provider is also the referring provider) and the MCSC for NADFM who elect to participate in the ABA Pilot.

Note: BCBA, BCBA-Ds or other TRICARE authorized ABA providers practicing within the scope of their state license or state certification may not necessarily be trained in administration of the ADOS-2 or VBS-II; therefore, formal psychometric testing at baseline and every 180 days may need to be administered by qualified professionals (i.e., clinical psychologists) who possess the requisite training to administer the required measures.

5.7.7 The MCSC reviewer shall review all ABA referral documentation for appropriateness of care for NADFM who elect to participate in the ABA Pilot. The BCBA, BCBA-D, or other TRICARE authorized ABA provider practicing within the scope of his/her state license or state certification shall provide the MCSC with the ABA TP updates during the month prior to reauthorization being due for NADFM who elect to participate in the ABA Pilot.

5.7.8 The MCSC shall provide (via fax or other appropriate means) the referring provider a copy of the initial ABA TP and all ABA TP updates.

5.7.9 These requirements apply to all NADFM who elect to participate in the ABA Pilot for ABA provided under the TRICARE Basic Program (i.e., TRICARE Prime, TPR, TRICARE Standard, TRICARE Extra, TRICARE Reserve Select (TRS), TRICARE Retired Reserve (TRR), TRICARE For Life (TFL)) and for the additional ABA reinforcement under the ABA Pilot. ABA shall appear on the "Requires Prior Authorization" list under TRICARE Standard.

5.7.10 Exception. For continuity of care purposes meant to minimize the risk of regression during times of change, ADFMs enrolled in the ECHO Autism Demonstration who transition to NADFM status through retirement of the AD sponsor will be allowed direct entry into the ABA Pilot for NADFM. A one year grace period will be granted to meet all diagnosis, referral and assessment requirements of this section. The requirement for the VABS-II every 180 days as per [paragraph 5.7.5](#) is not waived.

5.8 ABA Providers

5.8.1 For NADFM who elect to participate in the ABA Pilot concerning ABA provided under the TRICARE Basic Program, the following individuals who otherwise meet all applicable requirements of TRICARE-authorized providers under the TRICARE Basic Program are TRICARE-authorized ABA providers when referred by and working under the referral and supervision of the referring

providers as set forth in [paragraph 9.0](#) of this policy:

5.8.1.1 Have a master's degree or above in a qualifying field as defined by the BACB;

5.8.1.2 Have a current state license as an Applied Behavior Analyst to provide ABA in those states providing state licensure;

5.8.1.3 Are currently state-certified as an Applied Behavior Analyst qualified to practice at the full clinical level; able to conduct an ABA assessment and develop the initial ABA TP and ABA TP updates independently for all complexity of cases; or

5.8.1.4 Where such state license or certification is not available, are certified by the BACB as a BCBA or BCBA-D.

5.8.1.5 The Applied Behavior Analyst (unless the Applied Behavior Analyst is also a licensed clinical psychologist) must work under the referral and supervision of the referring P-PCM or specialized ASD provider as defined in [paragraph 5.6.1](#).

Note: Individuals certified by the BACB as a BCaBA or ABA Tutors are not TRICARE-authorized ABA providers under the TRICARE Basic Program.

5.9 Appropriate Care Requirements For ABA Authorization

5.9.1 Before the MCSC can approve a referral for ABA for an ASD NADFM who elect to participate in the ABA Pilot, the referral and ABA TP must demonstrate that appropriate care standards are met. Appropriate care for ASDs implies the reasonable expectation that ABA shall result in measurable improvement in each of the ABA targeted areas of impairment identified in the ABA TP and monitored in ABA TP updates by baseline and every 180 day psychometric testing as described in [paragraph 5.12.1.5](#).

5.9.1.1 The degree of impairment(s) in social interaction, communication and behavior for NADFM who elect to participate in the ABA Pilot must present at a level that:

- Presents a health or safety risk to self or others (e.g., severely disruptive behaviors, repetitive/stereotyped behaviors, aggression toward others); or
- Significantly interferes with home or community activities as measured by the appropriate assessment tools and psychometrics. See [paragraphs 5.12.1.3, 5.12.1.4, and 5.7.5](#).

5.9.1.2 The NADFM who elect to participate in the ABA Pilot must be able to actively participate in ABA as observed by the BCBA, BCBA-D, or other TRICARE authorized ABA provider practicing within the scope of his/her state license or state certification during the ABA assessment.

5.10 Payable ABA Provided By ABA Providers

5.10.1 Once the diagnosis of an ASD has been made by an ASD diagnosing provider in a child 18 months or older in accordance with [paragraph 5.6](#), the payable ABA provided by the BCBA, BCBA-D, or other TRICARE authorized ABA provider practicing within the scope of his/her state license or state certification for NADFM who elect to participate in the ABA Pilot include:

- Initial ABA assessment performed one-on-one, in person;
- Development of the initial ABA TP;
- Delivery of ABA TPs specialized interventions delivered by the BCBA, BCBA-D, or other TRICARE authorized ABA provider practicing within the scope of his/her state license or state certification;
- Follow up monitoring and repeat ABA assessment; and
- ABA TP updates.

The initial ABA assessment and initial ABA TP process consists of developing a written assessment of the objectives and goals of behavior modification of specific problematic behavioral targets and specific evidenced-based practices and techniques to be utilized by a BCBA, BCBA-D, or other TRICARE authorized ABA provider practicing within the scope of his/her state license or state certification.

5.10.2 Providing ABA specialized interventions with the TRICARE eligible NADFM who elect to participate in the ABA Pilot as well as training of TRICARE eligible family member/caregivers to provide ABA reinforcement in accordance with the ABA TP; and

5.10.3 Monitoring of the NADFM who elect to participate in the ABA Pilot's progress toward ABA TP objectives and goals specified in the initial ABA TP through annual ABA TP updates by the BCBA, BCBA-D, or other TRICARE authorized ABA provider practicing within the scope of his/her state license or state certification. The updated ABA TP must reflect new or modified objectives and goals, with strategies based on the individual needs of the patient.

Note: ABA reinforcement provided under the ABA Pilot to NADFM who elect to participate in the ABA Pilot is not a covered benefit under the TRICARE Basic Program and cannot be billed under the TRICARE Basic Program (see the TOM, [Chapter 18, Section 15](#)).

5.11 ABA Assessments and ABA TPs

The initial ABA assessment, the initial ABA TP, the repeat ABA assessment and ABA TP updates for NADFM who elect to participate in the ABA Pilot shall be completed by the BCBA, BCBA-D, or other TRICARE authorized ABA provider practicing within the scope of his/her state license or state certification under the TRICARE Basic Program. NADFM who elect to participate in the ABA Pilot are eligible for additional ABA reinforcement under the ABA Pilot in accordance with the requirements of the National Defense Authorization Act (NDAA) Fiscal Year (FY) 2013, Section 705

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for the duration of the one-year pilot period which expires July 24, 2014, and subsequently under the authority of 10 USC 1092.

5.12 ABA Documentation of ABA Assessment(s), Initial ABA TP and TP Updates

5.12.1 The initial TP for NADFM who elect to participate in the ABA Pilot shall include:

5.12.1.1 The beneficiary's name, date of birth, date the initial ABA assessment and initial ABA TP was completed, the sponsor's DoD Benefit Number (DBN) or other patient identifiers, name of the referring provider, background and history, objectives and goals, TRICARE eligible family member/caregiver training and ABA recommendations. The ABA assessment shall include documentation of the specific problematic behavioral targets and the corresponding specific ABA intervention to treat each target.

5.12.1.2 Background and history shall include information that clearly demonstrates the beneficiary's condition, diagnoses, medical comorbidities, family history, and how long the beneficiary has been receiving ABA.

5.12.1.3 A summary of baseline ASD psychometric testing findings on the ADOS-2 and the Vineland II (in accordance with [paragraph 5.3](#)).

Note: The core deficits identified on psychometric testing should be consistent with the deficits identified by the BCBA, BCBA-D, or other TRICARE authorized ABA provider practicing within the scope of his/her state license or state certification on the initial ABA assessment. The TP objectives and goals should address each deficit.

5.12.1.4 ABA objectives and goals shall include a detailed description of the targeted skills and behaviors that shall be addressed through specific ABA interventions for each target and the objectives that shall be measured. Objectives and goals are individualized based on beneficiary need and address identified deficits in each of the following domains:

- Social interaction
- Communication
- Behavior

5.12.1.5 TRICARE eligible family member/caregiver training shall be included in the initial ABA TP. TRICARE eligible family member/caregiver training for NADFM who elect to participate in the ABA Pilot shall be provided ABA service billable under [paragraph 6.3](#). The initial ABA TP shall include a detailed plan that specifies how TRICARE eligible family member/caregivers shall be trained to implement and reinforce skills and behaviors within a variety of settings.

5.12.1.6 The initial ABA TP shall include a summary of the expected extent that TRICARE eligible family member/caregivers shall be able to implement ABA interventions with the beneficiary in support of the ABA TP. The ABA TP update will include an annual reassessment of how well the TRICARE eligible family member/caregivers were consistently able to implement ABA interventions with the beneficiary.

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5.12.1.7 Annual repeat ABA assessment for NADFM who elect to participate in the ABA Pilot shall evaluate progress for each ABA intervention associated with each specific behavioral target identified on the initial ABA TP and the ABA TP updates. Documentation on the initial ABA TP shall also include the BCBA or BCBA-D recommendation for the number of weekly hours of ABA under the TRICARE Basic Program and the recommended number of weekly hours for ABA reinforcement by ABA Tutors or BCaBAs under the ABA Pilot for NADFM.

5.12.1.8 Annual repeat ABA reassessment and TP updates for NADFM who elect to participate in the ABA Pilot shall document the evaluation of progress for each behavioral target identified on the initial ABA TP and prior TP updates. Documentation of the annual ABA reassessment and TP update shall include:

- Date and time of the annual reassessment/TP update was done;
- Signature of the ABA provider conducting the reassessment/TP update;
- Evaluation of progress toward each behavioral target's objectives and goals;
- Revisions to the TP to include identification of new behavioral targets, objectives and goals;
- Report of the results of the most recent Vineland II psychometric testing; and
- Recommendation for continued ABA to include a recommendation for:
 - The number of weekly hours of ABA under the TRICARE Basic Program;
 - The number of weekly hours of ABA reinforcement under the ABA Pilot; and
 - A projected duration of ABA.

5.13 Authorization for Continued ABA

Authorization for NADFM who elect to participate in the ABA Pilot is based on continued appropriate care as measured by the required repeat ABA assessment documented on the ABA TP updates, the psychometric testing reports and on documentation on the referral in accordance with [paragraphs 5.6, 5.7, and 5.12.1.4](#) of this policy. The MCSC reviews the BCBA, BCBA-D's or other TRICARE authorized ABA provider's ABA TP updates, the psychometric testing reports and the referral documentation to determine whether the requirements for continued clinical appropriateness are met. Special attention shall be paid to evaluating whether the BCBA/BCBA-D, or other TRICARE authorized ABA provider's ABA TP updates and the psychometric testing reports concur regarding descriptions of beneficiary progress. If these conditions are met, the MCSC may reauthorize ABA for the specified time period as defined in [paragraph 5.7.5](#). If the psychometric testing report (using the Vineland II to include the maladaptive behavior scale) do not concur, the MCSC shall review the referral to consider all other factors (family member/caregiver input, BCBA input related to complexity of treatment needs) in determining whether to authorize continued ABA and ABA reinforcement under the Pilot.

5.14 ABA Discharge Criteria

5.14.1 The following discharge criteria are established to determine if/when ABA is no longer appropriate for NADFM who elect to participate in the ABA Pilot. Discharge decisions should take into consideration the family context and potential mitigating circumstances such as a parent's deployment, a family's move, or a change in school that might have an effect on the child's ability to progress:

5.14.1.1 No measurable progress has been made toward meeting goals identified on the ABA TP as indicated by BCBA/BCaBA/ABA Tutor observation, parent observation, and lack of improvement on the appropriate psychometric test(s) defined as in [paragraphs 5.7.3](#) and [5.7.4](#). The results of psychometric testing will not be used as the sole basis for determining if/when ABA is no longer appropriate.

5.14.1.2 ABA TP gains are determined not to be generalizable or durable over time and do not transfer to the larger community setting (to include school).

5.14.1.3 The patient or family member/caregiver can no longer participate in ABA.

5.14.1.4 The patient has met ABA TP goals and is no longer in need of ABA.

5.14.1.5 Loss of eligibility for TRICARE benefits as defined in [32 CFR 199.3](#).

5.15 ABA Benefit Hours

5.15.1 The appropriate number of ABA hours for NADFM who elect to participate in the ABA Pilot shall be authorized based on the individual beneficiary's appropriate care needs.

5.15.2 ABA shall be authorized for NADFM who elect to participate in the ABA Pilot for a period of one year at a time.

5.15.3 ABA hour and duration limits for NADFM who elect to participate in the ABA Pilot shall be set forth in the referral in accordance with the following:

5.15.3.1 An appropriate number of hours of ABA may be approved by the contractor under the TRICARE Basic Program. A second year of ABA may be authorized by the contractor based on sufficient documentation for those beneficiaries age 16 and younger. All other requests for additional ABA must be requested through the waiver process and approved by the MCSC medical director as outlined in [paragraph 5.15.4](#).

5.15.3.2 An appropriate number of hours of ABA reinforcement may be approved by the contractor. For NADFM receiving additional ABA reinforcement services under the ABA Pilot, the number of hours authorized under those programs shall be added to the number of weekly hours authorized under the TRICARE Basic Program to determine the total number of weekly hours authorized.

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5.15.4 Waiver of the duration of ABA limits for NADFM who elect to participate in the ABA Pilot. The specific benefit limitations set forth in this section may be waived by the contractor based on a determination that all of the following criteria are met. The criteria are:

5.15.4.1 ABA has been delivered for at least one year or when ABA duration limits have been reached for waiver requests for additional ABA duration. Supporting documentation includes:

- Documentation that progress has been insufficient due to the complexity of the ASD needs, and that more hours or a longer duration of ABA are justified to achieve ABA TP objectives and goals;
- A proposed ABA TP that identifies clear, realistic objectives and goals that the referring provider is optimistic can reasonably be achieved with the additional ABA;
- Justification specifying precisely how the additional hours or extended duration of ABA shall be used to achieve the ABA objectives and TP goals;
- Explicit documentation of TRICARE eligible family member/caregiver full engagement and ability to consistently implement the ABA TP specialized interventions in home/community settings; and
- The number of ABA hours and the number of ABA reinforcement hours per week, or the specific identified time frame for extended duration of ABA must be identified in the TP.

6.0 ABA COPAYMENTS AND REIMBURSEMENT

6.1 Claims for NADFM who elect to participate in the ABA Pilot for ABA under the TRICARE Basic Program shall be submitted by an authorized TRICARE provider on Centers for Medicare and Medicaid Services (CMS) 1500 (08/05). The following codes have been adopted for non-standardized usage for ABA provided by the BCBA, BCBA-D, or other TRICARE authorized ABA providers practicing within the scope of their state license or state certification under the TRICARE Basic Program for NADFM who elect to participate in the ABA Pilot. These codes apply for provision of ABA in all authorized settings (the office, home, or community setting).

6.2 Initial ABA assessment with initial ABA TP for NADFM who elect to participate in the ABA Pilot. The initial ABA assessment with development of the initial ABA TP shall be coded using Current Procedural Terminology² (CPT) procedure code 1181F meaning "Initial ABA assessment to determine appropriate indication for ABA."

6.2.1 Appropriate indication to accompany initial ABA assessment with initial ABA TP. The following three **G** codes must be used in conjunction with CPT² procedure code 1181F for billing purposes when the initial ABA assessment concludes that ABA is appropriate and that an initial ABA TP with ABA TP goal(s) is developed:

- G8539 - code for the initial ABA assessment and initial ABA TP development per 15

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minute units of time

- G9165 - the current patient status code
- G9166 - the initial ABA TP goal code

Note: Use of three **G** codes (HCPCS codes G8539, G9165, and G9166) for one encounter follows CMS 2013 coding guidance for billing for services such as occupational therapy and physical therapy. Guidance is for these claims to be submitted on the CMS 1500; therefore, unlike electronic billing, standard use of codes is not required. TRICARE authorized behavioral health providers (psychologists, psychiatrists, etc) only providing psychometric testing should use CPT³ codes (96101 - 96103, and 96118 - 96120 per [Section 3.10](#)) for standardized developmental, mental, emotional, and behavioral screening instruments for NADFM who elect to participate in the ABA Pilot. BCBA's and BCBA-Ds who are not TRICARE authorized behavioral health providers must use the ABA assessment codes above for their standardized testing for NADFM who elect to participate in the ABA Pilot.

6.2.2 In the event that the initial ABA assessment concludes that ABA is not appropriate for the NADFM who elect to participate in the ABA Pilot, the BCBA, BCBA-D, or other TRICARE authorized ABA provider practicing within the scope of his/her state license or state certification will code CPT³ procedure code 1181F meaning "Initial assessment to determine appropriate indication for ABA" and HCPCS code G8542 meaning "No deficiencies identified for which ABA would provide medical benefit, care plan not required per 15 minutes" thus indicating that ABA is not appropriate.

6.3 ABA rendered by a TRICARE authorized ABA provider, in-person, for TRICARE eligible family member/caregiver ABA training for NADFM who elect to participate in the ABA Pilot shall be billed using HCPCS code S5110 meaning "TRICARE eligible family member/caregiver training." ABA training may only be provided to a TRICARE eligible family member/caregiver.

6.4 HCPCS code S5115 meaning "Beneficiary ABA by a TRICARE authorized provider" shall be used for ABA provided directly to the beneficiary receiving ABA by a TRICARE authorized ABA provider listed in [paragraph 5.8](#) regardless of the setting where the ABA is provided.

6.5 ABA repeat assessment and ABA TP updates for NADFM who elect to participate in the ABA Pilot: ABA repeat assessments to determine beneficiary's progress and development of the ABA TP update prior to each reauthorization period shall be coded using CPT³ code 1450F meaning "Reassessment of symptoms for possible ABA. The three **G** codes identified below must be used in conjunction with CPT³ procedure code 1450F for claims processing/billing purposes:

- G8539 - ABA repeat assessment and ABA TP update (same code used for initial ABA assessment and initial ABA TP) per 15 minute units of time
- G9165 - current patient status code (same code as required during the initial assessment and initial ABA TP development)
- G9166 - ABA TP goal update code (the same code is used for initial ABA TP goal)

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Note: Use of the three **G** codes (HCPCS codes G8539, G9165, and G9166) for one encounter follows CMS 2013 coding guidance for billing for services such as occupational therapy and physical therapy.

