



DEFENSE  
HEALTH AGENCY

**MB&RS**

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

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

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**CHANGE 167  
6010.57-M  
JULY 19, 2016**

**REMOVE PAGE(S)**

**CHAPTER 1**

Table of Contents, page 1

Section 4.1, pages 5 through 12

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**CHAPTER 4**

Section 5.2, pages 1 and 2

Section 7.1, pages 1 and 2

**CHAPTER 8**

Section 13.1, pages 1 through 6

**APPENDIX A**

pages 1, 2, and 17 through 20

**INDEX**

pages 1 and 2

**INSERT PAGE(S)**

Table of Contents, page 1

Section 4.1, pages 5 through 12

Section 15.3, page 1

Section 5.2, pages 1 and 2

Section 7.1, pages 1 and 2

Section 13.1, pages 1 through 6

pages 1, 2, and 17 through 20

pages 1 and 2

## **SUMMARY OF CHANGES**

### **CHAPTER 1**

1. Section 4.1. This change corrects an unintentional error in Figure 1.4.1-3 and provides clarifying language regarding appeal rights to beneficiaries found not to be liable for the entire Episode of Care. EFFECTIVE DATE: 08/19/2016.
2. Section 15.3: This change establishes new American Medical Association Current Procedural Terminology codes allowing reimbursement for advance care planning consultation services. EFFECTIVE DATE: 01/01/2016.

### **CHAPTER 4**

3. Section 5.2. This change confirms external surgical garments (specifically designed as an integral part of an external prosthesis, i.e. mastectomy bras) are considered medical supply items and are covered in lieu of reconstructive breast surgery or when reconstruction surgery has failed. EFFECTIVE DATE: 08/19/2016.
4. Section 7.1. These changes provide clarification that Myofacial Pain Dysfunction Syndrome is the same as Temporomandibular Joint (TMJ) Syndrome, and also clarifies the type of dental trauma qualifying for coverage under the adjunctive dental benefit. EFFECTIVE DATE: 08/19/2016.

### **CHAPTER 8**

5. Section 13.1. These changes provide clarification that Myofacial Pain Dysfunction Syndrome is the same as Temporomandibular Joint (TMJ) Syndrome, and also clarifies the type of dental trauma qualifying for coverage under the adjunctive dental benefit. EFFECTIVE DATE: 08/19/2016.



# Chapter 1

## Administration

Section/Addendum	Subject/Addendum Title
1.1	General Policy And Responsibilities
1.2	Exclusions
1.3	Court-Ordered Care
2.1	Unproven Drugs, Devices, Medical Treatments, And Procedures
3.1	Rare Diseases
4.1	Waiver Of Liability
	Figure 1.4.1-1 Waiver Of Liability - Initial Denial Determinations
	Figure 1.4.1-2 Waiver Of Liability - MCSC Reconsideration Determinations
	Figure 1.4.1-3 Waiver Of Liability - TQMC Reconsideration Determinations
5.1	Requirements For Documentation Of Treatment In Medical Records
5.2	Medical Photography
6.1	Non-Availability Statement (NAS) (DD Form 1251) For Inpatient Care
	Figure 1.6.1-1 DD 1251 (Sample)
	Figure 1.6.1-2 Delivery Of Health Care At Military Treatment Facilities (MTFs)
7.1	Special Authorization Requirements
8.1	Primary Care Managers (PCMs)
9.1	Department Of Veterans Affairs (DVA) And Department Of Defense (DoD) Health Care Resources Sharing
10.1	Individual Case Management Program For Persons With Extraordinary Conditions (ICMP-PEC)
11.1	Category II Codes - Performance Measurement
12.1	Category III Codes
13.1	Healthcare Common Procedure Coding System (HCPCS) "C" And "S" Codes
14.1	Relationship Between TRICARE And Employer-Sponsored Group Health Plans (GHPs)
15.1	Transitional Care Management Services
15.2	Chronic Care Management (CCM) Services
15.3	Advance Care Planning (ACP) Services



will be found to have received the Initial Denial Determination if there is substantial evidence that a representative of the inpatient facility hand delivered the facility's copy of the Initial Denial Determination to the beneficiary. If the beneficiary receiving inpatient care is a minor and the Initial Denial Determination was mailed to the home of the beneficiary's parent, the beneficiary is considered to have received the Notice of Denial on the same day as the parent.

**2.3.2.5** The beneficiary signed a statement (drafted by the provider) before the fifth day after the date on the Initial Denial Determination in which the beneficiary agreed to personally pay for specifically identified services that TRICARE does not cover. Under these circumstances, the signed statement is evidence the beneficiary knew that the specified services were excludable before the fifth day after the date on the Initial Denial Determination. General agreements to pay, such as those signed by the beneficiary at the time of the admission, are not evidence that the beneficiary knew specific services were excludable.

## **2.4 Beneficiary's Knowledge That Services Were Excludable**

### **2.4.1 Definition of Beneficiary**

For purposes of determining beneficiary knowledge, the term beneficiary includes the beneficiary or representative of the beneficiary, including the parent of a beneficiary under 18 years of age, the beneficiary's attorney, legal guardian or representative specifically designated by the beneficiary to act on his or her behalf regarding the services at issue. An individual who is subject to the conflict of interest provisions of [32 CFR 199.10\(a\)\(2\)\(i\)\(B\)](#), may not act as the beneficiary's representative under this section.

### **2.4.2 Effect of Beneficiary's Knowledge**

In most cases, the beneficiary's liability begins on the date the beneficiary is found to have known that the services were excludable based on the PRO's retrospective determination that such services were not medically necessary. An exception is when the beneficiary is receiving ongoing inpatient services. In this case, the beneficiary's liability for excluded services will begin on the day after the date the beneficiary is found to have known services were excludable.

### **2.4.3 Determining Beneficiary's Knowledge**

It is presumed that the beneficiary did not know, or could not have been reasonably expected to know, that the services were excludable. However, a beneficiary will be found to know that the services were excludable: (1) following receipt by the beneficiary, or someone acting in behalf of the beneficiary (see [paragraph 2.4.1](#)) of **written notice** that the services were excludable, or (2) that comparable services provided on a previous occasion were excluded and that notice was given by **Defense Health Agency (DHA)**, a PRO or other TRICARE contractor, a group or committee responsible for utilization review for the provider, or the provider who provided the services. Although the regulation provides that a beneficiary will be considered to know, **based on actual written notice**, that the services were excludable, if it is otherwise documented that the beneficiary in fact did know prior to receiving the services, the administrative presumption favorable to the beneficiary referred to in the first sentence of this paragraph, is rebutted. For example, if the beneficiary admits, and such admission is documented, that he or she had prior knowledge that payment for service would be denied, no further evidence is required and the presumption of lack of knowledge is rebutted.

## **2.5 Provider's Knowledge That Services Were Excludable**

### **2.5.1 Effect of Provider's Knowledge**

In most cases, cost-sharing will be denied beginning on the date the provider knew, or could reasonably be expected to know, that services were excludable. An exception is when the provider is rendering ongoing inpatient care to a beneficiary. In that case, cost-sharing will be denied beginning the day following the date on which the provider knew, or could be reasonably expected to know, services were excludable.

