



DEFENSE  
HEALTH AGENCY

**MB&RS**

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

**CHANGE 170  
6010.57-M  
SEPTEMBER 12, 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:** CONSOLIDATED CHANGES 16-003

**CONREQ:** 18042

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

**SUMMARY OF CHANGE(S):** See page 3.

**EFFECTIVE DATE:** See page 3.

**IMPLEMENTATION DATE:** October 12, 2016.

**FAZZINI.ANN**  
**.NOREEN.11**  
**99802271**  
Digitally signed by  
FAZZINI.ANN.NOREEN.1199802271  
DN: c=US, o=U.S. Government,  
ou=DoD, ou=PKI, ou=DHA,  
cn=FAZZINI.ANN.NOREEN.11998022  
71  
Date: 2016.09.07 11:42:19 -06'00'

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

**CHANGE 170**  
**6010.57-M**  
**SEPTEMBER 12, 2016**

**REMOVE PAGE(S)**

**CHAPTER 2**

Section 4.1, pages 3 and 4

**CHAPTER 4**

Table of Contents, pages 1 and 2

Section 6.2, pages 1 and 2

Section 15.1, pages 1 through 3

Section 17.1, pages 1 and 2

**CHAPTER 7**

Section 2.3, page 1

**INDEX**

pages 1 through 6

**INSERT PAGE(S)**

Section 4.1, pages 3 and 4

Table of Contents, pages 1 and 2

Section 6.2, pages 1 and 2

Section 15.1, pages 1 through 3

Section 17.1, pages 1 and 2

Section 2.3, pages 1 and 2

pages 1 through 6

## **SUMMARY OF CHANGES**

### **CHAPTER 2**

1. Section 4.1. This change clarifies policy regarding adjudication of claims on pain associated with pregnancy. EFFECTIVE DATE: As stated in the issuance.

### **CHAPTER 4**

2. Section 6.2. This change provides clarification on existing policy that ultrasound bone growth stimulators are covered. EFFECTIVE DATE: As stated in the issuance.
3. Section 15.1. This change clarifies existing policy on medically necessary reversal of male surgical sterilization as a covered benefit under the TRICARE Basic Program. EFFECTIVE DATE: As stated in the issuance.
4. Section 17.1. This change clarifies existing policy on medically necessary reversal of female surgical sterilization as a covered benefit under the TRICARE Basic Program. EFFECTIVE DATE: As stated in the issuance.

### **CHAPTER 7**

5. Section 2.3. This change clarifies existing policy on medically necessary reversal of male and female surgical sterilization as a covered benefit under the TRICARE Basic Program. EFFECTIVE DATE: As stated in the issuance.



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

### Chapter 2, Section 4.1

#### Emergency Department (ED) Services

---

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 or the date of admission, whichever occurs first (refer to the TRICARE Operations Manual (TOM)).

**5.8** ED services as defined in "POLICY" above are cost-shared as follows:

**5.8.1** Outpatient care when the beneficiary is discharged home, regardless of any subsequent hospital admission related to the reason for the ED visit.

**5.8.2** As inpatient care when:

**5.8.2.1** An immediate inpatient admission for acute care follows the outpatient ED services.

**5.8.2.1.1** "Immediate" includes the time lapse associated with the beneficiary's direct transfer to an acute care facility more capable of providing the required level-of-care. ED care includes otherwise payable services of both the transferring and receiving facilities.

**5.8.2.1.2** This will be done even when the ED care is billed separately, as is required for all hospital services provided on an outpatient basis when the related inpatient stay is subject to the TRICARE DRG-based payment system. In determining if the ED care was immediately followed by an inpatient admission, the TRICARE contractor is required only to examine the claim for ED care for evidence of a subsequent admission and to examine its in-house claims records (history).

**5.8.2.2** An ED patient dies while awaiting formal hospital admission for continued medically necessary acute care.

**Note:** See [paragraph 6.0](#) for Prime, Extra, and Standard-specific cost-sharing provisions for non-emergency care sought in an ED.