6.6 Discharge from ABA for NADFM who elect to participate in the ABA Pilot. If upon BCBA, BCBA-D, or other TRICARE authorized ABA provider repeat assessment, it is determined that the beneficiary is to be discharged from ABA, CPT⁴ procedure code 1450F is to be used in conjunction with the following two **G** codes:

- G8542 - continued ABA is not indicated
- G9167 - discharge from ABA

6.7 Reimbursement of claims for NADFM who elect to participate in the ABA Pilot shall be the lesser of:

6.7.1 The CHAMPUS Maximum Allowable Charge (CMAC); that is the CHAMPUS national pricing system built on established CPT/HCPCS codes and based on Medicare or TRICARE claims data (at this time there are no CPT/HCPCS codes or CMAC rates for ABA);

6.7.2 The prevailing local market rate;

6.7.3 One hundred and twenty-five dollars (\$125) per hour for ABA specified in [paragraph 5.10](#) provided by the TRICARE authorized ABA provider listed in [paragraph 5.8](#); or

6.7.4 The negotiated rate; or

6.7.5 The billed charge.

6.8 ABA for NADFM who elect to participate in the ABA Pilot is a specialty service under the TRICARE Basic Program requiring a specialty referral; therefore, specialty care cost-shares apply.

- ABA for NADFM who elect to participate in the ABA Pilot is an outpatient service. However, ABA is not “an outpatient behavioral health” service; therefore, outpatient behavioral health benefit rules do not apply. ABA is not subject to the two visits per week limit that applies to outpatient behavioral health visits. ABA is comprised of specialized interventions per [paragraph 4.3](#) provided up to several hours a day and up to five days (Monday - Friday) a week.

6.9 BCBA, BCBA-D, or other TRICARE authorized ABA provider supervision of BCaBAs and ABA Tutors to include discussions of the ABA TPs, progress, and follow-up ABA assessments shall be billed under the ABA Pilot for NADFM who elect to participate in the ABA Pilot.

6.10 The MCSCs shall ensure all TRICARE Encounter Data (TED) requirements outlined in the TRICARE Systems Manual (TSM), [Chapter 2](#) are met including appropriate use of Special Processing Code “AP Applied Behavior Analysis (ABA) Pilot” for NADFM who elect to participate in the ABA Pilot.

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7.0 EXCLUSIONS

The following exclusions apply to provision of ABA under the TRICARE Basic Program for NADFM who elect to participate in the ABA Pilot:

- ABA provided in a group format.
- ABA rendered by a TRICARE authorized provider type other than those authorized to provide ABA under this Chapter.
- ABA rendered by an ABA provider not authorized and certified under TRICARE.
- ABA for all other diagnoses that are not an ASD/PDD.
- Educational and vocational rehabilitation services.
- Respite care.
- ABA not provided one-on-one, in person by the TRICARE authorized BCBA or BCBA-D.
- ABA provided through remote means, for example through telemedicine/telehealth.
- ABA provided when there is no ASD diagnosis rendered by a TRICARE authorized ASD diagnosing provider as specified in [paragraph 5.6](#).
- ABA provided when there is no ABA referral from a TRICARE authorized ASD referring provider as specified in [paragraph 5.7](#).
- ABA provided by a BCBA, BCBA-D, or other TRICARE authorized ABA provider (unless the ABA provider is a licensed clinical psychologist) when there is no supervision by the TRICARE authorized ASD referring provider as required in [paragraph 9.0](#) of this policy.
- ABA provided when there is no baseline and 180 day interval follow-up psychometric testing.
- ABA involving aversive techniques or rewards that can be construed as abuse.

8.0 CREDENTIALING OF APPLIED BEHAVIOR ANALYSTS

8.1 Master's degree or above BCBAs or BCBA-Ds and other ABA providers practicing within the scope of their state license or state certification meeting the requirements for TRICARE Basic Program providers are encouraged to become a TRICARE network provider. Requirements for credentials review for network providers apply. Master's degree or above BCBAs or BCBA-Ds and other ABA providers practicing within the scope of their state license or state certification who do not wish to become part of the TRICARE network may become TRICARE authorized non-network providers. These non-network BCBAs or BCBA-Ds and other TRICARE authorized ABA providers practicing within the scope of their state license or state certification shall undergo a modified

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credentials review process that shall include review of state licensure or state certification status (if applicable), a review BCBA board certification by the BACB, a check of BACB complaints section of the BACB web site or a review for complaints to state license or certification boards, and a criminal history review (see the TOM, [Chapter 4, Section 1](#)). The credentials of the non-network BCBAs or BCBA-Ds and other TRICARE authorized ABA providers practicing within the scope of their state license or state certification shall be reviewed every three years to ensure that credentials are still valid and that no adverse actions have been taken by the BACB or applicable practice jurisdiction against the BCBA, BCBA-D, or other TRICARE authorized ABA providers practicing within the scope of their state license or state certification.

8.2 All claims submitted by the BCBA, BCBA-D, or other TRICARE authorized ABA providers practicing within the scope of their state license or state certification for ABA for NADFM who elect to participate in the ABA Pilot shall use the HIPAA taxonomy (provider code) 103K00000X, Behavior Analyst.

9.0 REFERRAL AND SUPERVISION OF APPLIED BEHAVIOR ANALYSTS

9.1 The referring P-PCM or specialized ASD provider as defined in [paragraphs 5.6](#) and [5.7](#) is required to provide referral and supervision of the BCBA ABA (unless the BCBA-D is a licensed clinical psychologist) for NADFM who elect to participate in the ABA Pilot.

9.1.1 Referral and supervision (see [paragraph 4.6](#)) means that the referring provider shall actually see the beneficiary to evaluate the qualifying ASD condition prior to referring the beneficiary to the BCBA, BCBA-D, or other TRICARE authorized ABA provider practicing within the scope of his/her state license or state certification, and that the referring provider provides ongoing oversight of the course of referral-related ABA throughout the period that the beneficiary is receiving ABA in response to the referral.

9.1.2 The referring provider is not required to be physically located on the premises of the BCBA, BCBA-D, or other TRICARE authorized ABA provider.

9.2 The BCBA, BCBA-D, other TRICARE authorized ABA provider (practicing within the scope of his/her state license or state certification), or MCSC shall send the referring P-PCM or specialized ASD provider as defined in [paragraphs 5.6.1.1](#) and [5.6.1.2](#) the initial ABA assessment, the ABA TP, and all ABA TP updates and shall respond to referring provider questions regarding the ABA TP for NADFM who elect to participate in the ABA Pilot. All ABA providers and referring providers shall maintain clinical records in accordance with medical records requirements set forth under the TRICARE Basic Program.

9.3 The TRICARE authorized provider administering the baseline and every 180 day psychometric testing shall send the reports of psychometric findings to the referring P-PCM or specialized (non-psychologist) ASD provider (as defined in [paragraphs 5.6.1.1](#) and [5.6.1.2](#)) and the MCSC for NADFM who elect to participate in the ABA Pilot.

9.4 The MCSC shall require the BCBA, BCBA-D, or other TRICARE authorized ABA provider (practicing within the scope of his/her state license or state certification) to send the initial ABA TP and the ABA TP annual updates to the MCSC no later than one month prior to current authorization

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expiration for NADFM who elect to participate in the ABA Pilot. The MCSC shall transmit the ABA TP to the referring provider.

9.5 The referring P-PCM or specialized ASD provider shall review and sign the initial ABA TP, all ABA TP updates and the baseline and every 180 day psychometric testing reports for NADFM who elect to participate in the ABA Pilot.

9.6 The referring P-PCM or specialized ASD provider shall review the initial ABA TP, all ABA TP updates and the psychometric testing reports with the TRICARE eligible family member/caregiver and the beneficiary directly receiving ABA during the annual clinic visits for NADFM who elect to participate in the ABA Pilot. The provider shall write a new referral for repeat psychometric testing to assess progress (every 180 days) and for continued ABA (annually) if the psychometric testing reports support continued appropriate ABA.

10.0 QUALITY ASSURANCE (QA)

10.1 Given that ABA involves provision of care to a vulnerable patient population, the MCSC/TOP/Uniformed Services Family Health Plan (USFHP) contractor shall have a process in place for evaluating and resolving TRICARE eligible family member/caregiver concerns regarding ABA provided by the BCBA, the BCBA-Ds or other TRICARE authorized ABA providers (practicing within the scope of their state license or state certification). This includes ABA reinforcement provided under the supervision of such ABA providers under the ABA Pilot.

10.2 The process shall include identification of a beneficiary family member/caregiver complaint officer for each regional MCSC/TOP/USFHP contractor. Contact information shall be provided to all TRICARE eligible family member/caregivers of beneficiaries receiving ABA under the TRICARE Basic Program.

10.3 Allegations of risk to patient safety must be reported to the MCSC Program Integrity (PI) unit and **Defense Health Agency (DHA)** PI must also be advised of alleged risk to patient safety by a provider of ABA. The MCSC PI unit must take action in accordance with the TOM, [Chapter 13](#), developing for potential patient harm, fraud, and abuse issues.

10.4 Potential complaints shall be ranked by severity categories. Allegations involving risk to patient safety are to be considered the most severe and shall be addressed immediately and reported to the required agencies. For example, allegations of physical, psychological or sexual abuse shall be addressed through immediate reporting to state Child Protective Services, to the BACB and to state license or certification boards as indicated, in accordance with other governing laws, regulations, policies and mandated reporting requirements.

10.5 TRICARE may not cost-share services of a BCBA, BCBA-D, or other TRICARE authorized ABA provider practicing within the scope of their state license or state certification who has any restriction on their certification imposed by the BACB or any restriction on their state license or certification for those having a state license or certification.

10.6 Potential categories requiring quality monitoring and oversight are, but not limited to:

- Fraudulent billing practices;
- Lack of progress due to poor quality of ABA;
- Lack of an ASD diagnosis from a provider qualified to provide such per [paragraph 5.6](#);
- Lack of an ABA referral from a TRICARE authorized ASD referring provider as per [paragraph 5.7](#);
- Lack of the required psychometric testing reports for baseline and every 180 day monitoring of ABA progress as per [paragraphs 5.7.3](#) and [5.7.4](#); and/or
- Lack of maintenance of the required medical record documentation.
 - Billing for office supplies to include therapeutic supplies.
 - Billing for ABA using aversive techniques.

10.7 Risk management policies and processes shall be established by the MCSCs for the BCBA, BCBA-Ds and other TRICARE authorized ABA providers practicing within the scope of their state license or state certification.

11.0 QUALITY OVERSIGHT MONITORING

11.1 Clinical requirements for documentation on the initial ABA TP and ABA TP updates shall be defined by the TRICARE Regional Offices to establish enterprise-wide documentation standards. See http://www.bacb.com/Downloadfiles/ABA_Guidelines_for_ASD.pdf, Guidelines: Health Plan Coverage of ABA Treatment for ASD (2012). Documentation requirements shall address the requirements for:

- Session progress notes that identify the specific ABA intervention used for each behavioral target;
- At minimum, progress notes should contain the following documentation elements in compliance with [Chapter 1, Section 5.1](#), "Requirements For Documentation Of Treatment In Medical Records":
 - Date and time of session
 - Length of session
 - Current status of beneficiary
 - Content of the session
 - Therapeutic interventions delivered
 - Beneficiary response to interventions
 - Beneficiary progress toward meeting each objective and goal

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- TP update assessment notes addressing progress toward short-term and long-term treatment goals for the identified targets in each domain;
- Documentation on the initial ABA TP and the ABA TP updates of the level of support required for the beneficiary to demonstrate progress toward short and long-term goals (Note: The level of support required to demonstrate progress is important because it is directly associated with severity of the ASD and is an important factor in determining the number of hours of ABA per week to authorize);
- Documentation of baseline and thereafter every 180 days for ABA progress as measured by the age appropriate required standardized psychometric testing (VBS-II); and
- Documentation of TRICARE eligible family member/caregiver engagement and implementation of the ABA TP at home.

11.2 The TRICARE Quality Monitoring Contractor (TQMC) shall perform random record review for coding compliance and quality monitoring of the ABA TP every 180 days. TQMC findings of improper coding compliance shall be reported to the MCSC PI unit for potential development in accordance with the TOM, [Chapter 13](#).

12.0 EFFECTIVE DATE

Requirements of this revised policy are effective July 25, 2013. Claims for ABA prior to July 25, 2013, will continue to be paid in accordance with the guidance provided in TPM, Change 73, published on August 10, 2012.

- END -

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Appendix A

Acronyms And Abbreviations

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
CCSW	Certified Clinical Social Worker
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

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Acronyms And Abbreviations

CEA	Carotid Endarterectomy
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

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Acronyms And Abbreviations

CMS	Centers for Medicare and Medicaid Services
CMVP	Cryptographic Module Validation Program
CNM	Certified Nurse Midwife
CNS	Central Nervous System Clinical Nurse Specialist
CO	Contracting Officer
COB	Close of Business Coordination of Benefits
COBC	Coordination of Benefits Contractor
COBRA	Consolidated Omnibus Budget Reconciliation Act
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

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CSE	Communications Security Establishment (of the Government of Canada)
CSP	Corporate Service Provider Critical Security Parameter
CST	Central Standard Time
CSU	Channel Sending Unit
CSV	Comma-Separated Value
CSW	Clinical Social Worker
CT	Central Time Computerized Tomography
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

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DE	Durable Equipment
DECC	Defense Enterprise Computing Center
DED	Dedicated Emergency Department
DEERS	Defense Enrollment Eligibility Reporting System
DELM	Digital Epiluminescence Microscopy
DENC	Detailed Explanation of Non-Concurrence
DepSecDef	Deputy Secretary of Defense
DES	Data Encryption Standard Disability Evaluation System
DFAS	Defense Finance and Accounting Service
DG	Diagnostic Group
DGH	Denver General Hospital
DHA	Defense Health Agency
DHA-GL	Defense Health Agency-Great Lakes (formerly Military Medical Support Office (MMSO))
DHHS	Department of Health and Human Services
DHP	Defense Health Program
DHS	Department of Homeland Security
DIA	Defense Intelligence Agency
DIACAP	DoD Information Assurance Certification And Accreditation Process
DII	Defense Information Infrastructure
DIS	Defense Investigative Service
DISA	Defense Information System Agency
DISCO	Defense Industrial Security Clearance Office
DISN	Defense Information Systems Network
DISP	Defense Industrial Security Program
DITSCAP	DoD Information Technology Security Certification and Accreditation Process
DLAR	Defense Logistics Agency Regulation
DLE	Dialyzable Leukocyte Extract ⁰
DLI	Donor Lymphocyte Infusion
DM	Disease Management
DMDC	Defense Manpower Data Center
DME	Durable Medical Equipment
DMEPOS	Durable medical equipment, prosthetics, orthotics, and supplies
DMI	DMDC Medical Interface
DMIS	Defense Medical Information System
DMIS-ID	Defense Medical Information System Identification (Code)
DMLSS	Defense Medical Logistics Support System
DMR	Direct Member Reimbursement
DMZ	Demilitarized Zone
DNA	Deoxyribonucleic Acid
DNA-HLA	Deoxyribonucleic Acid - Human Leucocyte Antigen

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Acronyms And Abbreviations

DNACI	DoD National Agency Check Plus Written Inquiries
DO	Doctor of Osteopathy Operations Directorate
DOB	Date of Birth
DOC	Dynamic Orthotic Cranioplasty (Band)
DoD	Department of Defense
DoD AI	Department of Defense Administrative Instruction
DoDD	Department of Defense Directive
DoDI	Department of Defense Instruction
DoDIG	Department of Defense Inspector General
DoDM	Department of Defense Manual
DoD P&T	Department of Defense Pharmacy and Therapeutics (Committee)
DOE	Department of Energy
DOEBA	Date of Earliest Billing Action
DOES	DEERS Online Enrollment System
DOHA	Defense Office of Hearings and Appeals
DOJ	Department of Justice
DOLBA	Date of Latest Billing Action
DOS	Date Of Service
DP	Designated Provider
DPA	Differential Power Analysis
DPCLO	Defense Privacy and Civil Liberties Office
DPI	Designated Providers Integrator
DPO	DEERS Program Office
DPPO	Designated Provider Program Office
DRA	Deficit Reduction Act
DREZ	Dorsal Root Entry Zone
DRG	Diagnosis Related Group
DRPO	DEERS RAPIDS Program Office
DRS	Decompression Reduction Stabilization
DSA	Data Sharing Agreement
DSAA	Data Sharing Agreement Application Defense Security Assistance Agency
DSC	DMDC Support Center
DSCC	Data and Study Coordinating Center
DS Logon	DoD Self-Service Logon
DSM	Diagnostic and Statistical Manual of Mental Disorders
DSM-III	Diagnostic and Statistical Manual of Mental Disorders, Third Edition
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition
DSMC	Data and Safety Monitoring Committee
DSMO	Designated Standards Maintenance Organization
DSMT	Diabetes Self-Management Training

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DSO	DMDC Support Office
DSPOC	Dental Service Point of Contact
DSU	Data Sending Unit
DTF	Dental Treatment Facility
DTM	Directive-Type Memorandum
DTR	Derived Test Requirements
DTRO	Director, TRICARE Regional Office
DUA	Data Use Agreement
DVA	Department of Veterans Affairs
DVAHCF	Department of Veterans Affairs Health Care Finder
DVD	Digital Versatile Disc (formerly Digital Video Disc)
DVD-R	Digital Versatile Disc-Recordable
DWR	DSO Web Request
Dx	Diagnosis
DXA	Dual Energy X-Ray Absorptiometry
E-ID	Early Identification
E-NAS	Electronic Non-Availability Statement
e-QIP	Electronic Questionnaires for Investigations Processing
E&M	Evaluation & Management
E2R	Enrollment Eligibility Reconciliation
EACH	Essential Access Community Hospital
EAL	Common Criteria Evaluation Assurance Level
EAP	Employee-Assistance Program Ethandamine phosphate
EBC	Enrollment Based Capitation
ECA	External Certification Authority
ECAS	European Cardiac Arrhythmia Society
ECG	Electrocardiogram
ECHO	Extended Care Health Option
ECT	Electroconvulsive Therapy
ED	Emergency Department
EDC	Error Detection Code
EDI	Electronic Data Information Electronic Data Interchange
EDIPI	Electronic Data Interchange Person Identifier
EDIPN	Electronic Data Interchange Person Number
EDI_PN	Electronic Data Interchange Patient Number
EEG	Electroencephalogram
EEPROM	Erasable Programmable Read-Only Memory
EFD	Energy Flux Density
EFM	Electronic Fetal Monitoring
EFMP	Exceptional Family Member Program

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EFP	Environmental Failure Protection
eFRC	Electronic Federal Records Center
EFT	Electronic Funds Transfer
	Environmental Failure Testing
EGHP	Employer Group Health Plan
E/HPC	Enrollment/Health Plan Code
EHHC	ECHO Home Health Care
	Extended Care Health Option Home Health Care
EHP	Employee Health Program
EHRA	European Heart Rhythm Association
EIA	Educational Interventions for Autism Spectrum Disorders
EID	Early Identification
	Enrollment Information for Dental
EIDS	Executive Information and Decision Support
EIIP	External Insulin Infusion Pump
EIN	Employer Identification Number
EIP	External Infusion Pump
EKG	Electrocardiogram
ELN	Element Locator Number
ELISA	Enzyme-Linked Immunoabsorbent Assay
E/M	Evaluation and Management
EMC	Electronic Media Claim
	Enrollment Management Contractor
EMDR	Eye Movement Desensitization and Reprocessing
EMG	Electromyogram
eMSM	Enhanced Multi-Service Market
EMTALA	Emergency Medical Treatment & Active Labor Act
ENTNAC	Entrance National Agency Check
EOB	Explanation of Benefits
EOBs	Explanations of Benefits
EOC	Episode of Care
EOE	Evoked Otoacoustic Emission
EOG	Electro-oculogram
EOMB	Explanation of Medicare Benefits
EOP	Explanation of Payment
ePHI	electronic Protected Health Information
EPO	Erythropoietin
	Exclusive Provider Organization
EPR	EIA Program Report
EPROM	Erasable Programmable Read-Only Memory
ER	Emergency Room
ERA	Electronic Remittance Advice
ERISA	Employee Retirement Income and Security Act of 1974

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Acronyms And Abbreviations

ESRD	End Stage Renal Disease
EST	Eastern Standard Time
ESWT	Extracorporeal Shock Wave Therapy
ET	Eastern Time
ETIN	Electronic Transmitter Identification Number
EWPS	Enterprise Wide Provider System
EWRAS	Enterprise Wide Referral and Authorization System
F&AO	Finance and Accounting Office(r)
FAI	Femoroacetabular Impingement
FAP	Familial Adenomatous Polyposis
FAR	Federal Acquisition Regulations
FASB	Federal Accounting Standards Board
FBI	Federal Bureau of Investigation
FCC	Federal Communications Commission
FCCA	Federal Claims Collection Act
FDA	Food and Drug Administration
FDB	First Data Bank
FDL	Fixed Dollar Loss
Fed	Federal Reserve Bank
FEHBP	Federal Employee Health Benefit Program
FEL	Familial Erythrophagocytic Lymphohistiocytosis
FEV ₁	Forced Expiratory Volume
FFM	Foreign Force Member
FHL	Familial Hemophagocytic Lymphohistiocytosis
FI	Fiscal Intermediary
FIPS	Federal Information Processing Standards (or System)
FIPS PUB	FIPS Publication
FISH	Fluorescence In Situ Hybridization
FISMA	Federal Information Security Management Act
FL	Form Locator
FMCRA	Federal Medical Care Recovery Act
FMRI	Functional Magnetic Resonance Imaging
FOBT	Fecal Occult Blood Testing
FOC	Full Operational Capability
FOIA	Freedom of Information Act
FOUO	For Official Use Only
FPO	Fleet Post Office
FQHC	Federally Qualified Health Center
FR	Federal Register Frozen Records
FRC	Federal Records Center
FSH	Follicle Stimulating Hormone

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FSO	Facility Security Officer
FTC	Federal Trade Commission
FTE	Full Time Equivalent
FTP	File Transfer Protocol
FX	Foreign Exchange (lines)
FY	Fiscal Year
GAAP	Generally Accepted Accounting Principles
GAF	Geographic Adjustment Factor
GAO	General Accounting Office
GDC	Guglielmi Detachable Coil
GFE	Government Furnished Equipment
GHP	Group Health Plan
GHz	Gigahertz
GIFT	Gamete Intrafallopian Transfer
GIQD	Government Inquiry of DEERS
GP	General Practitioner
GPCI	Geographic Practice Cost Index
GTMCPA	General Temporary Military Contingency Payment Adjustment
H/E	Health and Environment
HAC	Health Administration Center Hospital Acquired Condition
HAVEN	Home Assessment Validation and Entry
HBA	Health Benefits Advisor
HBO	Hyperbaric Oxygen Therapy
HCC	Health Care Coverage
HCDP	Health Care Delivery Program
HCF	Health Care Finder
HCFA	Health Care Financing Administration
HCG	Human Chorionic Gonadotropin
HCIL	Health Care Information Line
HCM	Hypertrophic Cardiomyopathy
HCO	Healthcare Operations Division
HCP	Health Care Provider
HCPC	Healthcare Common Procedure Code (formerly HCFA Common Procedure Code)
HCPCS	Healthcare Common Procedure Coding System (formerly HCFA Common Procedure Coding System)
HCPR	Health Care Provider Record
HCSR	Health Care Service Record
HDC	High Dose Chemotherapy
HDC/SCR	High Dose Chemotherapy with Stem Cell Rescue
HDE	Humanitarian Device Exemption
HDGC	Hereditary Diffuse Gastric Cancer

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HDL	Hardware Description Language
HDR	High Dose Radiation
HEAR	Health Enrollment Assessment Review
HEDIS	Health Plan Employer Data and Information Set
HE ESWT	High Energy Extracorporeal Shock Wave Therapy
HepB-Hib	Hepatitis B and Hemophilus influenza B
HH	Home Health
HHA	Home Health Agency
HHA PPS	Home Health Agency Prospective Payment System
HHC	Home Health Care
HHC/CM	Home Health Care/Case Management
HHRG	Home Health Resource Group
HHS	Health and Human Services
HI	Health Insurance
HIAA	Health Insurance Association of America
HIC	Health Insurance Carrier
HICN	Health Insurance Claim Number
HINN	Hospital-Issued Notice Of Noncoverage
HINT	Hearing in Noise Test
HIPAA	Health Insurance Portability and Accountability Act (of 1996)
HIPEC	Hyperthermic Intraperitoneal Chemotherapy
HIPPS	Health Insurance Prospective Payment System
HIQH	Health Insurance Query for Health Agency
HITECH	Health Information Technology for Economic and Clinical Health
HIV	Human Immunodeficiency Virus
HL7	Health Level 7
HLA	Human Leukocyte Antigen
HMAC	Hash-Based Message Authentication Code
HMO	Health Maintenance Organization
HNPCC	Hereditary Non-Polyposis Colorectal Cancer
HOPD	Hospital Outpatient Department
HPA&E	Health Program Analysis & Evaluation
HPSA	Health Professional Shortage Area
HPV	Human Papilloma Virus
HRA	Health Reimbursement Arrangement
HRG	Health Resource Group
HRS	Heart Rhythm Society
HRT	Heidelberg Retina Tomograph Hormone Replacement Therapy
HSCRC	Health Services Cost Review Commission
HSWL	Health, Safety and Work-Life
HTML	HyperText Markup Language

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HTTP	HyperText Transfer (Transport) Protocol
HTTPS	Hypertext Transfer (Transport) Protocol Secure
HUAM	Home Uterine Activity Monitoring
HUD	Humanitarian Use Device
HUS	Hemolytic Uremic Syndrome
HVPT	Hyperventilation Provocation Test
IA	Information Assurance
IATO	Interim Approval to Operate
IAVA	Information Assurance Vulnerability Alert
IAVB	Information Assurance Vulnerability Bulletin
IAVM	Information Assurance Vulnerability Management
IAW	In accordance with
IBD	Inflammatory Bowel Disease
IC	Individual Consideration Integrated Circuit
ICASS	International Cooperative Administrative Support Services
ICD	Implantable Cardioverter Defibrillator
ICD-9-CM	International Classification of Diseases, 9th Revision, Clinical Modification
ICD-10-CM	International Classification of Diseases, 10th Revision, Clinical Modification
ICD-10-PCS	International Classification of Diseases, 10th Revision, Procedure Coding System
ICF	Intermediate Care Facility
ICMP	Individual Case Management Program
ICMP-PEC	Individual Case Management Program For Persons With Extraordinary Conditions
ICN	Internal Control Number
ICSP	Individual Corporate Services Provider
ID	Identification Identifier
IDB	Intradiscal Biacuplasty
IDD	Internal or Intervertebral Disc Decompression
IDE	Investigational Device Exemption Investigational Device
IDEA	Individuals with Disabilities Education Act
IDES	Integrated Disability Evaluation System
IDET	Intradiscal Electrothermal Therapy
IDME	Indirect Medical Education
IdP	Identity Protection
IDTA	Intradiscal Thermal Annuloplasty
IE	Interface Engine Internet Explorer
IEA	Intradiscal Electrothermal Annuloplasty
IEP	Individualized Educational Program
IFC	Interim Final Rule with comment
IFR	Interim Final Rule

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IFSP	Individualized Family Service Plan
IG	Implementation Guidance
IgA	Immunoglobulin A
IGCE	Independent Government Cost Estimate
IHC	Immunohistochemistry
IHI	Institute for Healthcare Improvement
IHS	Indian Health Service
IIHI	Individually Identifiable Health Information
IIP	Implantable Infusion Pump
IM	Information Management Instant Message/Messaging Intramuscular
IMRT	Intensity Modulated Radiation Therapy
IND	Investigational New Drugs
INR	International Normalized Ratio Intramuscular International Normalized Ratio
INS	Immigration and Naturalization Service
IOC	Initial Operational Capability
IOD	Interface Operational Description
IOLs	Intraocular Lenses
IOM	Internet Only Manual
IOP	Intraocular Pressure
IORT	Intra-Operative Radiation Therapy
IP	Inpatient
IPC	Information Processing Center (outdated term, see SMC)
IPHC	Intraperitoneal Hyperthermic Chemotherapy
IPN	Intraperitoneal Nutrition
IPP	In-Person Proofing
IPPS	Inpatient Prospective Payment System
IPS	Individual Pricing Summary
IPSEC	Secure Internet Protocol
IQ	Intelligence Quotient
IQM	Internal Quality Management
IRB	Institutional Review Board
IRF	Inpatient Rehabilitation Facility
IRR	Individual Ready Reserve
IRS	Internal Revenue Service
IRTS	Integration and Runtime Specification
IS	Information System
ISN	Investigation Schedule Notice
ISO	International Standard Organization
ISP	Internet Service Provider
IT	Information Technology