### **2.5.2 Determining Provider's Knowledge**

At the initial determination, in the absence of evidence in the file to the contrary, it may be presumed by the PRO that the provider knew, or could reasonably have been expected to know, that the services were excludable. However, should a denial of services be appealed to a reconsideration, the reconsideration determination must state which of the following criteria, demonstrating provider knowledge, exist.

**2.5.2.1** The provider received the Notice of Denial or the provider was informed by the PRO that similar or comparable services were excludable as not medically necessary.

**2.5.2.2** The utilization review group or committee for an institutional provider or the beneficiary's attending physician informed the provider that services were excludable. The name of the entity or individual who informed the provider and the date on which the provider was informed will be referenced in the reconsideration determination.

**2.5.2.3** The provider previously informed the beneficiary that services were excludable. The date on which the provider informed the beneficiary will be referenced in the reconsideration determination.

**2.5.2.4** The provider can reasonably be expected to know that services are excludable as not medically necessary based on any of the following circumstances:

**2.5.2.4.1** Provider received TRICARE notices (including TPM issuances, bulletins or other guidelines or directives from the MCSC, Regional Director (RD), or **DHA**). It is presumed the provider received these notices five days after such notices, addressed to the provider, were placed in the U.S. mail. The title of the notice and the date the notice was provided must be referenced in the reconsideration determination.

**2.5.2.4.2** Provider's knowledge of what are considered acceptable standards of practice by the local medical community. The reconsideration determination must specify what standards of practice were not met and how these standards were not met by the provider. There is a presumption that the generally accepted norms for medical practice in the United States are the same as local standards of practice. The provider may rebut this presumption by presenting substantial evidence that the standards of practice considered acceptable by the local medical community differ from the generally accepted norms for medical practice in the United States. If the provider rebuts the presumption, the burden will be on the provider to establish and define the local standards of practice; and the burden will be on the provider to prove the excludable services were consonant with these local standards.

**2.5.2.4.3** Provider's receipt of an Initial Denial Determination, which notifies the provider that certain services are excludable as not medically necessary, is also notice to other providers (who rendered services during the same EOC) that their services are also excludable.

**2.5.2.4.4** Preadmission authorization was required, but not obtained or concurrent review requirements were not followed. An exception is when the provider did not request preadmission authorization or concurrent review because the beneficiary failed to inform the provider of his or her status as a TRICARE beneficiary. The provider will be required to submit evidence that the beneficiary failed to disclose his or her status as a TRICARE beneficiary.

**Note:** A provider will be found to have known services were excludable as not medically necessary under the following circumstances: The PRO granted preauthorization based on the provider's omission of information necessary to a medical necessity determination or the provider's submission of inaccurate or misleading information. If the PRO later determines, based on accurate and/or more complete information received later by the PRO, that the preauthorized services were not medically necessary, then it will be found that the provider should have known that the services were excludable as not medically necessary.

## **2.6 Effect of Knowledge Determination on Liability and Cost-Sharing**

### **2.6.1 Beneficiary and Provider Did Not Know Services Were Excludable**

Services retrospectively determined to be excludable as not medically necessary shall not be excluded if neither the beneficiary nor the provider knew, nor could reasonably be expected to know, that the provided services were subject to exclusion. Payment will be made for such services as if the exclusion did not apply. The beneficiary is responsible for appropriate deductible and cost-share amounts.

**Note:** Certain providers are required to enter into Participation Agreements with **DHA** whereby the providers agree to accept the TRICARE all-inclusive per diem rate, TRICARE-determined rate, or the TRICARE-determined allowable charge as payment in full for services provided to beneficiaries. Cost-sharing will not be provided even when these providers did not know, nor could reasonably be expected to know, that the denied services were excludable as not medically necessary. The institutional providers who are required to enter into such agreements are Residential Treatment Centers, Psychiatric Partial Hospitalization Programs, and Substance Use Disorder Rehabilitation Facilities. However, waiver of liability still applies to the beneficiary. Therefore, these institutional providers may not bill the beneficiary for excludable services if the beneficiary's liability is waived. (Conversely, if the beneficiary's liability is not waived, the beneficiary may be billed). The individual providers who are required to enter into such agreements are Certified Marriage and Family Therapists. Certified Marriage and Family Therapists must agree to hold the beneficiary harmless and therefore can not bill the beneficiary for "noncovered care," regardless of whether the beneficiary's liability is waived.

### **2.6.2 Beneficiary Did Not Know Services Were Excludable - Provider Knew Services Were Excludable**

If the beneficiary did not know, nor could reasonably be expected to know, that services were excludable as not medically necessary, but the provider did know, or could have been reasonably expected to know, that the services were excludable as not medically necessary, then

payment shall not be made for such services and the beneficiary will not be held liable for the excludable services.

### **2.6.2.1 Indemnification**

The beneficiary will be entitled to a full refund of any amount paid to the provider by the beneficiary for the excluded services, including any deductible and cost-share amounts. In order to obtain a refund, the beneficiary is not required to ask the provider to return the payments the beneficiary has made for excluded services. Instead, the beneficiary will be indemnified for any payments made by the beneficiary or other party (excluding an insurer or provider) to the provider for the excluded services. The beneficiary, or other party making payment on behalf of the beneficiary, must request indemnification in writing from the MCSC by the end of the sixth month following the month in which payment was made to the provider or by the end of the sixth month following the month in which the PRO or DHA advised the beneficiary that he or she was not liable for the excludable services. The time limit may be extended where good cause is shown. Good cause is defined as:

**2.6.2.1.1** Administrative error (such as, misrepresentation or mistake) of an officer or employee of DHA or a PRO, if performing functions under TRICARE and acting within the scope of that officer or employee's authority.

**2.6.2.1.2** Mental incompetence of the beneficiary or, in the case of a minor child, mental incompetence of his or her guardian, parent or sponsor.

**2.6.2.1.3** Adjudication delays by other health insurance (when not attributable to the beneficiary), if such adjudication is required under [32 CFR 199.8](#) (Double Coverage).

### **2.6.3 Beneficiary and Provider Knew Services Were Excludable**

If both the beneficiary and the provider knew, or could reasonably be expected to know, that services were excludable as not medically necessary, then payment will not be made for such services and the beneficiary will be responsible for payment for the excluded services.

### **2.6.4 Beneficiary Knew Services Were Excludable - Provider Did Not Know Services Were Excludable**

If the beneficiary knew, but the provider did not know, nor could reasonably be expected to know, that services were excludable as not medically necessary, cost-sharing will not be allowed under the criteria set forth in [32 CFR 199.4\(h\)](#), which allows cost-sharing for otherwise excludable services. The beneficiary will be responsible for payment for the excluded services.

**Example:** A beneficiary sought preauthorization for care from the PRO, which was denied because it was deemed not medically necessary. The beneficiary then went to a non-network provider and did not inform the provider of the previous denial of preauthorization (or prior denials of authorization for similar or comparable services). The beneficiary received the same or similar/comparable services for which preauthorization was denied. Under these circumstances, cost-sharing will not be provided and the provider may seek payment from the beneficiary or other insurance, as applicable.

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**2.6.5 Provider Did Not Know Services Were Excludable Because Provider Did Not Know Beneficiary Was a TRICARE Beneficiary**

If the beneficiary did not tell the provider that he or she was a TRICARE beneficiary, then waiver of liability will not apply. It would not be equitable to allow the beneficiary to claim the protection waiver of liability provisions if the beneficiary did not inform the provider of his or her status as a TRICARE beneficiary. Cost-sharing will not be provided for services determined by the PRO to be not medically necessary and the provider may seek payment from the beneficiary or other insurance, as applicable.

**2.7 Appeals of Medical Necessity and Waiver of Liability Determinations.** A guide for applying waiver of liability in MCSC reconsideration determinations is in [Figure 1.4.1-2](#). A guide for applying waiver of liability in TQMC reconsideration determinations is in [Figure 1.4.1-3](#).

**2.7.1 Beneficiary**

**2.7.1.1** A beneficiary may appeal both a determination that services were excludable as not medically necessary and a waiver of liability determination that the beneficiary knew, or could reasonably be expected to know, that the services were excludable as not medically necessary. The beneficiary may request an appeal regardless of whether these determinations are made in an Initial Denial Determination, a reconsideration determination, or a formal review decision issued by DHA.

**2.7.1.2** A beneficiary found not to be liable for the entire Episode Of Care (EOC) will not be offered further appeal rights.

**2.7.2 Provider**

**2.7.2.1** A provider may appeal:

- A determination that services were excludable as not medically necessary,
- A waiver of liability determination that the provider knew, or could reasonably be expected to know, that services were excludable as not medically necessary, and
- A waiver of liability determination that the beneficiary did not know, or could not reasonably have been expected to know, that the services were excludable as not medically necessary, if these determinations are made in an Initial Denial Determination or reconsideration determinations issued by the MCSC.

**2.7.2.2** A provider may appeal a reconsideration determination issued by the TQMC only on the issue of whether the provider knew, or could have been reasonably expected to know, that services were excludable as not medically necessary. (32 CFR 199.15(i)) The provider may not appeal an TQMC determination that services were excludable as not medically necessary.

**2.7.3 Appeal Rights**

An Initial Denial Determination and a reconsideration determination must instruct the beneficiary and the provider as to what issues each may appeal and will contain the address to

which a request for appeal is to be mailed as applicable.

### 3.0 EFFECTIVE DATE

Implementation of the TRICARE PRO waiver of liability for denial determinations is effective for hospital admissions that occur on or after April 8, 1989, and outpatient service on or after December 6, 1993. Implementation of waiver of liability provisions for denial determinations for inpatient mental health care is effective for admissions that occur on or after November 18, 1991. Implementation of waiver of liability provisions for denial determinations for partial hospitalization care is effective for admissions that occur on or after September 29, 1993.

**FIGURE 1.4.1-1 WAIVER OF LIABILITY - INITIAL DENIAL DETERMINATIONS**

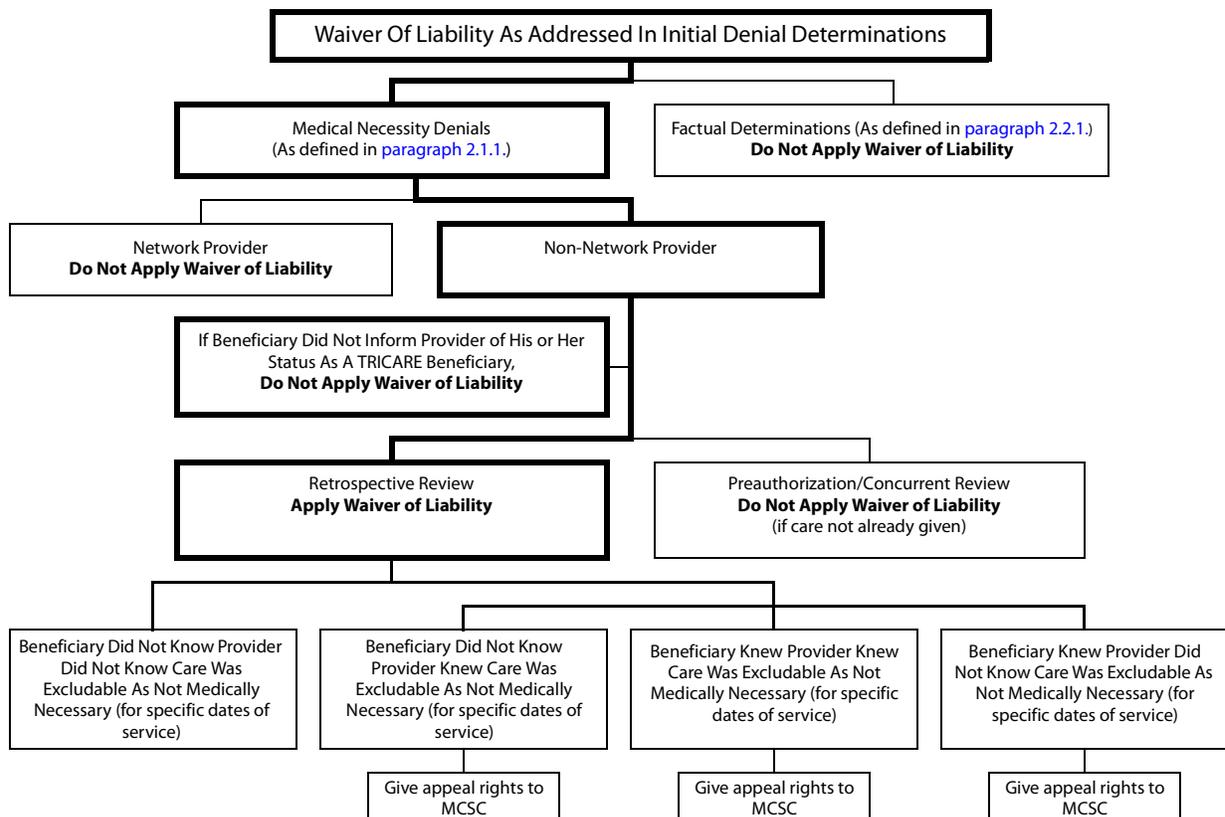
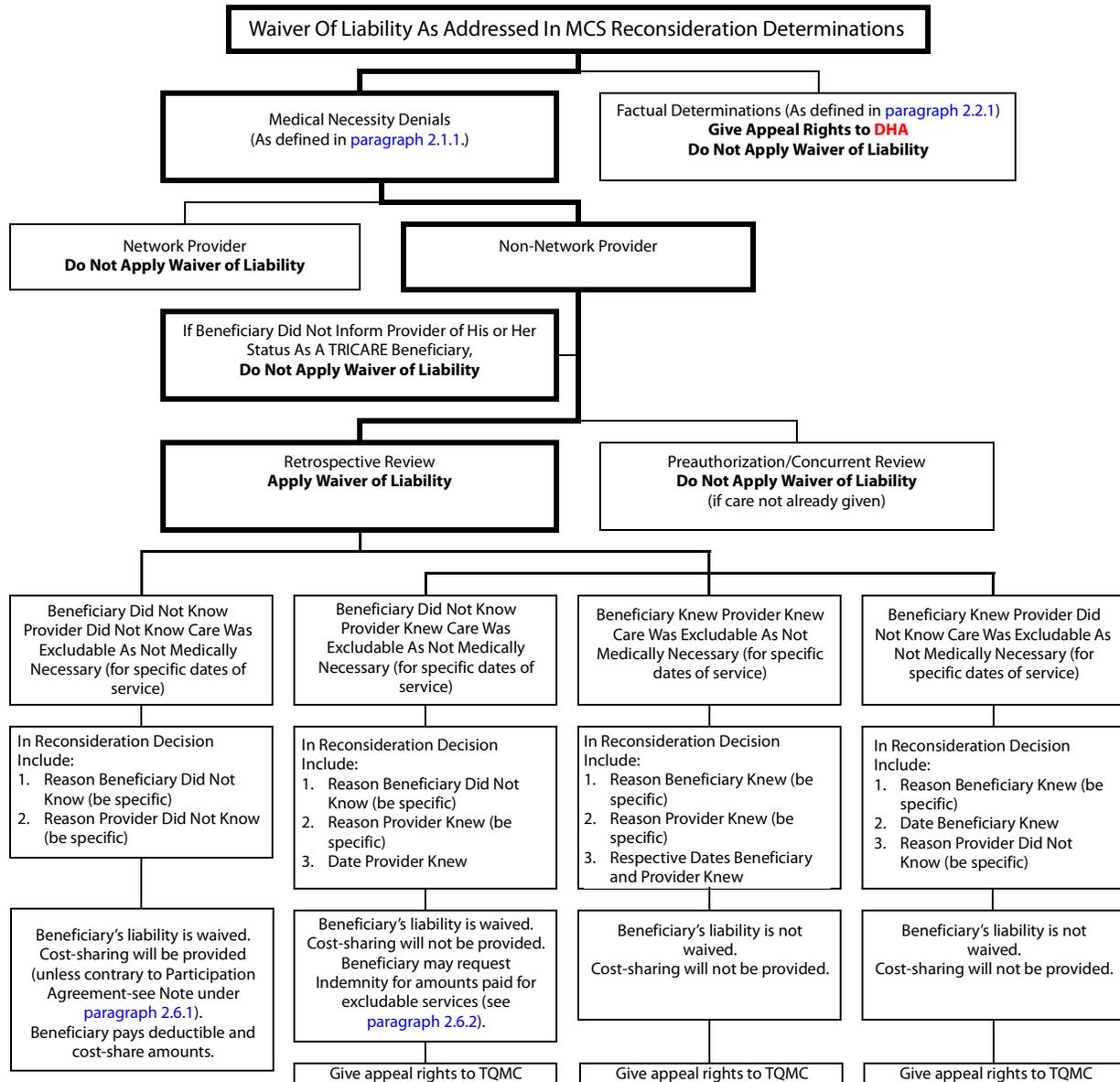


FIGURE 1.4.1-2 WAIVER OF LIABILITY - MCSC RECONSIDERATION DETERMINATIONS

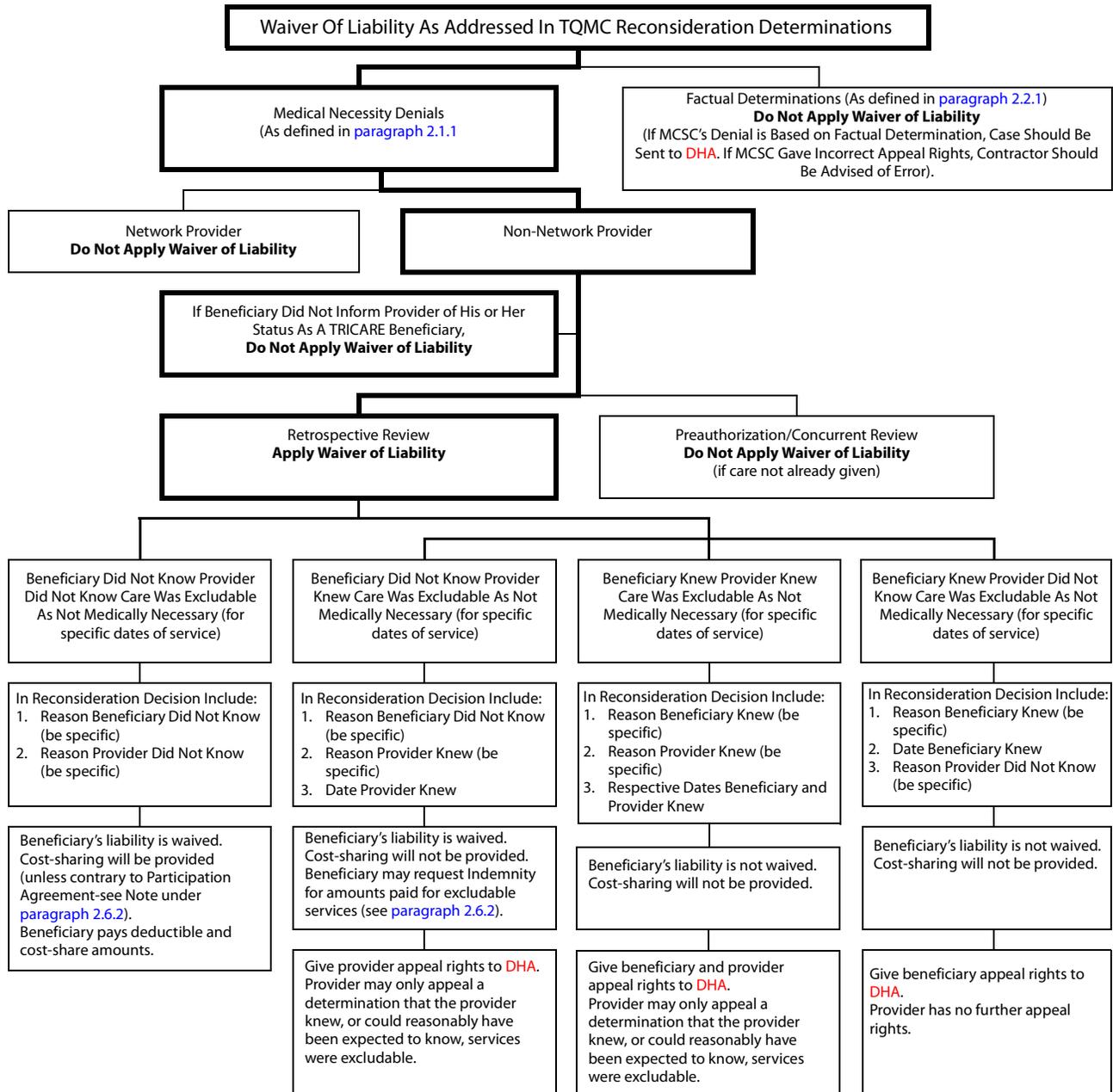


TRICARE Policy Manual 6010.57-M, February 1, 2008

Chapter 1, Section 4.1

Waiver Of Liability

FIGURE 1.4.1-3 WAIVER OF LIABILITY - TQMC RECONSIDERATION DETERMINATIONS



- END -

## Advance Care Planning (ACP) Services

Issue Date: July 19, 2016

Authority: [32 CFR 199.4\(c\)\(1\)\(ii\)](#)

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

99497, 99498

### 2.0 DESCRIPTION

ACP services are face-to-face consultation services between a TRICARE-authorized provider and a patient, family member, or surrogate for the purpose of discussing end-of-life care planning. These services may also include the completion of advance directive documents such as:

- Healthcare Proxy;
- Durable Power of Attorney for Health Care;
- Living Will and Medical Orders for Life-Sustaining Treatment.