## 6.0 LIMITATIONS

### 6.1 TRICARE PRIME Beneficiaries

**6.1.1** Prime enrollees must obtain all non-emergency primary health care from the Primary Care Manager (PCM) or from another provider to which the enrollee is referred by the PCM or the contractor. Therefore, if a TRICARE Prime beneficiary seeks treatment in an ED and there was not a referral by his/her PCM, and it is clearly a case of routine illness where the beneficiary's medical condition never was, or never appeared to be, a condition as defined in POLICY above, then payment shall be in accordance with the Point of Service (POS) option.

**6.1.2** Claims shall not be denied or paid at the POS option because a condition, which appeared to be a serious medical condition when presenting to the ED, turns out to be non-emergency in nature based on the final diagnosis (i.e., claims shall not be denied in situations where the beneficiary presents to the ED with a condition that would cause a prudent layperson to believe an emergency exists, but the final diagnosis is determined to be a non-emergency condition.) A common example of this situation is when a beneficiary seeks treatment in the ED for chest pain, but the final diagnosis is indigestion.

**6.2 Non-Enrolled TRICARE Beneficiaries (Standard And Extra)**

**6.2.1** While TRICARE Extra/Standard beneficiaries have the freedom to choose a provider of care, all TRICARE benefits must be “medically necessary” and “appropriate medical care”. (See the BACKGROUND section of this policy). If an Extra/Standard beneficiary seeks treatment in an ED and it was clearly a case of routine illness where the beneficiary’s medical condition never was, or never appeared to be, a condition as defined in [paragraph 4.0](#), then the facility charge shall be denied (i.e., the ED fee billed on the current Centers for Medicare and Medicaid Services (CMS) forms) and the professional services shall be allowed. Other professional ancillary services, including professional components of laboratory and radiology services, if appropriate can be also covered on an allowable charge basis. If an Extra or Standard beneficiary is referred to the ED by the contractor, (e.g., for after hours care), the care is to be allowed.

**6.2.2** Claims shall not be denied because a condition, which appeared to be a serious medical condition upon presenting to the ED, turns out to be non-emergency in nature based on the final diagnosis. (i.e., claims shall not be denied in situations where the beneficiary presents to the ED with a condition that would cause a prudent layperson to believe an emergency exists, but the final diagnosis is determined to be a non-emergency condition.) A common example of this situation is when a beneficiary seeks treatment in the ED for chest pain, but the final diagnosis is indigestion.

- END -

## Chapter 4

### Surgery

Section/Addendum	Subject/Addendum Title
1.1	Complications (Unfortunate Sequelae) Resulting From Noncovered Surgery Or Treatment
1.2	Treatment Of Unfortunate Sequelae And/Or Medically Necessary Follow-On Care Subsequent To Authorized Noncovered Initial Surgery Or Treatment In A Military Treatment Facility (MTF)
2.1	Cosmetic, Reconstructive, And Plastic Surgery - General Guidelines
2.2	General Surgery
3.1	Laser Surgery
4.1	Assistant Surgeons
5.1	Integumentary System
5.2	Post-Mastectomy Reconstructive Breast Surgery and Breast Prostheses
5.3	Prophylactic Mastectomy, Prophylactic Oophorectomy, And Prophylactic Hysterectomy
5.4	Reduction Mammoplasty For Macromastia
5.5	Silicone Or Saline Breast Implant Removal
5.6	Breast Reconstruction As A Result Of A Congenital Anomaly
5.7	Gynecomastia
5.8	Negative Pressure Wound Therapy (NPWT)
6.1	Musculoskeletal System
6.2	Bone Growth Stimulation
7.1	Oral Surgery
8.1	Respiratory System
8.2	Lung Volume Reduction Surgery (LVRS)
9.1	Cardiovascular System
9.2	Photopheresis
9.3	Intracoronary Stents
9.4	Therapeutic Apheresis
10.1	Transjugular Intrahepatic Portosystemic Shunt (TIPS)
11.1	Hemic And Lymphatic Systems

**TRICARE Policy Manual 6010.57-M, February 1, 2008**  
Chapter 4, Surgery

<b>Section/Addendum</b>	<b>Subject/Addendum Title</b>
12.1	Mediastinum And Diaphragm
13.1	Digestive System
13.2	Surgery For Morbid Obesity
14.1	Urinary System
15.1	Male Genital System
16.1	Intersex Surgery
17.1	Female Genital System
18.1	Maternity Care
18.2	Antepartum Services
18.3	Abortions
18.4	Cesarean Sections
18.5	Fetal Surgery
19.1	Endocrine System
20.1	Nervous System
20.2	Stereotactic Radiofrequency Pallidotomy With Microelectrode Mapping For Treatment Of Parkinson's Disease
20.3	Stereotactic Radiofrequency Thalamotomy
21.1	Eye And Ocular Adnexa
22.1	Auditory System
22.2	Cochlear Implantation
23.1	High Dose Chemotherapy (HDC) And Stem Cell Transplantation
24.1	Heart-Lung And Lung Transplantation
24.2	Heart Transplantation
24.3	Combined Heart-Kidney Transplantation (CHKT)
24.4	Small Intestine (SI), Combined Small Intestine-Liver (SI/L), And Multivisceral Transplantation
24.5	Liver Transplantation
24.6	Combined Liver-Kidney Transplantation (CLKT)
24.7	Simultaneous Pancreas-Kidney (SPK), Pancreas-After-Kidney (PAK), And Pancreas-Transplant-Alone (PTA), <b>And Pancreatic Islet Cell Transplantation</b>
24.8	Kidney Transplantation
24.9	Donor Costs

## Bone Growth Stimulation

Issue Date: October 6, 1988

Authority: [32 CFR 199.4\(c\)\(2\)\(i\)](#)

---

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

20974 - 20975, 20979, 20670, 20680

### 2.0 HCPCS PROCEDURE CODES

E0747 - E0749, E0760

### 3.0 DESCRIPTION

Electrical stimulation to augment bone repair can be accomplished through one of the following methods:

**3.1** A totally invasive method in which electrodes and power pack are surgically implanted within the extremity.

**3.2** A semi-invasive method in which electrodes penetrate the fracture and the power pack is externally placed and the leads are connected to the inserted electrodes.

**3.3** A totally noninvasive method in which the electrodes are placed over the cast surface and are connected to an external power pack.

### 4.0 POLICY

**4.1** Use of the invasive and semi-invasive types of devices are covered for nonunion of long bone fractures.

**4.2** Use of the noninvasive type of device is covered for the following procedures:

- Nonunion of long bone fractures.
- Failed fusion.
- Congenital pseudo-arthrooses.

---

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

**4.3** Use of the invasive or noninvasive type of device is covered as an adjunct to spinal fusions to increase the probability of fusion success for:

**4.3.1** Patients at high risk for pseudo-arthritis, including those patients with:

- One or more failed fusions;
- Grade 2 or 3 spondylolisthesis;
- Fusions at more than one level, or

**4.3.2** Fusions performed on patients considered to be at high risk (i.e., smokers, obese, etc.).

**4.4** Nonunion, for all types of devices. A nonunion is considered to be established when the fracture site shows no visibly progressive signs of healing.

**4.5** Ultrasound bone growth stimulators (CPT<sup>2</sup> procedure code 20979) are covered when medically necessary and appropriate (e.g. as a treatment to promote healing of some fresh fractures and to accelerate healing for nonunion of other fracture sites). See Chapter 8, Section 5.1 for TRICARE policy on medical devices.

**4.6** When determined to be medically necessary, the electrical bone stimulator may be rented following the durable medical equipment reimbursement procedures outlined in Chapter 8, Section 2.1.

**4.7** When determined to be medically necessary, repairs, adjustments and accessories necessary for the effective functioning of the device, and removal and replacement of the covered device, as well as associated surgical costs are covered.

- END -

---

<sup>2</sup> CPT only © 2006 American Medical Association (or such other date of publication of CPT). All Rights Reserved.

## Male Genital System

Issue Date: August 26, 1985

Authority: [32 CFR 199.4\(c\)\(2\)](#), [\(c\)\(3\)](#), [\(e\)\(3\)\(i\)\(B\)\(3\)](#), [\(e\)\(8\)](#), [\(e\)\(8\)\(i\)\(E\)](#), [\(e\)\(8\)\(ii\)\(D\)](#), and [\(g\)\(29\)](#)

---

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

54000 - 55300, **55400**, 55450 - 55705, 55720 - 55866, 55873 - 55899, 55970, 55980

### 2.0 DESCRIPTION

The male genital system includes the male organs of reproduction.

### 3.0 POLICY

**3.1** Medically necessary services and supplies required in the diagnosis and treatment of disease or injury involving the male genital system are covered.

**3.2** A vasectomy, unilateral or bilateral, performed as an independent procedure is a covered service. (See [Chapter 7, Section 2.3](#) for detailed policy concerning sterilization and birth control.)

**3.3** For Implantable Urethral Sphincter, see [Section 14.1](#).

**3.4** Diagnostic studies necessary to establish organic versus psychogenic impotence, such as lab work, a psychiatric evaluation, Doppler ultrasound, arteriography, cavernosography, cavernosometry, or electrophysiological testing may be cost-shared. (Also, see [Chapter 7, Section 1.1](#).)

**3.5** Organic impotence is defined as that which can be reasonably expected to occur following certain diseases, surgical procedures, trauma, injury, or congenital malformation. Impotence does not become organic because of psychological or psychiatric reasons.

**3.6** Treatment of organic impotency is covered subject to all applicable provisions of [32 CFR 199.4](#).

**3.6.1** Penile Implant.

**3.6.1.1** Insertion of an U.S. Food and Drug Administration (FDA) approved penile implant is covered when performed for organic impotence which has resulted from a disease process, trauma, radical surgery, or for correction of a congenital anomaly, or for correction of ambiguous genitalia which has been documented to be present at birth.

---

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

**3.6.1.2** Removal and reinsertion of covered penile implants and associated surgical fees may be cost-shared.

**3.6.2** Hormone injection, non-injectable delivery system or intracavernosal injection for the treatment of organic impotency, may be cost-shared providing the drugs are FDA approved and usage is considered generally accepted medical practice.

**3.6.3** External vacuum appliance for the treatment of organic impotency may be cost-shared providing the external appliance is FDA approved and usage is considered generally accepted medical practice.

**3.6.4** Orally administered medication for the treatment of erectile dysfunction may be cost-shared. Prior authorizations and quantity limits may be required (see [Chapter 8, Section 9.1](#)).

**3.6.5** Aortoiliac reconstruction, endarterectomy, and arterial dilatations for proximal lesions for the treatment of organic impotency may be cost-shared.

**3.6.6** Testicular prostheses.

**3.6.6.1** Insertion of an FDA approved testicular prosthesis is covered when performed following disease, trauma, injury, radical surgery, or for correction of a congenital anomaly, or for correction of ambiguous genitalia which has been documented to be present at birth.

**3.6.6.2** If the initial testicular prosthesis surgery was for an indication covered or coverable by TRICARE, treatment of complications may be covered following reconstruction (including prosthesis removal and reinsertion) regardless of when the reconstruction was performed. Complications that may result following removal and reinsertion of prostheses are covered.

**3.6.6.3** If the initial testicular prosthesis surgery was for an indication not covered or coverable by TRICARE, implant removal may be covered only if it is necessary treatment of a complication which represents a separate medical condition. See [Section 1.1](#).

**3.7** Infertility testing and treatment, including correction of the physical cause of infertility may be cost-shared. Hypothalamic disease, pituitary disease, disorders of sperm transport, disorders of sperm motility or function, and/or sexual dysfunction may cause male infertility. Diagnostic Services may include semen analysis, hormone evaluation, chromosomal studies, immunologic studies, special and sperm function tests, and/or bacteriologic investigation. Therapy may include, but is not limited to, hormonal treatment, surgery, antibiotics, administration of Human Chorionic Gonadotropin (HCG), and/or radiation therapy, depending upon the cause.

**3.8** Sex gender change and intersex surgery (CPT<sup>2</sup> procedure codes 55970 and 55980) is limited to surgery performed to treat ambiguous genitalia which is documented to have been present at birth.

**3.9** Medically necessary reversal of surgical sterilization for the treatment of a disease or injury such as intractable chronic scrotal pain or post-vasectomy pain (CPT<sup>2</sup> procedure codes 55400, 54900, and 54901) may be cost-shared.

---

<sup>2</sup> CPT only © 2006 American Medical Association (or such other date of publication of CPT). All Rights Reserved.

#### 4.0 EXCLUSIONS

- 4.1** Penile implants and related services when performed for psychological impotence, sex gender change surgery, or such other conditions as gender dysphoria.
- 4.2** Testicular prosthesis and related services when performed for sex gender change surgery or such other conditions as gender dysphoria.
- 4.3** Therapy for sexual dysfunctions or inadequacies (see [Chapter 7, Section 1.1](#)).
- 4.4** Arterial revascularization for distal lesions and venous leakage when treatment is for organic impotency.
- 4.5** All services and supplies directly and indirectly related to surgical treatment (i.e., sex gender change), except when performed to correct ambiguous genitalia, which is documented to have been present at birth (CPT<sup>3</sup> procedure codes 55970 and 55980).
- 4.6** Reversal of surgical sterilization (CPT<sup>3</sup> procedure codes 54900, 54901, and 55400), **except as stated in [paragraph 3.9](#)**.
- 4.7** Cryosurgery for prostate metastases M or N is unproven.
- 4.8** Electroejaculation (CPT<sup>3</sup> procedure code 55870).
- 4.9** Prophylactics (condoms).
- 4.10** Over-The-Counter (OTC) spemicidal products.
- 4.11** Prostate saturation biopsy (CPT<sup>3</sup> procedure code 55706).
- 4.12** Penile Vibratory Stimulation (PVS) devices, such as Ferticare Personal 2 medical vibrator.

- END -

---

<sup>3</sup> CPT only © 2006 American Medical Association (or such other date of publication of CPT). All Rights Reserved.



## Female Genital System

Issue Date: August 26, 1985

Authority: [32 CFR 199.4\(c\)\(2\)](#), [\(c\)\(3\)](#), [\(e\)\(3\)](#), [\(e\)\(8\)\(ii\)\(D\)](#), [\(g\)\(29\)](#), and [\(g\)\(34\)](#)

---

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

11975 - 11977, 37243, 55970, 55980, 56405 - 58301, 58340, 58345, 58346, 58350, 58353, 58356, 58400 - **58673**, 58679, 58700 - 58740, **58750 - 58770**, 58800 - 58960, 58999, 59001

### 2.0 DESCRIPTION

The female genital system includes the female organs of reproduction.

### 3.0 POLICY

**3.1** Services and supplies required in the diagnosis and treatment of illness or injury involving the female genital system are covered. Infertility testing and treatment, including correction of the physical cause of infertility, are covered under this provision. This does not include artificial insemination or Assisted Reproductive Technology (ART) procedures, which is excluded from coverage.

**3.2** Uterine suspension; parametrial fixation as treatment for uterine prolapse may be cost-shared only to retain the uterus for biologic purposes.

**3.3** Sex gender change and intersex surgery (CPT<sup>1</sup> procedure codes 55970 and 55980) is limited to surgery performed to treat ambiguous genitalia which is documented to have been present at birth.

**3.4** Medically necessary reversal of surgical sterilization for the treatment of a disease or injury such as chronic pelvic pain (CPT<sup>1</sup> procedure codes 58672, 58673, 58750 - 58770) may be cost-shared.

**Note:** For policy on prophylactic mastectomy, prophylactic oophorectomy, and prophylactic hysterectomy, see [Section 5.3](#).

### 4.0 POLICY CONSIDERATION

Benefits are payable for Uterine Artery Embolization (UAE), as an alternative treatment (CPT<sup>1</sup> procedure code 37243) to hysterectomy or myomectomy, for those individuals with confirmed, symptomatic uterine fibroids who are premenopausal and who do not wish to preserve their

---

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

childbearing potential.

## **5.0 EXCLUSIONS**

**5.1** Prophylactics (condoms).

**5.2** Over-the-counter (OTC) spermicidal products.

**5.3** Reversal of a surgical sterilization procedure (CPT<sup>2</sup> procedure codes 58672, 58673, 58750 - 58770), **except as stated in paragraph 3.4.**

**5.4** Artificial insemination, including any costs related to donors and semen banks (CPT<sup>2</sup> procedure codes 58321 - 58323).

**5.5** In Vitro Fertilization (IVF), Gamete Intrafallopian Transfer (GIFT), Zygote Intrafallopian Transfer (ZIFT), Tubal Embryo Transfer (TET), and all other non-coital reproductive procedures, including all services and supplies related to, or provided in conjunction with, those technologies (CPT<sup>2</sup> procedure codes 58970 - 58976).

**5.6** Hysterectomy (CPT<sup>2</sup> procedure codes 58150 - 58285, 58550, 59525) performed solely for purposes of sterilization in the absence of pathology.

**5.7** Cervicography (CPT<sup>2</sup> category III procedure code 0003T) is unproven.

**5.8** UAE for individuals with specific contraindications, including such conditions as pelvic malignancy and pelvic inflammatory disease, and premenopausal patients who wish to preserve their childbearing potential.

**5.9** Ultrasound ablation (destruction of uterine fibroids) with Magnetic Resonance Imaging (MRI) guidance (CPT<sup>2</sup> procedure code 0071T) in the treatment of uterine leiomyomata is unproven.

**5.10** Percutaneous transcatheter embolization of ovarian and/or internal iliac veins for the treatment of Pelvic Congestion Syndrome (PCS) is unproven.

**5.11** All services and supplies directly and indirectly related to surgical treatment (i.e., sex gender change) except when performed to correct ambiguous genitalia, which is documented to have been present at birth (CPT<sup>2</sup> procedure codes 55970 and 55980).

- END -

---

<sup>2</sup> CPT only © 2006 American Medical Association (or such other date of publication of CPT). All Rights Reserved.

## Chapter 7

## Section 2.3

### Family Planning

Issue Date: August 26, 1985  
Authority: [32 CFR 199.4\(e\)\(3\)](#)

---

#### 1.0 POLICY

The family planning procedures listed below may be cost-shared:

- 1.1 Surgical insertion, removal, and replacement of intrauterine devices.
- 1.2 Measurement for, and purchase of, contraceptive diaphragms, including remeasurement and replacement.
- 1.3 Prescription contraceptives and prescription contraceptives used as emergency contraceptives.

**Note:** Implantable prescription contraceptives are covered if the U.S. Food and Drug Administration (FDA) approved and used for the labeled indication.

- 1.4 Male and female surgical sterilization.

#### 2.0 EXCLUSIONS

- 2.1 Prophylactics (condoms).
- 2.2 Spermicidal foams, jellies, and sprays not requiring a prescription.
- 2.3 Services and supplies related to noncoital reproductive technologies, including but not limited to artificial insemination (including cost related to donors and semen banks), In Vitro Fertilization (IVF) and Gamete Intrafallopian Transfer (GIFT).
- 2.4 Male and female reversal of a surgical sterilization procedure, **except medically necessary reversal of surgical sterilization for the treatment of a disease or injury (see Chapter 4, Sections 15.1 and 17.1).**
- 2.5 For routine screening Papanicolaou (PAP) smear tests, routine gynecologic examinations, and related laboratory testing, see the Preventive Services policy.

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

Chapter 7, Section 2.3

Family Planning

---

**2.6** The family planning benefit does not include screening PAP smear tests, routine gynelologic examinations, including related laboratory testing. However, family planning benefits may be allowed during an office visit for a screening PAP test.

- END -

# 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	3.1
Adjunctive Dental Care	8	13.1
Advance Care Planning (ACP) Services	1	15.3
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
Bone Growth Stimulation	4	6.2
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

B (CONTINUED)	Chap	Sec/Add
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	3.9
	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



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

Index

<b>F (CONTINUED)</b>	<b>Chap</b>	<b>Sec/Add</b>	<b>I (CONTINUED)</b>	<b>Chap</b>	<b>Sec/Add</b>
Freestanding			Intersex Surgery	4	16.1
Ambulatory Surgery Center (ASC)	11	6.2	Intracoronary Stents	4	9.3
Partial Hospitalization Program (PHP)	11	2.6			
<b>G</b>	<b>Chap</b>	<b>Sec/Add</b>	<b>K</b>	<b>Chap</b>	<b>Sec/Add</b>
Gastroenterology	7	5.1	Kidney Transplant	4	24.8
Gender Dysphoria	7	1.2			
General Policy And Responsibilities	1	1.1	<b>L</b>	<b>Chap</b>	<b>Sec/Add</b>
General Surgery	4	2.2	Laser Surgery	4	3.1
Genetic Testing	7	2.1	Lenses (Intraocular Or Contact) And Eye Glasses	7	6.2
Gynecomastia	4	5.7	Liquid Protein Diets	8	7.2
<b>H</b>	<b>Chap</b>	<b>Sec/Add</b>	Liver Transplant	4	24.5
Health And Behavior Assessment/ Intervention	7	16.2	Living Donor Liver Transplant (LDLT)	4	24.5
Healthcare Common Procedure Coding System (HCPCS) "C" And "S" Codes	1	13.1	Lung Transplantation	4	24.1
Hearing Aids And Hearing Aid Services	7	8.2	Lung Volume Reduction Surgery (LVRS)	4	8.2
Heart Transplant	4	24.2	<b>M</b>	<b>Chap</b>	<b>Sec/Add</b>
Heart-Lung Transplant	4	24.1	Magnetic Resonance Angiography (MRA)	5	1.1
Hemic And Lymphatic Systems	4	11.1	Magnetic Resonance Imaging (MRI)	5	1.1
High Dose Chemotherapy (HDC) And Stem Cell Transplantation	4	23.1	Male Genital System	4	15.1
Home Infusion Therapy	8	20.1	Maternity Care	4	18.1
Home Prothrombin Time (PT)			Mediastinum And Diaphragm	4	12.1
International Normalized Ratio (INR) Monitor	8	2.5	Medical Devices	8	5.1
Home Sleep Studies	7	19.1	Medical Photography	1	5.2
Home Uterine Activity Monitor (HUAM)	4	18.1	Medical Supplies And Dressings (Consumables)	8	6.1
Hospital Care	2	2.1	Memorandum Of Understanding (MOU) Between the Department of Veterans Affairs (DVA) and the DoD	11	2.1
Hydration, Therapeutic, Prophylactic, And Diagnostic Injections And Infusions	7	2.8	Mental Health Counselor	11	3.11
Hyperbaric Oxygen (HBO) Therapy	7	20.1	Moderate (Conscious) Sedation	3	1.2
Hyperthermia	5	3.3	Multivisceral Transplant	4	24.4
<b>I</b>	<b>Chap</b>	<b>Sec/Add</b>	Musculoskeletal System	4	6.1
Implantable Infusion Pump (IIP)	8	2.3	<b>N</b>	<b>Chap</b>	<b>Sec/Add</b>
Individual Case Management Program For Persons With Extraordinary Conditions (ICMP-PEC)	1	10.1	Negative Pressure Wound Therapy (NPWT)	4	5.8
Infantile Apnea Cardiorespiratory Monitor	8	2.2	Neonatal And Pediatric Critical Care Services	2	4.2
Injections And Infusions	7	2.8	Nervous System	4	20.1
Inpatient Concurrent Care	2	2.2	Neurology And Neuromuscular Services	7	15.1
Institutional Care	9	10.1	Neuromuscular Electrical Stimulation (NMES) Devices	8	5.2
Institutional Provider, Individual Provider, And Other Non-Institutional Provider Participation	11	1.2	Non-Availability Statement (NAS) (DD Form 1251) For Inpatient Care	1	6.1
Integumentary System	4	5.1	Non-Invasive Vascular Diagnostic Studies	7	12.1
			Nuclear Medicine	5	4.1



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

Index

<b>R (CONTINUED)</b>	<b>Chap</b>	<b>Sec/Add</b>	<b>S (CONTINUED)</b>	<b>Chap</b>	<b>Sec/Add</b>
Reduction Mammoplasty For Macromastia	4	5.4	Substance Use Disorder Rehabilitation Facilities (SUDRFs) Certification Process	11	8.1
Registered Dietitian (RD)	11	3.14	Substance Use Disorders (SUDs)	7	3.5
Rehabilitation - General	7	18.1	Supervised Mental Health Counselor (SMHC)	11	3.11
Requirements For Documentation Of Treatment In Medical Records	1	5.1	Surgery For Morbid Obesity	4	13.2
Residential Treatment Center (RTC) Care					
Preauthorization and Concurrent Review	7	3.2			
Respiratory System	4	8.1			
Routine Physical Examinations	7	2.6			
<b>S</b>	<b>Chap</b>	<b>Sec/Add</b>	<b>T</b>	<b>Chap</b>	<b>Sec/Add</b>
Sensory Evoked Potentials (SEP)	7	15.2	Telemental Health (TMH)/Telemedicine	7	22.1
Services Rendered By Employees Of Authorized Independent Professional Providers	11	10.1	Therapeutic Apheresis	4	9.4
Sexual Dysfunctions And Paraphilic Disorders	7	1.1	Therapeutic Shoes For Diabetics	8	8.2
Silicone Or Saline Breast Implant Removal	4	5.5	Thermography	5	5.1
Simultaneous Pancreas-Kidney (SPK) Transplant	4	24.7	Transfusion Services For Whole Blood, Blood Components, And Blood Derivatives	6	2.1
Single Photon Emission Computed Tomography (SPECT)	5	4.1	Transitional Assistance Management Program (TAMP)	10	5.1
Skilled Nursing Facility (SNF) Visits	2	3.1	Transitional Care Management Services	1	15.1
Small Intestine (SI) Transplant	4	24.4	Transitional Survivor Status And Survivor Status	10	7.1
Small Intestine-Liver (SI/L) Transplant	4	24.4	Transjugular Intrahepatic Portosystemic Shunt (TIPS)	4	10.1
Smoking Cessation Counseling	8	19.1	Transplant		
Special Authorization Requirements	1	7.1	Combined Heart-Kidney (CHKT)	4	24.3
Special Education And Other Services	9	9.1	Combined Liver-Kidney (CLKT)	4	24.6
Special Otorhinolaryngologic Services	7	8.1	Donor Costs	4	24.9
Specific Learning Disorders	7	3.6	Heart	4	24.2
Speech Services	7	7.1	Heart-Lung	4	24.1
Standards			Kidney	4	24.8
Inpatient Rehabilitation And Partial Hospitalization For The Treatment Of Substance Use Disorders	11	F	Liver	4	24.5
Psychiatric Partial Hospitalization Programs (PHPs)	11	A	Living Donor Liver (LDLT)	4	24.5
Residential Treatment Centers (RTCs) Serving Children And Adolescents	11	H	Lung	4	24.1
State Licensure And Certification	11	3.2	Multivisceral	4	24.4
State Vaccine Programs (SVPs) As TRICARE-Authorized Providers	11	9.2	Pancreas-After-Kidney (PAK)	4	24.7
Stereotactic Radiofrequency Pallidotomy With Microelectrode Mapping For Treatment Of Parkinson's Disease	4	20.2	Pancreas-Transplant-Alone (PTA)	4	24.7
Stereotactic Radiofrequency Thalamotomy	4	20.3	Pancreatic Islet Cell	4	24.7
			Simultaneous Pancreas-Kidney (SPK)	4	24.7
			Small Intestine (SI)	4	24.4
			Small Intestine-Liver (SI/L) Combined	4	24.4
			Treatment Of Mental Disorders	7	3.8
			Treatment Of Unfortunate Sequelae And/Or Medically Necessary Follow-On Care Subsequent To Authorized Noncovered Initial Surgery Or Treatment In A Military Treatment Facility (MTF)	4	1.2
			TRICARE Certified Mental Health Counselor (TCMHC)	11	3.11
			TRICARE For Life (TFL) And Other Medicare-Eligible Beneficiaries	10	6.1

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

Index

<b>T (CONTINUED)</b>	<b>Chap</b>	<b>Sec/Add</b>
----------------------	-------------	----------------

TRICARE Overseas Program (TOP)	12	1.1
Medical Benefit Variations	12	1.2
Outside The 50 United States And The District Of Columbia Locality-Based Reimbursement Rate Waiver	12	1.3
TRICARE Reserve And National Guard (NG) Family Member Benefits	10	8.1

<b>U</b>	<b>Chap</b>	<b>Sec/Add</b>
----------	-------------	----------------

Ultrasound	5	2.1
Unauthorized Institution - Related Professional Services	11	4.1
Unauthorized Provider - Emergency Services	11	4.2
Unproven Drugs, Devices, medical Treatments, And Procedures	1	2.1
Urinary System	4	14.1

<b>V</b>	<b>Chap</b>	<b>Sec/Add</b>
----------	-------------	----------------

Veterans Affairs (VA) Health Care Facilities	11	2.1
--	----	-----

<b>W</b>	<b>Chap</b>	<b>Sec/Add</b>
----------	-------------	----------------

Waiver Of Liability	1	4.1
Initial Denial Determination	1	4.1
MCSC Reconsideration Determinations	1	4.1
TQMC Reconsideration Determinations	1	4.1
Well-Child Care	7	2.5
Wigs Or Hairpiece	8	12.1

- END -