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ITSEC	Information Technology Security Evaluation Criteria
IV	Initialization Vector Intravenous
IVD	In Vitro Diagnostic Ischemic Vascular Disease
IVF	In Vitro Fertilization
JC	Joint Commission (formerly Joint Commission on Accreditation of Healthcare Organizations (JCAHO))
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
JCIH	Joint Committee on Infant Hearing
JCOS	Joint Chiefs of Staff
JFTR	Joint Federal Travel Regulations
JNI	Japanese National Insurance
JTF-GNO	Joint Task Force for Global Network Operations
JUSDAC	Joint Uniformed Services Dental Advisory Committee
JUSMAC	Joint Uniformed Services Medical Advisory Committee
JUSPAC	Joint Uniformed Services Personnel Advisory Committee
KB	Knowledge Base
KO	Contracting Officer
LAA	Limited Access Authorization
LAC	Local Agency Check
LAK	Lymphokine-Activated Killer
LAN	Local Area Network
LASER	Light Amplification by Stimulated Emission of Radiation
LCD	Local Coverage Determination
LCF	Long-term Care Facility
LCIS	Lobular Carcinoma In Situ
LDL	Low Density Lipoprotein
LDLT	Living Donor Liver Transplantation
LDR	Low Dose Rate
LDT	Laboratory Developed Test
LE ESWT	Low Energy Extracorporeal Shock Wave Therapy
LGS	Lennox-Gastaut Syndrome
LH	Luteinizing Hormone
LIS	Low Income Subsidy
LLLT	Low Level Laser Therapy
LNT	Lexical Neighborhood Test
LOC	Letter of Consent
LOD	Letter of Denial/Revocation Line of Duty
LOI	Letter of Intent
LOS	Length-of-Stay
LOT	Life Orientation Test

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LPN	Licensed Practical Nurse
LSIL	Low-grade Squamous Intraepithelial Lesion
LSN	Location Storage Number
LTC	Long-Term Care
LUPA	Low Utilization Payment Adjustment
LV	Left Ventricle [Ventricular]
LVEF	Left Ventricular Ejection Fraction
LVN	Licensed Vocational Nurse
LVRS	Lung Volume Reduction Surgery
LVSD	Left Ventricular Systolic Dysfunction
MAC	Maximum Allowable Charge Maximum Allowable Cost
MAC III	Mission Assurance Category III
MAID	Maximum Allowable Inpatient Day
MAP	MYH-Associated Polyposis
MB&RB	Medical Benefits and Reimbursement Branch
MBI	Molecular Breast Imaging
MCIO	Military Criminal Investigation Organization
MCS	Managed Care Support
MCSC	Managed Care Support Contractor
MCSS	Managed Care Support Services
MCTDP	Myelomeningocele Clinical Trial Demonstration Protocol
MD	Doctor of Medicine
MDI	Mental Developmental Index Multiple Daily Injection
MDR	MHS Data Repository
MDS	Minimum Data Set
MEB	Medical Evaluation Board
MEC	Marketing and Education Committee
MEI	Medicare Economic Index
MEPS	Military Entrance Processing Station
MEPRS	Medical Expense Performance Reporting System
MESA	Microsurgical Epididymal Sperm Aspiration
MET	Microcurrent Electrical Therapy
MFCC	Marriage and Family Counseling Center
MGCRB	Medicare Geographic Classification Review Board
MGIB	Montgomery GI Bill
MH	Mental Health
MHCC	Maryland Health Care Commission
MHO	Medical Holdover
MHS	Military Health System
MHSO	Managing Health Services Organization

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MHSS	Military Health Services System
MI	Myocardial Infarction
MI&L	Manpower, Installations, and Logistics
MIA	Missing In Action
MIAP	Multi-Host Internet Access Portal
MIDCAB	Minimally Invasive Direct Coronary Artery Bypass
mild®	Minimally Invasive Lumbar Decompression
MIRE	Monochromatic Infrared Energy
MLNT	Multisyllabic Lexical Neighborhood Test
MMA	Medicare Modernization Act
MMEA	Medicare and Medicaid Extenders Act (of 2010)
MMP	Medical Management Program
MMPCMHP	Maryland Multi-Payer Patient-Centered Medical Home Program
MMPP	Maryland Multi-Payer Patient
MMR	Mismatch Repair
MMWR	Morbidity and Mortality Weekly Report
MNR	Medical Necessity Report
MOA	Memorandum of Agreement
MOH	Medal Of Honor
MOMS	Management of Myelomeningocele Study
MOP	Mail Order Pharmacy
MOU	Memorandum of Understanding
MPC	Medical Payments Coverage
MPI	Master Patient Index
MR	Magnetic Resonance Medical Review Mentally Retarded
MRA	Magnetic Resonance Angiography
MRHFP	Medicare Rural Hospital Flexibility Program
MRI	Magnetic Resonance Imaging
MRPU	Medical Retention Processing Unit
MRS	Magnetic Resonance Spectroscopy
MS	Microsoft® Multiple Sclerosis
MSA	Metropolitan Statistical Area
MSC	Military Sealift Command
MSI	Microsatellite Instability
MSIE	Microsoft® Internet Explorer
MSP	Medicare Secondary Payer
MSS	Medical Social Services
MST	Mountain Standard Time
MSUD	Maple Syrup Urine Disease

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MSW	Masters of Social Work Medical Social Worker
MT	Mountain Time
MTF	Military Treatment Facility
MUE	Medically Unlikely Edits
MV	Multivisceral (transplant)
MVS	Multiple Virtual Storage
MWR	Morale, Welfare, and Recreation
MYH	mutY homolog
N/A	Not Applicable
N/D	No Default
NAC	National Agency Check
NACHA	National Automated Clearing House Association
NACI	National Agency Check Plus Written Inquiries
NACLC	National Agency Check with Law Enforcement and Credit
NADFM	Non-Active Duty Family Member
NARA	National Archives and Records Administration
NAS	Naval Air Station Non-Availability Statement
NATO	North Atlantic Treaty Organization
NAVMED	Naval Medical (Form)
NBCC	National Board of Certified Counselors
NCCI	National Correct Coding Initiatives
NCCN	National Comprehensive Cancer Network
NCD	National Coverage Determination
NCE	National Counselor Examination
NCF	National Conversion Factor
NCI	National Cancer Institute
NCMHCE	National Clinical Mental Health Counselor Examination
NCPAP	Nasal Continuous Positive Airway Pressure
NCPDP	National Council of Prescription Drug Program
NCQA	National Committee for Quality Assurance
NCVHS	National Committee on Vital and Health Statistics
NDAA	National Defense Authorization Act
NDC	National Drug Code
NDMS	National Disaster Medical System
NED	National Enrollment Database
NETT	National Emphysema Treatment Trial
NF	Nursing Facility
NG	National Guard
NGPL	No Government Pay List
NHLBI	National Heart, Lung and Blood Institute

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NHSC	National Health Service Corps
NICHHD	National Institute of Child Health and Human Development
NIH	National Institutes of Health
NII	Networks and Information Integration
NIPRNET	Nonsecure Internet Protocol Router Network
NIS	Naval Investigative Service
NISPOM	National Industrial Security Program Operating Manual
NIST	National Institute of Standards and Technology
NLDA	Nursery and Labor/Delivery Adjustment
NLT	No Later Than
NMA	Non-Medical Attendant
NMES	Neuromuscular Electrical Stimulation
NMOP	National Mail Order Pharmacy
NMR	Nuclear Magnetic Resonance
NMT	Nurse Massage Therapist
NOAA	National Oceanic and Atmospheric Administration
NoPP	Notice of Private Practices
NOSCASTC	National Operating Standard Cost as a Share of Total Costs
NP	Nurse Practitioner
NPDB	National Practitioner Data Bank
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
NPR	Notice of Program Reimbursement
NPS	Naval Postgraduate School
NPWT	Negative Pressure Wound Therapy
NQF	National Quality Forum
NRC	Nuclear Regulatory Commission
NRS	Non-Routine [Medical] Supply
NSDSMEP	National Standards for Diabetes Self-Management Education Programs
NSF	Non-Sufficient Funds
NTIS	National Technical Information Service
NUBC	National Uniform Billing Committee
NUCC	National Uniform Claims Committee
O/ATIC	Operations/Advanced Technology Integration Center
OA	Office of Administration
OAE	Otoacoustic Emissions
OASD(HA)	Office of the Assistant Secretary of Defense (Health Affairs)
OASD (H&E)	Office of the Assistant Secretary of Defense (Health and Environment)
OASD (MI&L)	Office of the Assistant Secretary of Defense (Manpower, Installations, and Logistics)
OASIS	Outcome and Assessment Information Set
OB/GYN	Obstetrician/Gynecologist

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OBRA	Omnibus Budget Reconciliation Act
OCE	Outpatient Code Editor
OCHAMPUS	Office of Civilian Health and Medical Program of the Uniformed Services
OCMO	Office of the Chief Medical Officer
OCONUS	Outside of the Continental United States
OCR	Office for Civil Rights Optical Character Recognition
OCSP	Organizational Corporate Services Provider
OCT	Optical Coherence Tomograph
OD	Optical Disk
OF	Optional Form
OGC	Office of General Counsel
OGC-AC	Office of General Counsel-Appeals, Hearings & Claims Collection Division
OGP	Other Government Program
OHI	Other Health Insurance
OHS	Office of Homeland Security
OIG	Office of Inspector General
OIT	Oral Immunotherapy
OLT	Orthotopic Liver Transplantation
OMB	Office of Management and Budget
OP/NSP	Operation/Non-Surgical Procedure
OPD	Outpatient Department
OPM	Office of Personnel Management
OPPS	Outpatient Prospective Payment System
OR	Operating Room
OSA	Obstructive Sleep Apnea
OSAS	Obstructive Sleep Apnea Syndrome
OSD	Office of the Secretary of Defense
OSHA	Occupational Safety and Health Act
OSS	Office of Strategic Services
OT	Occupational Therapy (Therapist)
OTC	Over-The-Counter
OTCD	Ornithine Transcarbamylase Deficiency
OUSD	Office of the Undersecretary of Defense
OUSD (P&R)	Office of the Undersecretary of Defense (Personnel and Readiness)
P/O	Prosthetic and Orthotics
P&CL	Privacy & Civil Liberties [Office]
P&T	Pharmacy And Therapeutics (Committee)
PA	Physician Assistant
PACAB	Port Access Coronary Artery Bypass
PACO ₂	Partial Pressure of Carbon Dioxide
PAO ₂	Partial Pressure of Oxygen

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PAK	Pancreas After Kidney (transplant)
PAP	Papanicolaou
PAS	Privacy Act Statement
PAT	Performance Assessment Tracking
PATH Intl	Professional Association of Therapeutic Horsemanship International
PatID	Patient Identifier
PAVM	Pulmonary Arteriovenous Malformation
PBM	Pharmacy Benefit Manager
PBT	Proton Beam Therapy
PC	Peritoneal Carcinomatosis Personal Computer Professional Component
PCA	Patient Controlled Analgesia
PCDIS	Purchased Care Detail Information System
PCI	Percutaneous Coronary Intervention
PCM	Primary Care Manager
PCMBN	PCM By Name
PCMH	Patient-Centered Medical Home
PCMRA	PCM Research Application
PCMRS	PCM Panel Reassignment (Application) PCM Reassignment System
PCO	Procurement (Procuring) Contracting Officer
PCP	Primary Care Physician Primary Care Provider
PCS	Pelvic Congestion Syndrome Permanent Change of Station
PCSIB	Purchased Care Systems Integration Branch
PD	Passport Division
PDA	Patent Ductus Arteriosus Personal Digital Assistant
PDD	Percutaneous (or Plasma) Disc Decompression
PDDBI	Pervasive Developmental Disorders Behavior Inventory
PDDNOS	Pervasive Developmental Disorder Not Otherwise Specified
PDF	Portable Document Format
PDI	Potentially Disqualifying Information
PDQ	Physicians's Data Query
PDR	Person Data Repository
PDS	Person Demographics Service
PDTS	Pharmacy Data Transaction System
PDX	Principal Diagnosis
PE	Physical Examination
PEC	Pharmacoeconomic Center
PEP	Partial Episode Payment

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PEPR	Patient Encounter Processing and Reporting
PERMS	Provider Education and Relations Management System
PESA	Percutaneous Epididymal Sperm Aspiration
PET	Positron Emission Tomography
PFCRA	Program Fraud Civil Remedies Act
PFP	Partnership For Peace
PFPWD	Program for Persons with Disabilities
PGD	Preimplantation Genetic Diagnosis
Phen-Fen	Pondimin and Redux
PHI	Protected Health Information
PHIMT	Protected Health Information Management Tool
PHP	Partial Hospitalization Program
PHS	Public Health Service
PI	Program Integrity (Office)
PIA	Privacy Impact Assessment (Online)
PIC	Personnel Investigation Center
PIE	Pulsed Irrigation Evacuation
PII	Personally Identifiable Information
PIN	Personnel Identification Number
PIP	Personal Injury Protection Personnel Identity Protection
PIRFT	Percutaneous Intradiscal Radiofrequency Thermocoagulation (PIRFT)
PIT	PCM Information Transfer
PIV	Personal Identity Verification
PK	Public Key
PKE	Public Key Enabling
PKI	Public Key Infrastructure
PKU	Phenylketonuria
PLS	Preschool Language Scales
PM-DRG	Pediatric Modified-Diagnosis Related Group
PMPM	Per Member Per Month
PMR	Percutaneous Myocardial Laser Revascularization
PNET	Primitive Neuroectodermal Tumors
PNT	Policy Notification Transaction
POA	Power of Attorney Present On Admission
POA&M	Plan of Action and Milestones
POC	Pharmacy Operations Center Plan of Care Point of Contact
POL	May 1996 TRICARE/CHAMPUS Policy Manual 6010.47-M

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POS	Point of Sale (Pharmacy only) Point of Service Public Official's Statement
POV	Privately Owned Vehicle
PPACA	Patient Protection and Affordable Care Act
PPC-PCMH	Physician Practice Connections Patient-Centered Medical Home
PPD	Per Patient Day
PPN	Preferred Provider Network
PPO	Preferred Provider Organization
PPP	Purchasing Power Parity
PPS	Prospective Payment System Ports, Protocols and Services
PPSM	Ports, Protocols, and Service Management
PPV	Pneumococcal Polysaccharide Vaccine
PQI	Potential Quality Indicator Potential Quality Issue
PR	Periodic Reinvestigation
PRC	Program Review Committee
PRFA	Percutaneous Radiofrequency Ablation
PRG	Peer Review Group
PRO	Peer Review Organization
ProDUR	Prospective Drug Utilization Review
PROM	Programmable Read-Only Memory
PRP	Personnel Reliability Program
PRPP	Pharmacy Redesign Pilot Project
PSA	Prime Service Area Physician Scarcity Area
PSAB	Personnel Security Appeals Board
PSCT	Peripheral Stem Cell Transplantation
PSD	Personnel Security Division
PSF	Provider Specific File
PSG	Polysomnography
PSI	Personnel Security Investigation
PST	Pacific Standard Time
PT	Pacific Time Physical Therapist Physical Therapy Prothrombin Time
PTA	Pancreas Transplant Alone Percutaneous Transluminal Angioplasty
PTC	Processed To Completion
PTCA	Percutaneous Transluminal Coronary Angioplasty
PTK	Phototherapeutic Keratectomy

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PTNS	Posterior Tibial Nerve Stimulation
PTSD	Post-Traumatic Stress Disorder
PVCs	Premature Ventricular Contractions
QA	Quality Assurance
QABA	Qualified Applied Behavior Analysis
QASP	Qualified Autism Services Practitioner
QC	Quality Control
QI	Quality Improvement Quality Issue
QII	Quality Improvement Initiative
QIO	Quality Improvement Organization
QIP	Quality Improvement Program
QLE	Qualifying Life Event
QM	Quality Management
QUIG	Quality Indicator Group
RA	Radiofrequency Annuloplasty Remittance Advice
RADDP	Remote Active Duty Dental Program
RAM	Random Access Memory
RAP	Request for Anticipated Payment
RAPIDS	Real-Time Automated Personnel Identification System
RARC	Remittance Advice Remark Code
RBT	Registered Behavior Technician
RC	Reserve Component
RCC	Recurring Credit/Debit Charge Renal Cell Carcinoma
RCCPDS	Reserve Component Common Personnel Data System
RCN	Recoupment Case Number Refund Control Number
RCS	Report Control Symbol
RD	Regional Director Registered Dietitian
RDBMS	Relational Database Management System
RDDDB	Reportable Disease Database
REM	Rapid Eye Movement
RF	Radiofrequency
RFA	Radiofrequency Ablation
RFI	Request For Information
RFP	Request For Proposal
RHA	Records Holding Area
RHC	Rural Health Clinic
RHHI	Regional Home Health Intermediary
RhoGAM	RRho (D) Immune Globulin

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RIA	Radioimmunoassay
RM	Records Management
RN	Registered Nurse
RNG	Random Number Generator
RO	Regional Office
ROC	Resumption of Care
ROFR	Right of First Refusal
ROM	Read-Only Memory Rough Order of Magnitude
ROMF	Record Object Metadata File
ROT	Read-Only Table
ROTC	Reserved Officer Training Corps
ROVER	RHHI OASIS Verification
RPM	Record Processing Mode
RRA	Regional Review Authority
RRS	Records Retention Schedule
RTC	Residential Treatment Center
rTMS	Repetitive Transcranial Magnetic Stimulation
RUG	Resource Utilization Group
RV	Residual Volume Right Ventricle [Ventricular]
RVU	Relative Value Unit
SAAR	System Authorization Access Request
SAD	Seasonal Affective Disorder
SADMERC	Statistical Analysis Durable Medical Equipment Regional Carrier
SAFE	Sexual Assault Forensic Examination
SAMHSA	Substance Abuse and Mental Health Services Administration
SAO	Security Assistant Organizations
SAP	Special Access Program
SAPR	Sexual Assault Prevention and Response
SAS	Sensory Afferent Stimulation
SAT	Service Assist Team
SAVR	Surgical Aortic Valve Replacement
SBCC	Service Branch Classification Code
SBI	Special Background Investigation
SCA	Service Contract Act
SCH	Sole Community Hospital
SCHIP	State Children's Health Insurance Program
SCI	Sensitive Compartmented Information Spinal Cord Injury
SCIC	Significant Change in Condition
SCOO	Special Contracts and Operations Office
SCR	Stem Cell Rescue

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S/D	Security Division
SD (Form)	Secretary of Defense (Form)
SEP	Sensory Evoked Potentials
SES	Senior Executive Service
SelRes	Selected Reserve
SF	Standard Form
SFTP	Secure File Transfer Protocol
SGDs	Speech Generating Devices
SHCP	Supplemental Health Care Program
SI	Sensitive Information Small Intestine (transplant) Special Indicator (code) Status Indicator
SIDS	Sudden Infant Death Syndrome
SIF	Source Input Format
SII	Special Investigative Inquiry
SI/L	Small Intestine-Live (transplant)
SIOP-ESI	Single Integrated Operational plan-Extremely Sensitive Information
SIP	System Identification Profile
SIRT	Selective Internal Radiation Therapy
SIT	Standard Insurance Table
SLP	Speech-Language Pathology
SMC	System Management Center
SMHC	Supervised Mental Health Counselor
SN	Skilled Nursing
SNF	Skilled Nursing Facility
SNS	Sacral Nerve Root Stimulation
SOC	Start of Care
SOFA	Status Of Forces Agreement
SOIC	Senior Officer of the Intelligence Community
SON	Submitting Office Number
SOR	Statement of Reasons System of Records
SORN	System of Records Notice
SPA	Simple Power Analysis
SPC	Special Processing Code
SPECT	Single Photon Emission Computed Tomography
SPK	Simultaneous Pancreas Kidney (transplant)
SPOC	Service Point of Contact
SPR	SECRET Periodic Reinvestigation
SQL	Structured Query Language
SRE	Serious Reportable Event

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SSA	Social Security Act Social Security Administration
SSAA	Social Security Authorization Agreement
SSAN	Social Security Administration Number
SSBI	Single-Scope Background Investigation
SSDI	Social Security Disability Insurance
SSL	Secure Socket Layer
SSM	Site Security Manager
SSN	Social Security Number
SSO	Short-Stay Outlier
ST	Speech Therapy
STF	Specialized Treatment Facility
STS	Specialized Treatment Services
STSF	Specialized Treatment Service Facility
SUBID	Sub-Identifier
SUD	Substance Use Disorder
SUDRF	Substance Use Disorder Rehabilitation Facility
SVO	SIT Validation Office
SVP	State Vaccine Program State Vaccine Program entity
SVT	Supraventricular Tachycardia
SWLS	Satisfaction With Life Scale
T-3	TRICARE Third Generation
TAD	Temporary Additional Duty
TAFIM	Technical Architecture Framework for Information Management
TAH	Total Artificial Heart
TAMP	Transitional Assistance Management Program
TAO	TRICARE Alaska Office TRICARE Area Office
TAR	Total Ankle Replacement
TARO	TRICARE Alaska Regional Office
TAVR	Transcatheter Aortic Valve Replacement
TB	Tuberculosis
TBD	To Be Determined
TBE	Tick Borne Encephalitis
TBI	Traumatic Brain Injury
TC	Technical Component
TCMHC	TRICARE Certified Mental Health Counselor
TCP/IP	Transmission Control Protocol/Internet Protocol
TCSRC	Transitional Care for Service-Related Conditions
TDD	Targeted Disc Decompression
TDEFIC	TRICARE Dual Eligible Fiscal Intermediary Contract
TDP	TRICARE Dental Program/Plan

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Appendix A

Acronyms And Abbreviations

TDR	Total Disc Replacement
TDRL	Temporary Disability Retired List
TDY	Temporary Duty
TED	TRICARE Encounter Data
TEE	Transesophageal Echocardiograph [Echocardiography]
TEFRA	Tax Equity and Fiscal Responsibility Act
TEOB	TRICARE Explanation of Benefits
TEPRC	TRICARE Encounter Pricing (Record)
TEPRV	TRICARE Encounter Provider (Record)
TET	Tubal Embryo Transfer
TF	Transfer Factor
TFL	TRICARE For Life
TFMDDP	TRICARE (Active Duty) Family Member Dental Plan
TGRO	TRICARE Global Remote Overseas
TGROHC	TGRO Host Country
TIFF	Tagged Imaged File Format
TIL	Tumor-Infiltrating Lymphocytes
TIMPO	Tri-Service Information Management Program Office
TIN	Taxpayer Identification Number
TIP	Thermal Intradiscal Procedure
TIPS	Transjugular Intrahepatic Portosystemic Shunt
TIS	TRICARE Information Service
TLAC	TRICARE Latin America/Canada
TLC	Total Lung Capacity
TMA	TRICARE Management Activity
TMA-A	TRICARE Management Activity - Aurora
TMAC	TRICARE Maximum Allowable Charge
TMCPA	Temporary Military Contingency Payment Adjustment
TMH	Telemental Health
TMI&S	Technology Management Integration & Standards
TMOP	TRICARE Mail Order Pharmacy
TMR	Transmyocardial Revascularization
TMS	Transcranial Magnetic Stimulation
TN	Termination Notice
TNEX	TRICARE Next Generation (MHS Systems)
TNP	Topical Negative Pressure
TOB	Type of Bill
TOE	Target of Evaluation
TOL	TRICARE Online
TOM	August 2002 TRICARE Operations Manual 6010.51-M February 2008 TRICARE Operations Manual 6010.56-M
TOP	TRICARE Overseas Program

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Appendix A

Acronyms And Abbreviations

TOPO	TRICARE Overseas Program Office
TP	Treatment Plan
TPA	Third Party Administrator
TPC	Third Party Collections
TPharm	TRICARE Pharmacy
TPL	Third Party Liability
TPM	August 2002 TRICARE Policy Manual 6010.54-M February 2008 TRICARE Policy Manual 6010.57-M
TPN	Total Parenteral Nutrition
TPOCS	Third Party Outpatient Collections System
TPR	TRICARE Prime Remote
TPRADFM	TRICARE Prime Remote Active Duty Family Member
TPRADSM	TRICARE Prime Remote Active Duty Service Member
TPRC	TRICARE Puerto Rico Contract(or)
TPSA	Transitional Prime Service Area
TQMC	TRICARE Quality Monitoring Contractor
TRDP	TRICARE Retiree Dental Program
TRI	TED Record Indicator
TRIAP	TRICARE Assistance Program
TRIP	Temporary Records Information Portal
TRM	August 2002 TRICARE Reimbursement Manual 6010.55-M February 2008 TRICARE Reimbursement Manual 6010.58-M
TRO	TRICARE Regional Office
TRO-N	TRICARE Regional Office-North
TRO-S	TRICARE Regional Office-South
TRO-W	TRICARE Regional Office-West
TRPB	TRICARE Retail Pharmacy Benefits
TRR	TRICARE Retired Reserve
TRRx	TRICARE Retail Pharmacy
TRS	TRICARE Reserve Select
TRSA	TRICARE Reserve Select Application
TSC	TRICARE Service Center
TSF	Target of Evaluation Security Functions
TSM	August 2002 TRICARE Systems Manual 7950.1-M February 2008 TRICARE Systems Manual 7950.2-M
TSP	Target of Evaluation Security Policy
TSR	TRICARE Select Reserve
TSRDP	TRICARE Select Reserve Dental Program
TSRx	TRICARE Senior Pharmacy
TSS	TRICARE Senior Supplement
TSSD	TRICARE Senior Supplement Demonstration
TTOP	TRICARE Transitional Outpatient Payment
TTPA	Temporary Transitional Payment Adjustment

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Appendix A

Acronyms And Abbreviations

TTY	Teletypewriter
TUNA	Transurethral Needle Ablation
TYA	TRICARE Young Adult
UAE	Uterine Artery Embolization
UARS	Upper Airway Resistance Syndrome
UB	Uniform Bill
UBO	Uniform Business Office
UCBT	Umbilical Cord Blood Stem Cell Transplantation
UCC	Uniform Commercial Code Urgent Care Center
UCSF	University of California San Francisco
UIC	Unit Identification Code
UIN	Unit Identifier Number
UM	Utilization Management
UMO	Utilization Management Organization
UMP	User Maintenance Portal
UPIN	Unique Physician Identification Number
UPPP	Uvulopalatopharyngoplasty
URFS	Unremarried Former Spouse
URL	Universal Resource Locator
US	Ultrasound United States
US-CERT	United States-Computer Emergency Readiness Team
USA	United States of America
USACID	United States Army Criminal Investigation Division
USAF	United States Air Force
USAO	United States Attorneys' Office
USC	United States Code
USCG	United States Coast Guard
USCO	Uniformed Services Claim Office
USD	Undersecretary of Defense
USD (P&R)	Undersecretary of Defense (Personnel and Readiness)
USDI	Undersecretary of Defense for Intelligence
USFHP	Uniformed Services Family Health Plan
USHBP	Uniformed Services Health Benefit Plan
USMC	United States Marine Corps
USMTF	Uniformed Services Medical Treatment Facility
USN	United States Navy
USPDI	United States Pharmacopoeia Drug Information
USPHS	United States Public Health Service
USPS	United States Postal Service
USPSTF	U.S. Preventive Services Task Force

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Acronyms And Abbreviations

USS	United Seaman's Service
USTF	Uniformed Services Treatment Facility
UV	Ultraviolet
VA	Veterans Affairs (hospital) Veterans Administration
VAC	Vacuum-Assisted Closure
VAD	Ventricular Assist Device
VAMC	VA Medical Center
VATS	Video-Assisted Thorascopic Surgery
VAX-D	Vertebral Axial Decompression
VD	Venereal Disease
VO	Verifying Office (Official)
VPN	Virtual Private Network
VPOC	Verification Point of Contact
VRDX	Reason Visit Diagnosis
VSAM	Virtual Storage Access Method
VSD	Ventricular Septal Defect
WAC	Wholesale Acquisition Cost
WAN	Wide Area Network
WATS	Wide Area Telephone Service
WC	Worker's Compensation
WebDOES	Web DEERS Online Enrollment System (application)
WEDI	Workgroup for Electronic Data Interchange
WHS	Washington Headquarters Services
WIC	Women, Infants, and Children (Program)
WII	Wounded, Ill, and Injured
WLAN	Wireless Local Area Network
WORM	Write Once Read Many
WRAMC	Walter Reed Army Medical Center
WTC	World Trade Center
WTRR	Wire Transfer Reconciliation Report
WTU	Warrior Transition Unit
WWW	World Wide Web
X-Linked SCID	X-Linked Severe Combined Immunodeficiency Syndrome
XML	eXtensible Markup Language
ZIFT	Zygote Intrafallopian Transfer
2D	Two Dimensional
3D	Three Dimensional

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