### 3.0 POLICY

**3.1** ACP services are covered when provided in connection with medically and psychologically necessary treatment of an injury or illness in an outpatient, inpatient, or Skilled Nursing Facility (SNF) setting.

**3.2** Cost-sharing and copays apply.

### 4.0 EXCLUSION

ACP services are not covered when provided in connection with a preventive services office visit (e.g., CPT<sup>1</sup> codes 99381-99387 and 99391-99397).

### 5.0 EFFECTIVE DATE

January 1, 2016.

- END -

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## Post-Mastectomy Reconstructive Breast Surgery and Breast Prosthesis

Issue Date: October 7, 1982

Authority: [32 CFR 199.4\(e\)\(8\)\(i\)\(D\)](#) and 10 USC 1079(a)(12)

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

19160 - 19240, 19340 - 19499 (For post-mastectomy reconstruction surgery)  
19316, 19318, 19324 - 19325 (For contralateral symmetry surgery)

### 2.0 HCPCS CODES

Q4116 (Alloderm®)

### 3.0 DESCRIPTION

Breast reconstruction consists of mound reconstruction, nipple-areola reconstruction and areolar/nipple tattooing.

### 4.0 POLICY

**4.1** Payment may be made for post-mastectomy reconstruction of the breast following a covered mastectomy.

**4.2** Payment may be made for contralateral symmetry surgery (i.e., reduction mammoplasty, augmentation mammoplasty, or mastopexy performed on the other breast to bring it into symmetry with the post-mastectomy reconstructed breast).

**Note:** Services related to the augmentation, reduction, or mastopexy of the contralateral breast in post-mastectomy reconstructive breast surgery are not subject to the regulatory exclusion for mammoplasties performed primarily for reasons of cosmesis.

**4.3** Treatment of complications following reconstruction (including implant removal) regardless of when the reconstruction was performed, and complications that may result following symmetry surgery, removal and reinsertion of implants are covered. See [Chapter 4, Section 5.5](#).

**4.4** External surgical garments/**mastectomy bras** (those specifically designed as an integral part of an external prosthesis) are considered medical supply items and are covered in lieu of reconstructive breast surgery **or when reconstruction surgery has failed**.

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**Note:** Benefits are subject to two initial **external surgical garments/mastectomy bras** and two replacement **external surgical garments/mastectomy bras** per calendar year.

**4.5** Breast prosthesis is limited to the first initial device per missing body part. Requests for replacements are subject to medical review to determine reason for replacement.

**4.6** U.S. Food and Drug Administration (FDA) approved implant material and customized external breast prostheses are covered.

**4.7** Breast Magnetic Resonance Imaging (MRI) to detect implant rupture is covered. The implantation of the breast implants must have been covered by TRICARE.

**4.8** Alloderm® (an acellular allograft) is a covered benefit, effective July 8, 2008, when used in a covered breast reconstruction surgery for women who have any of the following indications:

**4.8.1** Have insufficient tissue expander or implant coverage by the pectoralis major muscle and additional coverage is required; or

**4.8.2** There is viable, but compromised or thin post-mastectomy skin flaps that are at risk of dehiscence or necrosis; or

**4.8.3** The infra-mammary fold and lateral mammary folds have been undermined during mastectomy and re-establishment of these landmarks are needed.

- END -

## Oral Surgery

Issue Date: October 8, 1986

Authority: [32 CFR 199.4\(e\)\(10\)](#) and [\(g\)\(37\)](#)

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### 1.0 AMERICAN DENTAL ASSOCIATION (ADA) DENTAL NOMENCLATURE CODES

07285 - 07286, 07410 - 07420, 07430 - 07431, 07440 - 07441, 07450 - 07451, 07460 - 07461, 07465, 07480, 07490, 07520, 07530, 07540, 07550, 07560, 07610, 07620, 07630, 07640, 07650, 07660, 07670, 07680, 07710, 07720, 07730, 07740, 07750, 07760, 07770, 07780, 07810, 07820, 07830, 07840, 07860, 07870, 07910 - 07912, 07920, 07955, 07980 - 07983, 20605, 21010, 21050, 21060, 21141 - 21142, 21193 - 21198, 21215, 21240 - 21243, 21480, 21485, 21490, 21499, 29804.

### 2.0 DESCRIPTION

There are certain oral surgical procedures which are performed by both physicians and dentists, and which are essentially medical rather than dental care.

### 3.0 POLICY

**3.1** The following are examples of procedures are considered to be in this category and are covered:

**3.1.1** Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth, when such conditions require a pathological (histological) examination.

**3.1.2** Surgical procedures required to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth.

**3.1.3** Treatment of oral and/or facial cancer.

**3.1.4** Treatment of fractures of facial bones.

**3.1.5** External (extraoral) incision and drainage of cellulitis.

**3.1.6** Surgery of accessory sinuses, salivary glands or ducts.

**3.1.7** Surgical treatment of the temporal bone and the lower bone of the jaw.

**3.1.7.1** The following are examples of conditions under which surgical treatment of the temporomandibular joint will be allowed:

- Osteoarthritis
- Trauma
- Congenital causes, e.g., agenesis or hypoplastic condyle
- Ankylosis
- Tumors
- Dislocations

**3.1.7.2** The contractor may use the current recommendations for Management of Patients with Temporomandibular Joint Implants published by the American Academy of Oral Maxillofacial Surgeons in their adjudication of claims involving temporomandibular joint surgery.

**3.2** Any oral surgical procedure which falls within the cosmetic, reconstructive and/or plastic surgery definition is subject to the limitations and requirements set forth in [32 CFR 199.4\(e\)\(8\)](#). Surgical correction of prognathism and micrognathism and congenital craniofacial anomalies (i.e., Treacher-Collins syndrome, hemifacial microsomia, etc.) is covered.

**3.3** Oral surgical procedures for treatment of the following medical conditions are also covered:

**3.3.1** Osteomyelitis.

**3.3.2** Removal of a foreign body which is hazardous to the patient's health, which is reaction-producing or complicates a primary medical condition.

**3.3.3** Intrinsic and traumatic diseases of the temporomandibular joint which require surgery such as rheumatoid arthritis and osteoarthritis.

**3.3.4** Mandibular bone grafts performed for other than orthodontia or dental support.

**3.3.5** Surgical treatment of the temporomandibular joint.

**3.3.6** The Therabite Jaw Motion System may be considered for cost-sharing as Durable Medical Equipment (DME).

## **4.0 EXCLUSIONS**

**4.1** Treatment of Temporomandibular Joint Syndrome, also known as Myofascial Pain Dysfunction Syndrome, occlusal equilibration and restorative occlusal rehabilitation are excluded from this category. See [Chapter 8, Section 13.1](#).

**4.2** Extraction of unerupted or partially erupted, malposed or impacted teeth, with or without the attached follicular or development tissues, are not covered oral surgery procedures except when the care is indicated in preparation for, or as a result of, dental trauma caused by the medically necessary treatment of an injury or illness.

## Adjunctive Dental Care

Issue Date: October 8, 1986

Authority: [32 CFR 199.4\(e\)\(10\)](#)

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### 1.0 DESCRIPTION

Adjunctive dental care is that dental care which is medically necessary in the treatment of an otherwise covered medical (not dental) condition, is an integral part of the treatment of such medical condition; or is required in preparation for, or as the result of, dental trauma which may be or is caused by medically necessary treatment of an injury or disease.

### 2.0 POLICY

**2.1** Adjunctive dental care requires preauthorization. However, if a beneficiary fails to obtain preauthorization before receiving the services, the contractor shall extend benefits if the services or supplies qualify for benefits. Where adjunctive dental care involves a medical (not dental) emergency (such as facial injuries resulting from an accident), the requirement for preauthorization is waived. Such waiver is limited to the essential adjunctive dental care related to the medical condition requiring the immediate emergency treatment.

**2.2** Hospital services and supplies will be covered for a patient who requires a hospital setting for noncovered, nonadjunctive dental care when medically necessary to safeguard the life of the patient from the effects of dentistry on an underlying nondental organic condition. Professional services related to the noncovered dental care are not covered; professional services related to the medical condition (excluding the dentist and anesthesiologist) are covered.

**2.3** Benefits may be cost-shared for the treatment of the following conditions:

#### 2.3.1 Intraoral Abscesses

An intraoral abscess should be considered a medical condition only when it extends beyond the dental alveolus. These abscesses may require immediate attention in an acute phase which would preclude preauthorization.

#### 2.3.2 Extraoral Abscesses

In some cases, it is necessary to incise and treat abscesses extraorally; e.g., when the infection follows the facial planes.

### 2.3.3 Cellulitis and Osteitis

Elimination of a non-local infection which is clearly exacerbating and directly affecting a medical condition currently under treatment.

### 2.3.4 Facial Trauma Requiring Removal of Teeth or Tooth Fragments

**2.3.4.1** Removal of teeth and tooth fragments in order to treat and repair facial trauma resulting from an accidental injury.

**2.3.4.2** Removal of an impacted tooth in the line of a fracture may be required in order to treat the fracture.

### 2.3.5 Myofacial Pain Dysfunction Syndrome, also known as Temporomandibular Joint (TMJ) Syndrome

**2.3.5.1** Treatment of this syndrome may be considered a medical problem only when it involves immediate relief of pain.

**2.3.5.2** Emergency treatment may include initial radiographs, up to four office visits and the construction of an occlusal splint, if necessary to relieve pain and discomfort.

**2.3.5.3** Treatment beyond four visits, or any repeat episodes of care within a six (6) month period, must receive individual consideration and be documented by the provider of services.

**Note:** Occlusal equilibration and restorative occlusal rehabilitation are specifically excluded for myofacial pain dysfunction syndrome and TMJ syndrome. See [Chapter 4, Section 7.1](#).

### 2.3.6 Total or Complete Ankyloglossia

This condition is commonly known as tongue-tie. It involves the lingual frenum resulting in fixation of the tip of the tongue to the degree that it interferes with swallowing and speech. Surgery for partial ankyloglossia is considered unnecessary, and of no medical value.

### 2.3.7 Severe Congenital Anomaly

Adjunctive dental and orthodontia is covered when directly related to, and an integral part of, the medical and surgical correction of a severe congenital anomaly.

#### 2.3.7.1 Coverage Guidelines

Depending on the severity or degree of involvement of the congenital anomaly, the patient may require adjunctive dental or orthodontic support from birth until the medical/surgical treatment of the anomaly has been completed; i.e., until the dentoalveolar arch discrepancies and/or maxillomandibular disharmonies are corrected through a combined effort of the surgeon and orthodontist. Treatment may include the fabrication of obturators early in life, and splints at the time of surgical treatment for stabilization of the maxilla and mandible. As the arches develop and teeth erupt, orthodontic treatment may be required to establish a functional relationship of the dental arches. When the deformity is severe and function is greatly impaired, obturators and

pharyngeal bulb appliances may be required to assure proper nutrition, deglutition and to avoid aspiration of foreign matter during the intake of food.

**2.3.7.1.1** Vestibuloplasty (CPT<sup>1</sup> procedure codes 40840 - 40845) may be considered adjunctive dental when it is determined to be an appropriate and medical necessary surgical procedure for correction of a severe cleft lip/cleft palate.

**Note:** Vestibuloplasty is EXCLUDED when performed to prepare the mouth for dentures.

**2.3.7.1.2** Orthodontics should be a covered treatment in any congenital deformity of the head and neck, wherein the orthodontia:

**2.3.7.1.2.1** Corrects dentoalveolar arch discrepancies that are part of, or the result of, the congenital anomaly and are severe enough to prevent the usual and normal action of mastication and ingestion of normally solid foods.

**2.3.7.1.2.2** Corrects dentoalveolar arch discrepancies, the correction of which is necessary to satisfactorily correct other aspects of the general deformity, or to prevent relapse of such treatment.

**2.3.7.1.2.3** Corrects dentoalveolar arch discrepancies that are, in themselves, severe enough to obviously disfigure the face.

**2.3.7.1.2.4** The following is a listing of congenital anomalies that affect the face and possibly the dentoalveolar arches, or their relationships to each other:

- Cleft palate isolated.
- Lateral or oblique facial clefting.
- Cleft mandible.
- Klippel-Fiel Syndrome.
- Pierre Robin Syndrome.
- Trisomies 18, 21, 13 - 15.
- Chondroectodermal dysplasia (Ellis-van Creveld Syndrome).
- Bird headed dwarfism (Nanocephalic or primordial dwarfism).
- Turner's Syndrome (X-0 Syndrome).
- Klinefelter's Syndrome.
- Craniofacial dysostosis (Crouzon's Syndrome).
- Occuloauriculovertebral dysplasia (Goldenhar's Syndrome).
- Occulamandibulofacial Syndrome (Hallerman Striff Syndrome, Ullrich et al Syndrome).
- Treacher Collins Syndrome.
- Hemifacial microsomia.
- Hemifacial hyperplasia.

**2.3.7.1.2.5** Coverage of orthodontia for congenital anomalies of the head and/or neck which do not appear in the above listing must be evaluated to assess the significance of their functional

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impairments related to the dentoalveolar arch discrepancies described in paragraphs 2.3.7.1.2.1 and 2.3.7.1.2.2; i.e., the dentoalveolar arch discrepancies of an unlisted congenital anomaly must impose a significant functional impairment in order for coverage of orthodontia under TRICARE.

**2.3.7.1.2.6** The severity and functional impairment of a given congenital anomaly must be assessed on a case-by-case basis from a series of medical records over a period of time. The congenital impairment of the head and/or neck must be at a level resulting in an inability of a beneficiary to perform normal bodily functions (e.g., the inability to eat, breathe, and/or speak normally) in order for coverage to be extended. The functional impairment must be disabling and ongoing.

### **2.3.7.2 Preauthorization Requirements**

**2.3.7.3** Preauthorization is required for all adjunctive dental and orthodontia directly related to, and an integral part of, the medical and surgical correction of a severe congenital anomaly.

**2.3.7.4** Orthodontia benefits for severe congenital anomalies of the head and neck will be continued as long as the primary physician requires support of his/her treatment or until the best reasonably attainable results have been achieved by the orthodontist. Once active orthodontic treatment has been completed and the patient is placed in the retention phase of treatment, benefit payment ends. If the primary physician or dentist subsequently determines that additional orthodontia work is required, a new preauthorization is required.

### **2.3.8 Iatrogenic Dental Trauma**

Dental care which is prophylactic, restorative, prosthodontic (e.g., dentures and bridge work) and/or periodontic qualifies as adjunctive dental care when performed in preparation for, or as a result of, trauma to the teeth and supporting structures caused by medically necessary treatment of an injury or disease. There must be a direct cause-effect relationship between the otherwise covered medical treatment and the ensuing dental trauma, and the ensuing dental trauma must be functionally associated (adjunct) with the treatment of the physician induced trauma. This must be based on sound medical practice and substantiated in the current medical literature. The following are examples of conditions which are eligible for payment under the iatrogenic dental trauma provision. Because these examples are not meant to be all-inclusive, similar conditions or circumstances may be brought to the attention of the Deputy Director, **Defense Health Agency (DHA)**, or designee, for consideration.

#### **2.3.8.1 Radiation Therapy for Oral or Facial Cancer**

**2.3.8.1.1** It is generally recognized that certain dental care may be required in preparation for or as a result of in-line radiation therapy for oral or facial cancer.

**2.3.8.1.2** Treatment may include dental prophylactic, restorative, periodontic and/or orthodontic procedures. Without this necessary care, patients who undergo radiation therapy **around** the head may be at risk for development of osteonecrosis because their dental needs were not met either prior to, or in conjunction with, radiation therapy. Since the problem here deals with cancer, it may not be possible to wait for prior authorization before beginning radiation therapy. Out of necessity, dental care may have to be initiated before benefit authorization is granted.

Extraction of affected teeth due to poor dental health (e.g., multiple dental caries and/or periodontal disease) may necessitate the coverage of dentures or bridge work.

### **2.3.8.2 Gingival Hyperplasia**

**2.3.8.2.1** Gingival hyperplasia, or overgrowth of the gingival tissues, occurs frequently in patients who have undergone prolonged Dilantin therapy for epilepsy or seizure disorders. The incidence of this problem can be reduced by good oral hygiene and prophylactic gum care. Severe cases of gingival overgrowth may require surgical intervention to reduce the excessive fibrous tissue growth. The problem is more prevalent among young children, as the older population is not prone to the condition. Also, there is an important difference in the character of tissue between gingival hyperplasia and periodontal disease. Because of this, care needs to be taken in differentiating true gingival hyperplasia from periodontally diseased tissue.

**2.3.8.2.2** Treatment usually entails excision of the hyperplastic tissue; however, in some severe cases, free soft tissue grafts may be required.

**Note:** Because the above examples are not meant to be all-inclusive, similar conditions or circumstances may be brought to the attention of the contractors for review and consideration. Coverage will again be based on whether a direct cause-effect relationship can be established between the treatment of an otherwise covered medical condition and the ensuing dental trauma. Dental procedures will only apply when required to treat or rectify the dental trauma/damage resulting from the treatment of an underlying medical condition. For instance, if a beneficiary cracks or chips a tooth as a result of a fall, coverage would not be extended under the iatrogenic provision, since the trauma was purely dental in nature (i.e., trauma to the teeth and/or dental alveoli) and not related to the treatment of an underlying medical condition. The only possible coverage that could be extended would be for removal of teeth fragments from surrounding oral tissue other than the dental alveolus (e.g., from the tongue or inside of the cheek) resulting from the accident. On the other hand, if a beneficiary sustained a fracture to the mandible or maxilla requiring the extraction of a tooth for stabilization of the jaw (i.e., removal of a tooth to allow for wiring of the fracture site), coverage would be allowed since the resulting physician or oral surgeon induced dental trauma was directly related to the treatment of an otherwise covered medical condition. In this particular case, adjunctive dental coverage would extend up through prosthodontic restoration of the missing tooth.

### **2.3.8.3 Preauthorization Requirements**

The preauthorization criteria for dental care required in preparation for, or as a result of, trauma to the teeth and supporting structures caused by medically necessary treatment of an injury or disease are the same as those described in [paragraphs 2.3.7.3](#) and [2.3.7.4](#).

### **2.3.9 Dental Metal Amalgam/Alloy Hypersensitivity**

The removal of dental metal amalgam/alloy source may be cost-shared for procedures rendered after April 18, 1983, under the following conditions:

**2.3.9.1** Independent diagnosis by a physician allergist based upon generally accepted test(s) for any dental metal amalgam/alloy hypersensitivity, and

**2.3.9.2** Contemporary clinical record documentation which reasonably rules out sources of metal exposure other than the dental amalgam/alloy.

### **3.0 POLICY CONSIDERATIONS**

**3.1** Dental care which is routine, preventive, restorative, prosthodontic (adding or modifying of bridge work and dentures), periodontic or emergency does not qualify as adjunctive dental care except when performed in preparation for, or as a result of, dental trauma caused by medically necessary treatment of an injury or disease.

**3.2** Orthodontia is only covered when it is an integral part of the medical or surgical correction of a severe congenital anomaly or when required in preparation for, or as a result of, physician induced dental trauma.

**3.3** Clinical oral examinations, radiographs and laboratory tests and examinations may be payable only when necessary in conjunction with the diagnosis and treatment of covered adjunctive dental or oral surgery procedures.

**3.4** The Frankel Dental Appliance is categorized as orthodontia and must be denied unless adjunctive to the surgical correction of a cleft palate.

**3.5** The treatment of generally poor dental health (dental caries) due to certain systemic causes (e.g., congenital syphilis, malabsorption syndromes, rickets, etc.) is excluded from coverage.

**3.6** American Dental Association (ADA) claim forms and procedure codes may be used in the processing and payment of adjunctive dental claims.

- END -

## Acronyms And Abbreviations

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AA	Anesthesiologist Assistant
AA&E	Arms, Ammunition and Explosives
AAA	Abdominal Aortic Aneurysm
AAAHC	Accreditation Association for Ambulatory Health Care, Inc.
AAFES	Army/Air Force Exchange Service
AAMFT	American Association for Marriage and Family Therapy
AAP	American Academy of Pediatrics
AAPC	American Association of Pastoral Counselors
AARF	Account Authorization Request Form
AATD	Access and Authentication Technology Division
ABA	American Banking Association Applied Behavior Analysis
ABAT	Applied Behavior Analysis Technician
ABMT	Autologous Bone Marrow Transplant
ABPM	Ambulatory Blood Pressure Monitoring
ABR	Auditory Brainstem Response
AC	Active Component
ACA	Affordable Care Act
ACD	Augmentative Communication Devices
ACE	Angiotensin-Converting Enzyme
ACH	Automated Clearing House
ACI	Autologous Chondrocyte Implantation
ACIP	Advisory Committee on Immunization Practices
ACO	Administrative Contracting Officer
ACOG	American College of Obstetricians and Gynecologists
ACOR	Administrative Contracting Officer's Representative
ACP	<b>Advance Care Planning</b> American College of Physicians
ACS	American Cancer Society
ACSC	Ambulatory Care Sensitive Condition
ACSP	Autism Demonstration Corporate Services Provider
ACTUR	Automated Central Tumor Registry2
AD	Active Duty
ADA	American Dental Association American Diabetes Association Americans with Disabilities Act

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

## Appendix A

### Acronyms And Abbreviations

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ADAMHA	Alcohol, Drug Abuse, And Mental Health Administration
ADAMHRA	Alcohol, Drug Abuse, And Mental Health Reorganization Act
ADCP	Active Duty Claims Program
ADD	Active Duty Dependent
ADDP	Active Duty Dental Program
ADFM	Active Duty Family Member
ADH	Atypical Ductal Hyperplasia
ADL	Activities of Daily Living
ADP	Automated Data Processing
ADSM	Active Duty Service Member
AF	Atrial Fibrillation
AFAP	Attenuated Familial Adenomatous Polyposis
AFB	Air Force Base
AFOSI	Air Force Office of Special Investigations
AFS	Ambulance Fee Schedule
AGR	Active Guard/Reserve
AHA	American Hospital Association
AHCB	American Hippotherapy Certification Board
AHLTA	Armed Forces Health Longitudinal Technology Application
AHRQ	Agency for Healthcare Research and Quality
AI	Administrative Instruction
AIDS	Acquired Immune Deficiency Syndrome
AIF	Ambulance Inflation Factor
AIIM	Association for Information and Image Management
AIS	Ambulatory Infusion Suite Automated Information Systems
AIX	Advanced IBM Unix
AJ	Administrative Judge
ALA	Annual Letter of Assurance
ALB	All Lines Busy
ALH	Atypical Lobular Hyperplasia
ALL	Acute Lymphocytic Leukemia
ALOS	Average Length-of-Stay
ALS	Action Lead Sheet Advanced Life Support
ALT	Autolymphocyte Therapy
AM&S	Acquisition Management and Support (Directorate)
AMA	Against Medical Advice American Medical Association
AMCB	American Midwifery Certification Board
AMH	Accreditation Manual for Hospitals
AMHCA	American Mental Health Counselor Association
AML	Acute Myelogenous [Myeloid] Leukemia

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

### Appendix A

#### Acronyms And Abbreviations

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IEA	Intradiscal Electrothermal Annuloplasty
IEP	Individualized Educational Program
IFC	Interim Final Rule with comment
IFR	Interim Final Rule
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
<b>IPSF</b>	<b>Inpatient Provider Specific File</b>
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

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

### Appendix A

#### Acronyms And Abbreviations

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IS	Information System
ISN	Investigation Schedule Notice
ISO	International Standard Organization
ISP	Internet Service Provider
IT	Information Technology
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
DLT	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

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

## Appendix A

### Acronyms And Abbreviations

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LOD	Letter of Denial/Revocation Line of Duty
LOI	Letter of Intent
LOS	Length-of-Stay
LOT	Life Orientation Test
LPA	Licensed Psychological Associate
LPC	Licensed Professional Counselor
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&RS	Medical Benefits and Reimbursement <b>Section</b>
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

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

## Appendix A

### Acronyms And Abbreviations

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MGIB	Montgomery GI Bill
MH	Mental Health
MHCC	Maryland Health Care Commission
MHO	Medical Holdover
MHS	Military Health System
MHSO	Managing Health Services Organization
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
MM	Medical Management
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

# Index

A	Chap	Sec/Add
Abortions	4	18.3
Accreditation	11	3.3
Acronyms And Abbreviations		Appendix A
Acute Hospital Psychiatric Care: Preauthorization, Concurrent Review, and Payment Responsibility	7	3.3
Adjunctive Dental Care	8	13.1
<b>Advance Care Planning (ACP) Services</b>	<b>1</b>	<b>15.3</b>
Allergy Testing And Treatment	7	14.1
Ambulance Service	8	1.1
Ambulatory Surgery	11	6.1
Ancillary Inpatient Mental Health Services	7	3.9
Anesthesia	3	1.1
Dental	8	13.2
Anesthesiologist Assistant (AA)	11	3.5
Antepartum Services	4	18.2
Anticoagulant Management	2	5.2
Application Form For Corporate Services Providers	11	D
Applied Behavior Analysis (ABA)	7	3.16
For Non-Active Duty Family Members (NADFM) Who Participate In The ABA Pilot	7	3.17
Assistant Surgeons	4	4.1
Attention-Deficit/Hyperactivity Disorder	7	3.7
Audiology Service	7	8.1
Auditory System	4	22.1
Augmentative Communication Devices (ACDs)	7	23.1
Automated External Defibrillators (AEDs)	8	5.4

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

C	Chap	Sec/Add
Cancer Clinical Trials	7	24.1
Cardiac Rehabilitation	7	11.1
Cardiovascular System	4	9.1
Cardiovascular Therapeutic Services	7	6.3
Category II Codes - Performance Measurement	1	11.1
Category III Codes	1	12.1
Central Nervous System (CNS) Assessments/Tests	7	16.1
Certification Of Organ Transplant Centers	11	7.1
Certified Clinical Social Worker (CSW)	11	3.6
Certified Marriage And Family Therapist Certification Process	11	11.3
Certified Nurse Midwife (CNM)	11	3.12
Certified Physician Assistant	11	3.13
Certified Psychiatric Nurse Specialist (CPNS)	11	3.7
Cervical Cancer Screening	7	2.4
Cesarean Sections	4	18.4
Chelation Therapy	7	2.7
Chemotherapy Administration	7	16.3
Chest X-Rays	5	1.1
Chiropractic Manipulative Treatment (CMT)	7	18.5
Chronic Care Management Services	1	15.2
Chronic Fatigue Syndrome (CFS)	7	21.1
Clinical Preventive Services		
TRICARE Prime	7	2.2
TRICARE Standard	7	2.1
Clinical Psychologist	11	3.8
Cochlear Implantation	4	22.2
Cold Therapy Devices For Home Use	8	2.4
Collateral Visits	7	3.14
Combined Heart-Kidney Transplant (CHKT)	4	24.3
Combined Liver-Kidney Transplant (CLKT)	4	24.6
Combined Small Intestine-Liver (SI/L) Transplant	4	24.4
Complications (Unfortunate Sequelae) Resulting From Noncovered Surgery Or Treatment	4	1.1
Computerized Axial Tomography (CAT)	5	1.1
Computerized Tomography (CT)	5	1.1
Conscious Sedation	3	1.2
Consultations	2	5.1

