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TRICARE  
MANAGEMENT ACTIVITY

**MB&RB**

**CHANGE 4  
6010.57-M  
NOVEMBER 7, 2008**

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

**The TRICARE Management Activity has authorized the following addition(s)/revision(s) to the 6010.57-M, issued February 2008.**

**CHANGE TITLE: CONSOLIDATED CHANGE**

**PAGE CHANGE(S): See pages 2 through 4.**

**SUMMARY OF CHANGE(S): This change brings this Manual up-to-date with published changes to the Aug 2002 TRICARE Policy Manual (TPM), 6010.54-M. Included are changes 79, 81, 82, 83, 84, 85, 86, 87, 88, 89, and 90.**

**EFFECTIVE AND IMPLEMENTATION DATE: Upon direction of the Contracting Officer.**

**This change is made in conjunction with Feb 2008 TOM, Change No. 4, Feb 2008 TRM, Change No. 4, and Feb 2008 TSM, Change No. 4.**

**Reta Michak  
Chief, Office of Medical Benefits and  
Reimbursement Branch**

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## Rare Diseases

Issue Date: May 18, 1994

Authority: [32 CFR 199.2\(b\)](#) and [32 CFR 199.4\(g\)\(15\)](#)

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### 1.0 DESCRIPTION

TRICARE defines a rare disease as any disease or condition that affects less than 200,000 persons in the United States.

### 2.0 POLICY

**2.1** Coverage for treatment of rare diseases may be considered on a case-by-case basis. Case-by-case review is not required for drugs, devices, medical treatments, and procedures that have already been established as safe and effective for treatment of rare diseases.

**2.1.1** In reviewing the case, any or all of the following sources may be used to determine if the proposed benefit is considered safe and effective.

**2.1.2** Trials published in refereed medical literature.

**2.1.3** Formal technology assessments.

**2.1.4** National medical policy organization positions.

**2.1.5** National professional associations.

**2.1.6** National expert opinion organizations.

**2.2** If case review indicates that the proposed benefit for a rare disease is safe and effective for that disease, benefits may be allowed. If benefits are denied, an appropriate appealing party may request an appeal.

**2.3** Off-label use of rituximab may be considered for cost-sharing for the treatment of recurrent nodular CD20 positive lymphocyte predominant Hodgkin's disease. The effective date is January 1, 2003.

- END -



## Special Authorization Requirements

Issue Date: August 4, 1988

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

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### 1.0 POLICY

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

**1.1** Adjunctive dental care must be preauthorized.

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

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

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

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

**1.6** The Director, TRICARE Management Activity (TMA), or designee, may require preauthorization of admission to inpatient facilities.

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

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

**Note:** When a beneficiary has "other insurance" that provides primary coverage, preauthorization requirements in [paragraph 1.8](#) will not apply. Any medically necessary reviews the MCS contractor believes are necessary, to act as a secondary payor, shall be performed on a

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Special Authorization Requirements

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retrospective basis. The conditions for applying this exception are the same as applied to the Non-Availability Statement (NAS) exception in [Section 6.1, paragraph 3.1](#).

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

**2.0 EXCEPTION**

For dual eligible beneficiaries, these requirements apply when TRICARE is primary payer. As secondary payer, TRICARE will rely on and not replicate Medicare's determination of medical necessity and appropriateness in all circumstances where Medicare is primary payer. In the event that TRICARE is primary payer for these services and preauthorization was not obtained, the contractor will obtain the necessary information and perform a retrospective review.

- END -

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

Issue Date: November 6, 2007  
Authority:

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### 1.0 HCPCS "C" AND "S" CODES

C1000 - C9999; S0000 - S9999

### 2.0 DESCRIPTION

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

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

### 3.0 POLICY

**3.1** Upon implementation of TRICARE's Outpatient Prospective Payment System (OPPS), HCPCS "C" codes shall be paid according to OPPS guidelines as outlined in the TRICARE Reimbursement Manual (TRM), [Chapter 13](#). For Hospital Outpatient Department (HOPD) services provided prior to the implementation of TRICARE's OPPS, and thereafter, for services by exempt OPPS hospitals, the contractor shall allow payment of HCPCS "C" codes consistent with current policy as stated in the TRM, [Chapter 1, Section 24, paragraph 3.2](#).

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

**3.2.1** S9122, S9123, and S9124 for the Extended Care Health Option (ECHO) respite care benefit and the ECHO Home Health Care (EHHC) benefit; **S1040 for ECHO durable equipment**; and

**3.2.2** S0812, S1030, S1031, S2066, S2067, S2068, S2075, S2076, S2077, S2083, S2202, S2360, S2361, S2400, S2401, S2402, S2403, S2405, S2411, S3818, S3819, S3820, S3822, S3823, S8185, S8265, S8270, and S9430 for all beneficiaries;

**3.2.3** S5108 for direct Educational Interventions for Autism Spectrum Disorders (EIA) services provided to TRICARE beneficiaries under the Department of Defense (DoD) Enhanced Access to Autism Services Demonstration. (See the TRICARE Operations Manual (TOM), [Chapter 18, Section 9](#)).

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

**4.0 EXCLUSIONS**

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

- END -

## Chapter 2

### Evaluation And Management

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5.1	Consultations
<b>5.2</b>	<b>Anticoagulant Management</b>
6.1	Patient Transport
7.1	Physician Standby Charges



## Anticoagulant Management

Issue Date: August 25, 2008

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

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

99363, 99364

### 2.0 DESCRIPTION

Anticoagulant services are intended to describe the outpatient management of Warfarin therapy, including ordering, review, and interpretation of International Normalized Ratio (INR) testing, communication with patient, and dosage adjustments as appropriate.

### 3.0 POLICY

Outpatient anticoagulation management (CPT<sup>1</sup> procedure codes 99363 and 99364) for patients receiving long-term anticoagulant therapy (e.g., Warfarin) in the office or outpatient setting may be considered for cost-sharing.

- END -

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## Chapter 4

### Surgery

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24.8	Kidney Transplantation
24.9	Donor Costs

## Gynecomastia

Issue Date: May 18, 1994  
Authority: [32 CFR 199.4](#)

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

19300, 19304, 19318

### 2.0 DESCRIPTION

**2.1** Pathological gynecomastia (International Classification of Diseases, 9th Revision, Clinical Modification [ICD-9-CM] 611.1) is an abnormal enlargement of the male mammary glands. Some causes of pathological gynecomastia are testicular or pituitary tumors, some syndromes of male hypogonadism, cirrhosis of the liver, administration of estrogens for prostatic carcinoma, and therapy with steroidal compounds.

**2.2** Physiological (pubertal) gynecomastia occurs in teenage boys, usually between the ages of 13-15. In more than 90% of these boys, the condition resolves within a year. Gynecomastia persisting beyond one year is severe and is usually associated with pain in the breast from distension (ICD-9-CM 611.71) and fibrous tissue stroma.

### 3.0 POLICY

Benefits may be cost-shared for medically necessary medical, diagnostic, and surgical treatment.

**Note:** Coverage criteria for surgical interventions may include, but is not limited to: severe gynecomastia (enlargement has not resolved after one year); fibrous tissue stroma exists; or breast pain.

### 4.0 EXCLUSION

Surgical treatment performed purely for psychological reasons.

- END -

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## Respiratory System

Issue Date: August 26, 1985  
Authority: [32 CFR 199.4\(c\)\(2\)](#)

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

30000 - 32488, 32491, 32500 - 32999, 96570, 96571

### 2.0 DESCRIPTION

The respiratory system is comprised of the tubular and cavernous organs and structures by means of which pulmonary ventilation and gas exchange between ambient air and the blood are brought about.

### 3.0 POLICY

**3.1** Services and supplies required in the diagnosis and treatment of illness or injury involving the respiratory system are covered.

**3.2** Resection of pneumatoceles is a covered procedure.

**3.3** Lung Volume Reduction Surgery (LVRS) is a covered procedure, see [Section 8.2](#).

**3.4** Endoscopic thoracic sympathectomy (CPT<sup>1</sup> procedure code 32664) is covered for treatment of severe primary hyperhidrosis when appropriate nonsurgical therapies have failed and the hyperhidrosis results in significant functional impairment.

### 4.0 EXCLUSION

Pillar palatal implant system for the treatment of Obstructive Sleep Apnea (OSA) is unproven.

### 5.0 EFFECTIVE DATE

December 1, 2006, for endoscopic thoracic sympathectomy for severe primary hyperhidrosis.

- END -

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**3.7.2** A trial of conservative, non-operative treatment has failed. This would include mild exercise, avoidance of prolonged immobility, periodic elevation of legs, and compressive stockings.

**3.7.3** The patient's anatomy is amenable to endovenous ablation.

**3.8** Ambulatory Blood Pressure Monitoring (ABPM) is only covered for beneficiaries with suspected white coat hypertension and is NOT covered for any other uses. The information obtained by ABPM is necessary in order to determine the appropriate medical management of the beneficiary. Suspected white coat hypertension is considered to exist when the following is documented:

**3.8.1** There is no evidence of end-organ damage;

**3.8.2** Office blood pressure greater than 140/90 mm Hg on at least three separate clinic/office visits with two separate measurements made at each visit; and

**3.8.3** At least two blood pressure measurements taken outside the office which are less than 140/90 mm Hg.

**3.9** Pulmonary vein isolation/ablation (CPT<sup>3</sup> procedure code 93651) is covered for beneficiaries who meet the guidelines published in the Heart Rhythm Society (HRS)/European Heart Rhythm Association (EHRA)/European Cardiac Arrhythmia Society (ECAS) 2007 Consensus Statement as follows:

**3.9.1** Symptomatic Atrial Fibrillation (AF) refractory or intolerant to at least one Class 1 or 3 antiarrhythmic medication.

**3.9.2** In rare clinical situations, as first line therapy.

**3.9.3** Selected symptomatic patients with heart failure and/or reduced ejection fraction.

**3.9.4** The presence of a Left Atrial (LA) thrombus is a contraindication.

#### **4.0 EXCLUSIONS**

**4.1** Thermogram; cephalic (CPT<sup>3</sup> procedure code 93760); peripheral (CPT<sup>3</sup> procedure code 93762) are unproven.

**4.2** Percutaneous Myocardial Laser Revascularization (PMR) is unproven.

**4.3** Cardiomyoplasty (Cardiac Wrap) for treatment of heart failure is unproven.

**4.4** Minimally Invasive CABG surgery to include Minimally Invasive Direct Coronary Artery Bypass (MIDCAB) and Port Access Coronary Artery Bypass (PACAB) are unproven.

**4.5** Percutaneous Transluminal Angioplasty (PTA) in the treatment of obstructive lesions of the carotid, vertebral and cerebral arteries is unproven.

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Cardiovascular System

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- 4.6** Signal-Average Electrocardiography (CPT<sup>4</sup> procedure code 93278) is unproven.
- 4.7** Primary percutaneous transluminal mechanical thrombectomy (CPT<sup>4</sup> procedure code 37184) with or without second and all subsequent vessel(s) with the same vascular family (CPT<sup>4</sup> procedure code 37185) is unproven.
- 4.8** Secondary percutaneous transluminal thrombectomy (CPT<sup>4</sup> procedure code 37186) is unproven.
- 4.9** Percutaneous transluminal mechanical thrombectomy vein(s) including intraprocedural pharmacological thrombolytic injections and fluroscopic guidance (CPT<sup>4</sup> procedure code 37187) is unproven.
- 4.10** Percutaneous transluminal mechanical thrombectomy, vein(s) including intraprocedural pharmacological thrombolytic injections and fluroscopic guidance, repeat treatment on subsequent day during course of thrombolytic therapy (CPT<sup>4</sup> procedure code 37188) is unproven.

**5.0 EFFECTIVE DATES**

- 5.1** March 1, 2001, for gamma and beta intracoronary radiotherapy (brachytherapy).
- 5.2** January 1, 2002, for TMR.
- 5.3** October 1, 2003, for ventricular assist devices as destination therapy.
- 5.4** December 1, 2003, for endovenous radiofrequency ablation/obliteration.
- 5.5** January 1, 2005, for ABPM.
- 5.6** January 1, 2007, for pulmonary vein isolation/ablation.

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## Digestive System

Issue Date: August 26, 1985

Authority: [32 CFR 199.4\(c\)\(2\)](#) and [\(c\)\(3\)](#)

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

40490 - 40831, 40899 - 43644, **43647, 43648**, 43651 - 43761, 43800, 43810, 43820, 43842, 43846, 43848, 43880 - **43882**, 43999, 44005 - 47362, 47371, 47379, 47381, 47399 - 49999, 91123, 96570, 96571

### 2.0 DESCRIPTION

The digestive system involves the organs associated with the ingestion, digestion, and absorption of nutrients, and the elimination of solid waste.

### 3.0 POLICY

**3.1** Services and supplies required in the diagnosis and treatment of illness or injury involving the digestive system are covered.

**3.2** Gastric electrical stimulation (CPT<sup>1</sup> procedure codes **43647, 43648, 43881, and 43882**) for treatment of symptoms of nausea and vomiting from chronic gastroparesis that is refractory to medical management may be considered for coverage as a Humanitarian Use Device (HUD).

### 4.0 EXCLUSIONS

**4.1** Percutaneous interstitial thermal ablation in the treatment of hepatic cancer is unproven.

**4.2** The Stretta System (Curon Medical, Sunnyvale, CA) and Bard Endoscopic Suturing System for treatment of refractory Gastro-Esophageal Reflux Disease (GERD) is unproven (CPT<sup>1</sup> procedure codes **43201 and 43257**).

**4.3** For bariatric procedures, see [Section 13.2](#).

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## Urinary System

Issue Date: August 26, 1985

Authority: [32 CFR 199.4\(c\)\(2\)](#) and [\(c\)\(3\)](#)

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

50010 - 53899, 64561, 64581, 64585, 64590, 64595

### 2.0 DESCRIPTION

The urinary system involves those organs concerned in the production and excretion of urine.

### 3.0 POLICY

**3.1** Services and supplies required in the diagnosis and treatment of illness or injury involving the urinary system are covered.

**3.2** Benefits may be considered for the implantation of similar U.S. Food and Drug Administration (FDA) approved devices. The Sacral Nerve Root Stimulation (SNS) has received FDA approval. Services and supplies related to the implantation of the SNS may be covered for individuals with urge incontinence, nonobstructive urinary retention, or symptoms of urgency-frequency syndrome that is not due to a neurologic condition, who have failed previous conservative treatments, and who have had a successful peripheral nerve evaluation test.

**3.3** The use of a bedwetting alarm for the treatment of primary nocturnal enuresis may be considered for cost-sharing when prescribed by a physician and after physical or organic causes for nocturnal enuresis have been ruled out.

**3.4** Collagen implantation of the urethra and/or bladder neck may be covered for patients not amenable to other forms of urinary incontinence treatment.

**3.5** Cryoablation for renal cell carcinoma (CPT<sup>1</sup> procedure codes 50250 and 50542) may be considered for coverage under the Rare Disease policy ([Chapter 1, Section 3.1](#)) on a case-by-case basis. Effective June 1, 2006.

**3.6** Under the provisions for the treatment of rare diseases, coverage of laparoscopic radiofrequency ablation (CPT<sup>1</sup> procedure code 50542) and percutaneous radiofrequency ablation (CPT<sup>1</sup> procedure code 50592) may be considered on a case-by-case basis for the treatment of Renal Cell Carcinoma (RCC) and genetic syndromes associated with RCC including von Hippel-Lindau

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syndrome, hereditary papillary cell carcinoma, or hereditary clear-cell carcinoma for patients who are not appropriate candidates for surgical intervention.

#### 4.0 EXCLUSIONS

4.1 Peri-urethral Teflon injection is unproven.

4.2 Silastic gel implant.

4.3 Acrylic prosthesis (Berry prosthesis).

4.4 Bladder stimulators, direct or indirect, such as spinal cord, rectal and vaginal electrical stimulators, or bladder wall stimulators. Payment for any related service or supply, including inpatient hospitalization primarily for surgical implementation of a bladder stimulator.

4.5 Transurethral balloon dilation of the prostate (CPT<sup>2</sup> procedure code 52510) is unproven.

4.6 Laparoscopic radiofrequency ablation (CPT<sup>2</sup> procedure code 50542) and percutaneous radiofrequency ablation (CPT<sup>2</sup> procedure code 50592) for renal masses/tumors are unproven.

#### 5.0 EFFECTIVE DATE

5.1 Transurethral Needle Ablation (TUNA) of the prostate is proven (CPT<sup>2</sup> procedure code 53852). Effective June 1, 2004.

5.2 March 28, 2007, for laparoscopic radiofrequency ablation or percutaneous radiofrequency ablation for the treatment of RCC and genetic syndromes associated with RCC, including von Hippel-Lindau syndrome, hereditary papillary cell carcinoma, or hereditary clear-cell carcinoma.

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## Chapter 4

## Section 20.1

# Nervous System

Issue Date: August 29, 1985

Authority: [32 CFR 199.4\(c\)\(2\)](#) and [\(c\)\(3\)](#)

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

61000 - 61626, 61680 - 61860, 61863 - 63048, 63055 - 64484, 64508 - 64999, 95961, 95962, 95970 - 95975, 95978, 95979

### 2.0 POLICY

**2.1** Services and supplies required in the diagnosis and treatment of illness or injury involving the nervous system are covered.

**2.2** Therapeutic embolization (CPT<sup>1</sup> procedure code 61624) may be covered for the following indications. The list of indications is not all inclusive. Other indications are covered when documented by reliable evidence as safe, effective and comparable or superior to standard care (proven).

- Cerebral Arteriovenous Malformations (AVMs).
- Vein of Galen Aneurysm.
- Inoperable or High-Risk Intracranial Aneurysms.
- Dural Arteriovenous Fistulas.
- Meningioma.
- Pulmonary Arteriovenous Malformations (PAVMs).

**2.3** Implantation of depth electrodes is covered. Implantation of a U.S. Food and Drug Administration (FDA) approved vagus nerve stimulator as adjunctive therapy in reducing the frequency of seizures in adults and adolescents over 12 years of age, which are refractory to anti-epileptic medication is covered. Battery replacement is also covered.

**2.4** Spinal cord and deep brain stimulation are covered in the treatment of chronic intractable pain. Coverage includes:

**2.4.1** The accessories necessary for the effective functioning of the covered device.

**2.4.2** Repair, adjustment, replacement and removal of the covered device and associated surgical costs.

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**2.5** The Guglielmi Detachable Coil (GDC) may be cost-shared for embolizing unruptured intracranial aneurysms that, because of their morphology, their location, or the patient's general medical condition, are considered by the treating neurosurgical team to be:

**2.5.1** Very high risk for management by traditional operative techniques; or

**2.5.2** Inoperable; or

**2.5.3** For embolizing other vascular malformation such as AVMs and arteriovenous fistulae of the neurovasculature, to include arterial and venous embolizations in the peripheral vasculature.

### **3.0 EXCLUSIONS**

**3.1** N-butyl-2-cyanoacrylate (Histacryl Bleu®), iodinated poppy seed oils (e.g., Ethiodol®), and absorbable gelatin sponges are not FDA approved.

**3.2** Transcutaneous, percutaneous, functional dorsal column electrical stimulation in the treatment of multiple sclerosis or other motor function disorders is unproven.

**3.3** Deep brain neurostimulation in the treatment of insomnia, depression, anxiety, and substance abuse is unproven.

**3.4** Psychosurgery is not in accordance with accepted professional medical standards and is not covered.

**3.5** Endovascular GDC treatment of wide-necked aneurysms and rupture is unproven.

**3.6** Cerebellar stimulators/pacemakers for the treatment of neurological disorders are unproven.

**3.7** Dorsal Root Entry Zone (DREZ) thermocoagulation or microcoagulation neurosurgical procedure is unproven.

**3.8** Epidural steroid injections for thoracic pain are unproven.

**3.9** Extraoperative electrocortigraphy for stimulation and recording in order to determine electrical thresholds of neurons as an indicator of seizure focus is unproven.

**3.10** Neuromuscular electrical stimulation for the treatment of denervated muscles is unproven.

**3.11** Stereotactic cingulotomy is unproven.

**3.12** Sacral nerve neurostimulator (CPT<sup>2</sup> procedure codes 64561, 64581, 64585, 64590, and 64595). See [Section 14.1](#) for coverage policy for the urinary system and the Sacral Nerve Root Stimulation (SNS).

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**3.13** Laminoplasty, cervical with decompression of the spinal cord, two or more vertebral segments with reconstruction of the posterior bony elements (CPT<sup>3</sup> procedure codes 63050 and 63051).

**3.14** Balloon angioplasty, intracranial, percutaneous (CPT<sup>3</sup> procedure code 61630) is unproven. Effective January 1, 2006.

**3.15** Transcatheter placement of intravascular stent(s) intracranial, (e.g., atherosclerotic stenosis) including angioplasty, if performed (CPT<sup>3</sup> procedure code 61635) is unproven. Effective January 1, 2006.

**3.16** Balloon dilation of intracranial vasospasm, initial vessel (CPT<sup>3</sup> procedure code 61640) each additional vessel in same family (CPT<sup>3</sup> procedure code 61641) or different vascular family (CPT<sup>3</sup> procedure code 61642) is unproven. Effective January 1, 2006.

**3.17** Endoscopic thoracic sympathectomy.

**3.18** Trigger point injection for migraine headaches.

**3.19** Botox (chemodenervation), surgical denervation, and muscle resection for migraine headaches are unproven.

**3.20** Sphenopalatine ganglion block (CPT<sup>3</sup> procedure code 64505) for the treatment of chronic migraine headaches and neck pain is unproven.

#### **4.0 EFFECTIVE DATES**

**4.1** January 1, 1989, for PAVM.

**4.2** April 1, 1994, for therapeutic embolization for treatment of meningioma.

**4.3** July 14, 1997, for GDC.

**4.4** The date of FDA approval of the embolization device for all other embolization procedures.

**4.5** June 1, 2004, for Magnetoencephalography.

- END -

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- 3.2.2.3** The patient is in second or third complete remission.
- 3.2.3** Neuroblastoma.
  - 3.2.3.1** Stage III or IV, when the patient is one for whom further treatment with a conventional dose therapy is not likely to achieve a durable remission.
  - 3.2.3.2** Tandem autologous peripheral stem cell transplantation for high-risk neuroblastoma (INSS Stage III with either N-MYC gene amplification or unfavorable Shimada histology or INSS Stage IV).
- 3.2.4** Acute lymphocytic or nonlymphocytic leukemias (e.g., myelocytic, myelogenous, myeloblastic, or myelomonoblastic);
- 3.2.5** Primitive Neuroectodermal Tumors (PNET)/Ewing's Sarcoma.
- 3.2.6** Gliofibromas (also known as desmoplastic astrocytoma; desmoplastic glioblastoma).
- 3.2.7** Glioblastoma multiforme.
- 3.2.8** Posterior fossa teratoid brain tumors.
- 3.2.9** Rhabdomyosarcoma and undifferentiated sarcomas.
- 3.2.10** Multiple myeloma. Tandem autologous stem cell transplantation is covered for the treatment of multiple myeloma.
- 3.2.11** Chronic myelogenous leukemia.
- 3.2.12** Waldenstrom's macroglobulinemia.
- 3.2.13** AL (Amyloid Light-Chain) Amyloidosis.
- 3.2.14** Wilms' tumor.
- 3.2.15** Trilateral retinoblastoma/pineoblastoma.
- 3.2.16** Osteosarcoma (osteogenic sarcoma).
- 3.2.17** Germ cell tumors in a second or subsequent relapse.
- 3.2.18** HDC with ABMT or PSCT for the treatment of desmoplastic small round cell tumor may be considered on a case-by-case basis under the TRICARE provisions for treatment of rare diseases.

**3.3** Allogeneic bone marrow or allogeneic peripheral stem cell transplantation, with or without HDC, is covered in the treatment of the following disease processes when either a related or unrelated donor is used. The list of indications is not all inclusive. Other indications are covered when documented by reliable evidence as safe, effective and comparable or superior to standard care (proven).

- 3.3.1** Aplastic anemia.
- 3.3.2** Acute lymphocytic or nonlymphocytic leukemias (e.g., myelocytic, myelogenous, myeloblastic, myelomonoblastic); Chronic Myelogenous Leukemia (CML); or preleukemic syndromes.
- 3.3.3** Severe combined immunodeficiency; e.g., adenosine deaminase deficiency and idiopathic deficiencies.
  - 3.3.3.1** Partially matched-related donor stem cell transportation (without regard for the number of mismatched antigens in determining histocompatibility) in the treatment of Bare Lymphocyte Syndrome.
  - 3.3.3.2** Unrelated donor and/or related donor (without regard for mismatched antigens) with or without T cell lymphocyte depletion in the treatment of Familial Erythrophagocytic Lymphohistiocytosis, (FEL; generalized lymphohistiocytic infiltration; familial lymphohistiocytosis; familial reticuloendotheliosis; Familial Hemophagocytic Lymphohistiocytosis; FHL) for patients whose medical records document failure of conventional therapy (etoposide; corticosteroids; intrathecal methotrexate; and cranial irradiation).
  - 3.3.3.3** Partially matched-related donor stem cell transplantation (without regard for the number of mismatched antigens) in the treatment of X-linked Severe Combined Immunodeficiency Syndrome (X-Linked SCID).
- 3.3.4** Wiskott-Aldrich Syndrome.
- 3.3.5** Infantile malignant osteopetrosis (Albers-Schonberg syndrome or marble bone disease).
- 3.3.6** Thalassemia major.
- 3.3.7** Intermediate and high grade lymphoma.
- 3.3.8** Myeloproliferative/dysplastic syndromes.
- 3.3.9** Congenital mucopolysaccharidoses.
- 3.3.10** Congenital amegakaryocytic thrombocytopenia.
- 3.3.11** Metachromatic leukodystrophy.
- 3.3.12** Sickle cell disease.
- 3.3.13** Chronic Lymphocytic Leukemia (CLL) when previous therapy has failed or when the CLL is refractory to conventional therapy.
- 3.3.14** Hyperesinophilic Syndrome.
- 3.3.15** Multiple myeloma when HCD with ABMT or PSCT has failed.

**3.10** Benefits are allowed for Hepatitis B and pneumococcal vaccines for patients undergoing transplantation.

**3.11** Charges for stem cell and umbilical cord blood preparation and storage shall be billed through the transplantation facility in the name of the TRICARE patient.

**3.12** Charges for the umbilical cord blood bank may be allowed only for patients who have undergone a covered transplant.

**3.13** Claims for services and supplies related to the HDC and transplant for beneficiaries under the age of 18 will be reimbursed based on billed charges. Claims for HDC and transplant for adult patients, 18 years and older, will be reimbursed under the **Diagnosis** Related Group (DRG) payment system. Outpatient institutional facility charges will be paid as billed. Professional services are reimbursed under the CHAMPUS Maximum Allowable Charge (CMAC) Methodology.

**3.14** Transportation of the patient by air ambulance may be cost-shared when determined to be medically necessary. Benefits for advanced life support air ambulance (to include attendant) may be preauthorized by the appropriate preauthorizing authority on an individual case basis in conjunction with the preauthorization for the services themselves.

**3.15** In those cases where the beneficiary fails to obtain preauthorization, benefits may be extended if the services or supplies otherwise would qualify for benefits but for the failure to obtain preauthorization. If preauthorization is not received, the appropriate preauthorizing authority is responsible for determining if the patient meets the coverage criteria. Charges for transplant and transplant-related services provided to TRICARE Prime enrollees who failed to obtain PCM referral and contractor authorization for HDC with ABMT or PSCT will be reimbursed only under POS rules.

#### **4.0 EXCLUSIONS**

Benefits will not be paid for:

**4.1** HDC with ABMT or Autologous PSCT, Allogeneic BMT or Allogeneic PSCT, with or without HDC, or Allogeneic UCBT, with or without HDC, if the patient has a concurrent condition (other existing illness) that would jeopardize the achievement of successful transplantation.

**4.2** Expenses waived by the transplant center (i.e., beneficiary/sponsor not financially liable).

**4.3** Services and supplies not provided in accordance with applicable program criteria (i.e., part of a grant, or research program; unproven procedure).

**4.4** Administration of an unproven immunosuppressant drug that is not FDA approved.

**4.5** Pre- or post-transplant nonmedical expenses (i.e., out-of-hospital living expenses, to include, hotel, meals, privately owned vehicle for the beneficiary or family members).

**4.6** Transportation of a donor.

**4.7** Allogeneic bone marrow transplantation for treatment of low grade non-Hodgkin's lymphoma is not a benefit.

- 4.8** Autologous UCBT therapy as this procedure is considered unproven.
- 4.9** Allogeneic bone marrow transplantation for neuroblastoma as this procedure is considered unproven.
- 4.10** Allogeneic donor bone marrow transplantation (infusion) performed with or after organ transplants for the purpose of increasing tolerance of the organ transplant is considered unproven.
- 4.11** HDC with ABMT or PSCT is not a benefit for treatment of desmoplastic small round-cell tumor.
- 4.12** HDC with ABMT or PSCT is not covered for treatment of breast cancer.
- 4.13** HDC with allogeneic BMT is not a benefit for treatment of Waldenstrom's macroglobulinemia.
- 4.14** HDC with Stem Cell Rescue (SCR) is not a benefit for the treatment of epithelial ovarian cancer.
- 4.15** HDC with allogeneic stem cell transplantation is not covered for the treatment of cold agglutinin disease.
- 4.16** Donor lymphocyte infusion if not specifically listed as covered in [paragraph 3.4](#).

## **5.0 EFFECTIVE DATES**

- 5.1** May 1, 1987, for HDC with ABMT or PSCT for Hodgkin's disease, non-Hodgkin's lymphoma and neuroblastoma.
- 5.2** November 1, 1987, for HDC with ABMT or PSCT for acute lymphocytic and nonlymphocytic leukemias.
- 5.3** November 1, 1983, for HDC with allogeneic bone marrow transplants using related donors.
- 5.4** July 1, 1989, for HDC with allogeneic bone marrow transplants using unrelated donors.
- 5.5** July 11, 1996, for HDC with ABMT or PSCT for multiple myeloma.
- 5.6** January 1, 1994, for HDC with ABMT and PSCT for Wilms' tumor.
- 5.7** January 1, 1995, for allogeneic UCBTs.
- 5.8** January 1, 1994, for HDC with ABMT or PSCT for chronic myelogenous leukemia.
- 5.9** January 1, 1996, for HDC with ABMT or PSCT for Waldenstrom's macroglobulinemia.
- 5.10** January 1, 1996, for allogeneic bone marrow transplants using related 3 antigen mismatch donors for patients with undifferentiated leukemia, CML, aplastic anemia, ALL or AML.
- 5.11** October 1, 1996, for HDC with ABMT or PSCT for AL Amyloidosis.

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- 5.12** January 1, 1995, for allogeneic bone marrow transplant for hypereosinophilic syndrome.
- 5.13** May 1, 1997, for HDC with ABMT or PSCT for trilateral retinoblastoma/pineoblastoma.
- 5.14** January 1, 1997, for HDC with ABMT or PSCT for follicular lymphoma.
- 5.15** January 1, 1997, for HDC with ABMT or PSCT for non-Hodgkin's lymphoma in first complete remission.
- 5.16** November 28, 1997, for HDC with ABMT or PSCT for Hodgkin's disease in second or third remission.
- 5.17** January 1, 1996, for HDC with allogeneic BMT for multiple myeloma.
- 5.18** July 1, 1999, for HDC with ABMT or PSCT for germ cell tumors in a second or subsequent relapse.
- 5.19** January 1, 1998, for HDC with ABMT or PSCT for osteosarcoma (osteogenic sarcoma).
- 5.20** June 1, 1995, for allogeneic BMT for Chediak-Higashi syndrome.
- 5.21** January 1, 1998, for allogeneic peripheral stem cell transplantation.
- 5.22** June 1, 2003, for Langerhans Cell Histiocytosis, refractory to conventional treatment.
- 5.23** January 24, 2002, for allogeneic stem cell transplant for Hodgkin's disease.
- 5.24** May 19, 2005, for tandem autologous peripheral stem cell transplant for high-risk neuroblastoma.
- 5.25** January 1, 2006, for HDC with ABMT or PSCT for desmoplastic small round cell tumor.

- END -



## Simultaneous Pancreas-Kidney (SPK), Pancreas-After-Kidney (PAK), And Pancreas-Transplant-Alone (PTA), And Pancreatic Islet Cell Transplantation

Issue Date: February 5, 1996  
Authority: [32 CFR 199.4\(e\)\(5\)](#)

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

48160, 48550 - 48556

### 2.0 POLICY

**2.1** Benefits are allowed for Simultaneous Pancreas-Kidney (SPK) Transplantation, Pancreas-After-Kidney (PAK) Transplantation, and Pancreas-Transplantation-Alone (PTA).

**2.1.1** A TRICARE Prime enrollee must have a referral from his/her Primary Care Manager (PCM) and an authorization from the contractor before obtaining transplant-related services. If network providers furnish transplant-related services without prior PCM referral and contractor authorization, penalties will be administered according to TRICARE network provider agreements. If Prime enrollees receive transplant-related services from non-network civilian providers without the required PCM referral and contractor authorization. Managed Care Support Contractors (MCSCs) shall reimburse charges for the services on a Point of Service (POS) basis. Special cost-sharing requirements apply to POS claims.

**2.1.2** For Standard and Extra patients residing in a Managed Care Support (MCS) region, preauthorization authority is the responsibility of the MCS Medical Director or other designated utilization staff.

**2.2** SPK and PAK are covered when the transplantation is performed at a Medicare-approved renal transplantation center, for patients who:

**2.2.1** Are suffering from concomitant, Type I Diabetes Mellitus that is resistant to exogenous therapy and end stage chronic renal disease; and

**2.2.2** Have exhausted more conservative medical and surgical treatments for Type I Diabetes Mellitus and renal disease.

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

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Simultaneous Pancreas-Kidney (SPK), Pancreas-After-Kidney (PAK), And Pancreas-Transplant-Alone (PTA), And Pancreatic Islet Cell Transplantation

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**2.2.3** Have a realistic understanding of the range of clinical outcomes that may be encountered.

**2.2.4** Plans for long-term adherence to a disciplined medical regimen are feasible and realistic.

**2.3** PTA is covered when performed at a Medicare approved renal transplantation center, for patients who:

**2.3.1** Are suffering from labile Type I Diabetes Mellitus:

- Patient with diabetes must be beta cell autoantibody positive; or
- Patient must demonstrate insulinopenia defined as a fasting C-peptide level that is less than or equal to 110% of the lower limit of normal of the laboratory's measurement method. Fasting C-peptide levels will only be considered valid with a concurrently obtained fasting glucose less than or equal to 225 mg/Dl;

**2.3.2** Patients must have a history of medically-uncontrollable labile (brittle) insulin-dependent diabetes mellitus with documented recurrent, severe, acutely life-threatening metabolic complications that require hospitalization. Aforementioned complications include frequent hypoglycemia unawareness or recurring severe ketoacidosis, or recurring severe hypoglycemic attacks;

**2.3.3** Patients must have been optimally and intensively managed by an endocrinologist for at least 12 months with the most medically-recognized advanced insulin formulations and delivery systems;

**2.3.4** Patients must have the emotional and mental capacity to understand the significant risks associated with surgery and to effectively manage the lifelong need for immunosuppression

**2.3.5** Patients must otherwise be a suitable candidate for transplantation.

**2.4** Services and supplies related to SPK, PAK, and PTA are covered for:

**2.4.1** Evaluation of a potential candidate's suitability for SPK, PAK, and PTA whether or not the patient is ultimately accepted as a candidate for transplantation.

**2.4.2** Pre- and post-transplantation inpatient hospital and outpatient services.

**2.4.3** Surgical services and related pre- and postoperative services of the transplantation team.

**2.4.4** The donor acquisition team, including the costs of transportation to the location of the donor organ and transportation of the team and the donated organ to the location of the transplantation center.

**2.4.5** The maintenance of the viability of the donor organ after all existing legal requirements for excision of the donor organ have been met.

Simultaneous Pancreas-Kidney (SPK), Pancreas-After-Kidney (PAK), And Pancreas-Transplant-Alone (PTA), And Pancreatic Islet Cell Transplantation

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- 2.4.6** Donor costs.
- 2.4.7** Blood and blood products.
- 2.4.8** U.S. Food and Drug Administration (FDA) approved immunosuppression drugs to include off-label uses when reliable evidence documents that the off-label use is safe, effective and in accordance with the national standards of practice in the medical community (proven). Mycophenolate Mofetil (Cellcept) and Tacrolimus (Prograf) for the prophylaxis of organ rejection in patients receiving SPK, PAK, and PTA are covered.
- 2.4.9** Complications of the transplantation procedure, including inpatient care, management of infection and rejection episodes.
- 2.4.10** Periodic evaluation and assessment of the successfully transplanted patient.
- 2.4.11** Hepatitis B and pneumococcal vaccines for patients undergoing transplantation.
- 2.4.12** Deoxyribonucleic Acid-Human Leucocyte Antigen (DNA-HLA) tissue typing in determining histocompatibility.
- 2.4.13** Transportation of the patient by air ambulance and the services of a certified life support attendant.

**2.5** Autologous pancreatic islet cell transplantation as an adjunct to a total or near total pancreatectomy for the treatment of chronic pancreatitis is covered (CPT<sup>2</sup> procedure code 48160).

### **3.0 POLICY CONSIDERATIONS**

**3.1** For beneficiaries who fail to obtain preauthorization for SPK, PAK, and PTA benefits may be extended if the services or supplies otherwise would qualify for benefits but for the failure to obtain preauthorization. If preauthorization is not received, the appropriate preauthorizing authority is responsible for reviewing the claims to determine whether the beneficiary's condition meets the clinical criteria for the SPK transplantation benefit. Charges for transplant and transplant-related services provided to TRICARE Prime enrollees who failed to obtain PCM referral and contractor authorization will be reimbursed only under POS rules.

**3.2** Benefits for SPK, PAK, or PTA transplantation will only be allowed for transplants performed at a Medicare-approved renal transplantation center.

**3.3** Effective for admissions on or after October 1, 1999, SPK, PAK, and PTA transplantations shall be reimbursed under the assigned **Diagnosis** Related Group (DRG). Claims for admissions prior to October 1, 1999, shall be reimbursed based on billed charges.

**3.4** Claims for transportation of the donor organ and transplantation team shall be adjudicated on the basis of billed charges, but not to exceed the transport service's published schedule of

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charges, and cost-shared on an inpatient basis. Scheduled or chartered transportation may be cost-shared.

**3.5** Charges made by the donor hospital will be cost-shared on an inpatient basis and must be fully itemized and billed by the transplantation center in the name of the TRICARE patient.

**3.6** Acquisition and donor costs are not considered to be components of the services covered under the DRG and will be reimbursed based on billed charges. These costs must be billed separately on a standard Centers for Medicare and Medicaid Services (CMS) 1450 UB-04 claim form in the name of the TRICARE patient.

**3.7** When a properly preauthorized candidate is discharged less than 24 hours after admission because of extenuating circumstances, such as the available organ is found not suitable or other circumstances which prohibit the transplant from being timely performed, all otherwise authorized services associated with the admission shall be cost-shared on an inpatient basis, since the expectation at admission was that the patient would remain more than 24 hours.

**3.8** SPKs, PAKs, or PTAs performed on an emergency basis in an unauthorized renal transplant facility may be cost-shared only when the following conditions have been met:

- The unauthorized center must consult with the nearest Medicare-certified renal transplant center regarding the transplantation case; and
- It must be determined and documented by the transplant team physician(s) at the Medicare-approved renal transplantation center that transfer of the patient (to a Medicare-approved renal transplantation center) is not medically reasonable, even though transplantation is feasible and appropriate.

#### **4.0 EXCLUSIONS**

**4.1** SPK, PAK, and PTA are excluded when any of the following contraindications exist:

- Significant systemic or multisystemic disease (other than pancreatic-renal dysfunction) which limits the possibility of full recovery and may compromise the function of the newly transplanted organs.
- Active alcohol or other substance abuse.
- Malignancies metastasized to or extending beyond the margins of the kidney and/or pancreas.
- Significant coronary artery disease.

**4.2** The following are also excluded:

- Expenses waived by the transplantation center (e.g., beneficiary/sponsor not financially liable).

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- Services and supplies not provided in accordance with applicable program criteria (i.e., part of a grant or research program; unproven procedure).
- Administration of an unproven immunosuppressant drug that is not FDA approved or has not received TRICARE approval as an appropriate "off-label" drug indication.

**4.3** Pre- or post-transplantation nonmedical expenses (e.g., out-of-hospital living expenses, to include hotel, meals, privately owned vehicle for the beneficiary or family members).

**4.4** Transportation of an organ donor.

**4.5** Autologous islet cell transplantation, **when used alone, and allogeneic islet cell transplantation for the treatment of diabetes mellitus (CPT<sup>3</sup> procedure codes 0141T - 0143T and HCPCS codes G0341 - G0343, S2102).**

**5.0 EFFECTIVE DATES**

**5.1** October 1, 1995, for SPK transplants.

**5.2** January 1, 1996, for PAK and PTA transplants.

**5.3** **January 1, 2007, for autologous pancreatic islet cell transplantation as an adjunct to a total or near total pancreatectomy for treatment of chronic pancreatitis.**

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## Chapter 5

### Radiology

Section/Addendum	Subject/Addendum Title
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1.1	Diagnostic Radiology (Diagnostic Imaging)
2.1	Diagnostic Ultrasound
<b>2.2</b>	<b>Radiologic Guidance</b>
3.1	Radiation Oncology
3.2	Hyperthermia
4.1	Nuclear Medicine
5.1	Thermography



## Diagnostic Radiology (Diagnostic Imaging)

Issue Date: March 7, 1986

Authority: [32 CFR 199.4\(a\)](#), [\(b\)\(2\)\(x\)](#), [\(c\)\(2\)\(viii\)](#), [\(e\)\(14\)](#) and [32 CFR 199.6\(d\)\(2\)](#)

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

70010 - 72292, 73000 - 76083, 76086 - 76394, 76400, 76496 - 76499, 95965 - 95967, 0145T - 0151T

### 2.0 HCPCS PROCEDURE CODES

G0204 - G0207

### 3.0 DESCRIPTION

**3.1** Radiology is the science that deals with the use of radiant energy, such as X-rays, radium, and radioactive isotopes, in the diagnosis and treatment of disease. Radiology is an important diagnostic tool useful for the evaluation. The techniques used for diagnostic radiology are as follows:

**3.2** Magnetic Resonance Imaging (MRI) is a non-invasive method of graphically representing the distribution of water and other hydrogen-rich molecules in the human body. MRI uses radio frequency radiation in the presence of a carefully controlled magnetic field to produce high quality cross-sectional images of the head and body in any plane. These tomographic images represent the tissue being analyzed and the environment surrounding it. MRI has become a useful diagnostic imaging modality that is capable of demonstrating a wide variety of soft-tissue lesions with contrast resolution equal or superior to Computerized Tomography (CT) scanning in various parts of the body. Among the advantages of MRI are the absence of ionizing radiation and the ability to achieve high levels of tissue contrast resolution without injected iodinated contrast agents.

**3.3** Magnetic Resonance Angiography (MRA) techniques generate contrast between flowing blood and surrounding tissue, and provide anatomic images that can be provided in a format similar to that of conventional x-ray angiography, and can also provide physiologic information.

**3.4** A CT/Computerized Axial Tomography (CAT) scan is interchangeably referred to as either a CT or CAT scan. This diagnostic test uses x-ray technology to create three-dimensional, computerized images of internal organs. However, unlike a traditional x-ray, CT/CAT scans are able to distinguish between obscured and overlapping parts of the body. CAT scans are also capable of producing images of several different internal components, including soft tissue, blood vessels and bones.

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## 4.0 POLICY

**4.1** MRI and MRI with contrast media are covered when medically necessary, appropriate, and the standard of care. (CPT<sup>2</sup> procedure codes 70336, 70540 - 70543, 70551 - 70553, 71550 - 71552, 72141 - 72158, 72195 - 72197, 73218 - 73223, 73718 - 73723, 74181 - 74183, 75552 - 75556, and 76400.)

**4.2** Breast MRI (CPT<sup>2</sup> procedure codes 77058 and 77059) is covered for the following indications:

**4.2.1** To detect breast implant rupture (the implantation of the breast implants must have been covered by TRICARE).

**4.2.2** For detection of occult breast cancer in the setting of axillary nodal adenocarcinoma with negative physical exam and negative mammography.

**4.2.3** For presurgical planning for locally advanced breast cancer before and after completion of neoadjuvant chemotherapy, to permit tumor localization and characterization.

**4.2.4** For presurgical planning to evaluate the presence of multicentric disease in patients with locally advanced cancer who are candidates for breast conservation treatment.

**4.2.5** Evaluation of suspected cancer recurrence.

**4.2.6** To determine the presence of pectoralis major muscle/chest wall invasion in patients with posteriorly located tumor.

**Note:** For policy on breast MRI to screen for breast cancer in high risk women, see [Chapter 7, Sections 2.1](#) and [2.2](#).

**4.3** Open MRI and Open MRI with contrast media are covered when medically necessary, appropriate, and the standard of care.

**4.4** MRA is covered when medically necessary, appropriate and the standard of care. (CPT<sup>2</sup> procedure codes 70544 - 70549, 71555, 72159, 72198, 73225, 73725, and 74185.)

**4.5** CT scans are covered when medically necessary, appropriate and the standard of care and all criteria stipulated in [32 CFR 199.4\(e\)](#) are met. (CPT<sup>2</sup> procedure codes 70450 - 70498, 71250 - 71275, 72125 - 72133, 72191 - 72194, 73200 - 73206, 73700 - 73706, 74150 - 74175, 75635, and 76355 - 76380.)

**4.6** TRICARE considers three-dimensional (3D) rendering (CPT<sup>2</sup> procedure codes 76376 and 76377) medically necessary under certain circumstances (see [Section 2.1](#)).

**4.7** Helical (spiral) CT scans, with or without contrast enhancement, are covered when medically necessary, appropriate and the standard of care.

**4.8** Chest x-rays (CPT<sup>2</sup> procedure codes 71010 - 71035) are covered.

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**4.9** Diagnostic mammography (CPT<sup>3</sup> procedure codes 76090 - 76092/HCPCS codes G0204 - G0207) to further define breast abnormalities or other problems is covered.

**4.10** Portable X-ray services are covered. The suppliers must meet the conditions of coverage of the Medicare program, set forth in the Medicare regulations, or the Medicaid program in that state in which the covered service is provided. In addition to the specific radiology services, reasonable transportation and set-up charges are covered and separately reimbursable.

**4.11** Bone density studies (CPT<sup>3</sup> procedure codes 76070 - 76078) are covered for the following:

**4.11.1** The diagnosis and monitoring of osteoporosis.

**4.11.2** The diagnosis and monitoring of osteopenia.

**4.11.3** Patients must present with signs and symptoms of bone disease or be considered at high-risk for developing osteoporosis. High-risk factors which have been identified as the standard of care by the American College of Obstetricians and Gynecologists (ACOG) include:

- Women who are estrogen-deficient and at clinical risk for osteoporosis. Naturally or surgically post-menopausal women who have not been on **long-term** Hormone Replacement Therapy (HRT). However, **current** use of HRT does not preclude estrogen deficiency.
- Individuals who have vertebral abnormalities.
- Individuals receiving long-term glucocorticoid (steroid) therapy.
- Individuals with primary hyperparathyroidism.
- Individuals with positive family history of osteoporosis.
- Any other high-risk factor identified by ACOG as the standard of care.

**4.12** Radiological supervision and interpretation, percutaneous vertebroplasty or vertebral augmentation including cavity creation, per vertebral body; under fluoroscopic guidance (CPT<sup>3</sup> procedure code 72291) or under CT guidance (CPT<sup>3</sup> procedure code 72292) is covered.

**4.13** Multislice or multidetector row CT angiography (CPT<sup>3</sup> codes 0145T - 0151T) is covered for the following indications:

**4.13.1** Evaluation of heart failure of unknown origin when invasive coronary angiography +/- Percutaneous Coronary Intervention (PCI) is not planned, unable to be preformed or is equivocal.

**4.13.2** In an Emergency Department (ED) for patients with acute chest pain, but no other evidence of cardiac disease (low-pretest probability), when results would be used to determine the need for further testing or observation.

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**4.13.3** Acute chest pain or unstable angina when invasive coronary angiography or a PCI cannot be performed or is equivocal.

**4.13.4** Chronic stable angina and chest pain of uncertain etiology or other cardiac findings prompting evaluation for Coronary Artery Disease (CAD) (for example: new or unexplained heart failure or new bundle branch block).

**4.13.4.1** When invasive coronary angiography or PCI is not planned, unable to be performed, or is equivocal; AND

**4.13.4.2** Exercise stress test is unable to be performed or is equivocal; AND

**4.13.4.3** At least one of the following non-invasive tests were attempted and results could not be interpreted or where equivocal or none of the following tests could be performed:

**4.13.4.3.1** Exercise stress echocardiography

**4.13.4.3.2** Exercise stress echo with dobutamine

**4.13.4.3.3** Exercise myocardial perfusion (Single Photon Emission Computed Tomography (SPECT))

**4.13.4.3.4** Pharmacologic myocardial perfusion (SPECT)

**4.13.5** Evaluation of anomalous native coronary arteries in symptomatic patients when conventional angiography is unsuccessful or equivocal and when results would impact treatment.

**4.13.6** