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**CHANGE 165
6010.57-M
JUNE 22, 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: REVISIONS TO PROVISIONAL COVERAGE OF EMERGING SERVICES, SUPPLIES
POLICY AND SUPPLEMENTAL HC PROGRAM**

CONREQ: 17857

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): This change clarifies the coverage criteria regarding Flexion Abduction External Rotation provocation test, clarifies preauthorization requirements for provisional coverage, and revises chapter references, within the Provisional Coverage of Emerging Services and Supplies policy.

EFFECTIVE DATE: January 1, 2016.

IMPLEMENTATION DATE: July 22, 2016.

This change is made in conjunction with Feb 2008 TOM, Change No. 187.

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DN: c=US, o=U.S. Government, ou=DoD,
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Date: 2016.06.20 07:41:00 -0600

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**ATTACHMENT(S): 6 PAGE(S)
DISTRIBUTION: 6010.57-M**

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REMOVE PAGE(S)

CHAPTER 1

Section 7.1, pages 1 and 2

CHAPTER 13

Section 1.1, pages 1 through 4

INSERT PAGE(S)

Section 7.1, pages 1 and 2

Section 1.1, pages 1 through 4

Special Authorization Requirements

Issue Date: August 4, 1988

Authority: [32 CFR 199.4\(a\)\(12\)](#), [32 CFR 199.5\(h\)\(3\)](#) and [32 CFR 199.15\(b\)\(4\)](#)

1.0 POLICY

Unless otherwise specifically excepted, the adjudication of the following types of care is subject to the following authorization requirements:

1.1 Adjunctive dental care must be preauthorized.

1.2 Dental anesthesia and institutional benefit must be preauthorized. See [Chapter 8, Section 13.2, paragraph 2.5](#).

1.3 Extended Care Health Option (ECHO) benefits must be authorized in accordance with [Chapter 9, Section 4.1](#).

1.4 Effective October 1, 1991, preadmission and continued stay authorization is required before nonemergency inpatient mental health services may be cost-shared (includes Residential Treatment Center (RTC) care and alcoholism detoxification and rehabilitation). Effective September 29, 1993, preadmission and continued stay authorization is also required for all care in a Partial Hospitalization Program (PHP).

1.5 Effective November 18, 1991, psychoanalysis must be preauthorized.

1.6 The Director, [Defense Health Agency \(DHA\)](#), or designee, may require preauthorization of admission to inpatient facilities.

1.7 Organ and stem cell transplants are required to be preauthorized. For organ and stem cell transplants, the preauthorization shall remain in effect as long as the beneficiary continues to meet the specific transplant criteria set forth in this TRICARE Policy Manual (TPM), or until the approved transplant occurs.

1.8 Infusion therapy delivered in the home must be preauthorized in accordance with [Chapter 8, Section 20.1](#).

1.9 Effective for dates of service **June 1, 2010**, Skilled Nursing Facility (SNF) care received in the U.S. and U.S. territories must be preauthorized for TRICARE dual eligible beneficiaries. The TRICARE Dual Eligible Fiscal Intermediary Contract (TDEFIC) contractor will preauthorize SNF care beginning on day 101, when TRICARE becomes primary payer. For those beneficiaries inpatient on the effective date, a preauthorization will be required August 1, 2010. See the TRICARE Operations

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Special Authorization Requirements

Manual (TOM), [Chapter 7, Section 2](#) and the TRICARE Reimbursement Manual (TRM), [Chapter 8, Section 2](#).

1.10 Provisional coverage for emerging service and supplies shall be preauthorized in accordance with [Chapter 13, Section 1.1](#) and [TOM, Chapter 7, Section 2](#).

1.11 Each TRICARE Regional Managed Care Support Contractor (MCSC) may require additional care authorizations not identified in this section. Such authorization requirements may differ between regions. Beneficiaries and providers are responsible for contacting their contractor for a listing of additional regional authorization requirements.

Note: When a beneficiary has "other insurance" that provides primary coverage, preauthorization requirements in [paragraph 1.11](#) will not apply. Any medically necessary reviews the MCS contractor believes are necessary, to act as a secondary payor, shall be performed on a retrospective basis. The conditions for applying this exception are the same as applied to the Non-Availability Statement (NAS) exception in [Section 6.1, paragraph 3.1](#).

1.12 Provider payments are reduced for the failure to comply with the preauthorization requirements for certain types of care. See the TRM, [Chapter 1, Section 28](#).

2.0 EXCEPTIONS

2.1 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. In the event that TRICARE is primary payer for these services and preauthorization was not obtained, the contractor will obtain the necessary information and perform a retrospective review.

2.2 The requirement that a TRICARE Prime enrollee obtain a referral/authorization from their Primary Care Manager (PCM) to receive the H1N1 immunization from a non-network, TRICARE-authorized provider has been temporarily waived from October 1, 2009 to May 1, 2010. During this period, Prime enrollees may obtain the H1N1 immunization from a non-network TRICARE-authorized provider without prior authorization or PCM referral. Point Of Service (POS) cost-shares normally associated with non-referred care obtained by Prime enrollees from non-network providers without appropriate authorization will not apply during this period.

- END -

Provisional Coverage For Emerging Services And Supplies

Issue Date: December 1, 2015

Authority: 10 USC Chapter 55, Section 1079c

1.0 BACKGROUND

Section 704 of the National Defense Authorization Act for Fiscal Year 2015 (NDAA FY 2015) provided discretionary authority for provisional TRICARE coverage for emerging healthcare services and supplies.

2.0 POLICY

2.1 Consideration Of Evidence

In making a provisional coverage determination, the Assistant Secretary of Defense for Health Affairs (ASD(HA)) may consider—

- Clinical trials published in refereed medical literature;
- Formal technology assessments;
- The positions of national medical policy organizations;
- National professional associations;
- National expert opinion organizations; and
- Such other validated evidence as the Secretary considers appropriate.

2.2 Independent Evaluation

In making a provisional coverage determination the ASD(HA) may also arrange for an evaluation from the Institute of Medicine of the National Academies of Sciences or such other independent entity as the ASD(HA) selects.

2.3 Duration And Terms Of Coverage

2.3.1 Provisional coverage of a service or supply is effective for up to five years, but may be terminated at any time prior to the five year expiration date. Specific effective dates and expiration dates for each episode of provisional coverage will be specified in [Figure 13.1.1-1](#) of this policy.

2.3.2 Prior to the expiration of provisional coverage of a service or supply, the ASD(HA) shall determine the coverage, if any, that will follow such provisional coverage and take appropriate action to implement such a determination. If the ASD(HA) determines that the implementation of such determination regarding coverage requires legislative action, the ASD(HA) shall make a timely recommendation to Congress regarding such legislative action.

2.3.3 The ASD(HA), at any time, may:

2.3.3.1 Terminate the provisional coverage of a service or a supply prior to the five year expiration date referenced in [paragraph 2.3.1](#).

2.3.3.2 Establish or disestablish terms and conditions for such coverage.

2.3.3.3 Take any action with respect to such coverage.

2.4 Public Notice

The ASD(HA) shall promptly publish, on a publicly accessible Internet website of the TRICARE program, a notice for each service or supply that receives provisional coverage, including any terms and conditions for such coverage. Go to <http://www.tricare.mil/provisionalcoverage>.

2.5 Finality of Determinations

Any determination by the ASD(HA) to approve or disapprove a specific service or supply under the provisional coverage policy shall be final.

3.0 APPLICABILITY

Approved provisional coverage of services and supplies applies to all TRICARE-eligible beneficiaries.

4.0 CONTRACTOR RESPONSIBILITIES

The contractor shall:

4.1 Preauthorize the approved provisional coverage as required and verify coverage criteria are met according to all indications detailed in [Figure 13.1.1-1](#). Only the covered criteria/indications listed in [Figure 13.1.1-1](#), "Coverage Guidelines" may be considered when authorizing care. **See the TRICARE Operations Manual (TOM), Chapter 7, Section 2.**

4.2 Issue an authorization to the provider and beneficiary once a determination is made. The authorization shall include a list of all authorized services. The authorization must also include the following information: "[INSERT THE PRIMARY PROCEDURE/DEVICE/TREATMENT CODES] for the treatment of [INSERT PRIMARY DIAGNOSIS CODE] is an emerging service or supply."

4.2.1 Prime travel benefits shall be authorized in accordance with TRICARE Reimbursement Manual (TRM), [Chapter 1, Section 30](#).

4.2.2 Issue a denial to the provider and the beneficiary if coverage criteria requirements are not met.

4.3 Ensure all TRICARE Encounter Data (TED) requirements outlined in the TRICARE Systems Manual (TSM), [Chapter 2, Section 2.8](#) are met including appropriate use of Special Processing Code "PC" to identify provisional coverage records.

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- 4.4** Manage and resolve all inquiries related to the approved coverage.
- 4.5** Authorize benefits for otherwise covered treatment of complications resulting from a surgery or treatment authorized under this Provisional Coverage policy even if the provisional coverage status of such treatment is later terminated.
- 4.6** If preauthorization of care that otherwise meets the requirement of this policy is not obtained, the provision of the TRM, [Chapter 1, Section 28](#) applies. Contractors shall apply the reduction in payment outlined in that section.

FIGURE 13.1.1-1 APPROVED PROVISIONAL COVERAGE FOR EMERGING SERVICES AND SUPPLIES

Treatment & Diagnosis:	Open, Arthroscopic and Combined Hip; Surgical for the treatment of Femoroacetabular Impingement (FAI).
Effective Date:	January 1, 2016.
Termination Date:	December 31, 2020.
Coverage Guidelines:	<p>Open, arthroscopic and combined hip surgery is covered when the following criteria are met:</p> <ul style="list-style-type: none"> • Moderate to severe and persistent activity limiting hip pain that is worsened by flexion activities. • Physical examination consistent with the diagnosis of FAI with at least one positive test required: <ul style="list-style-type: none"> • Positive impingement sign (pain when bringing the knee up towards the chest and then rotating it inward towards the opposite shoulder); or • Flexion Abduction External Rotation (FABER) provocation test (the test is positive if it elicits similar pain as complained by the patient or the range of motion of the hip is significantly decreased compared to the contralateral hip); or • Posterior inferior impingement test (the test is positive if it elicits similar pain as complained by the patient). • Failure to improve with greater than three months of conservative treatment (e.g., physical therapy, activity modification, non-steroidal anti-inflammatory medications, intra-articular injection, etc.). Requests shall include what conservative treatments were used and how long; and • Radiographic evidence of FAI: <ul style="list-style-type: none"> • CAM: <ol style="list-style-type: none"> 1. Pistol-grip deformity (characterized on radiographs by flattening of the usually concave surface of the lateral aspect of the femoral head due to an abnormal extension of the more horizontally oriented femoral epiphysis); or 2. Alpha angle greater than 50 degrees (measurement of an abnormal alpha angle from an oblique axial image along the femoral neck); or • Pincer: <ol style="list-style-type: none"> 1. Coxa profunda (floor of the fossa acetabuli touching or overlapping the ilioischial line medially); or 2. Acetabular retroversion (the alignment of the mouth of the acetabulum does not face the normal anterolateral direction, but inclines more posterolaterally); or 3. Os acetabuli (an ossicle located at the acetabular rim); or 4. Protrusio acetabuli (an anteroposterior radiograph of the pelvis that demonstrates a center-edge angle greater than 40 degrees and medialization of the medial wall of the acetabulum past the ilioischial line); and

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FIGURE 13.1.1-1 APPROVED PROVISIONAL COVERAGE FOR EMERGING SERVICES AND SUPPLIES (CONTINUED)

Coverage Guidelines
(Continued):

- Absence of advanced arthritis (i.e., Tönnis Grade 2 [small cysts, moderate joint space narrowing, moderate loss of head sphericity] or Tönnis Grade 3 [large cysts, severe joint space narrowing, severe deformity of the head]).
 - Inclusion criteria must be documented.
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- END -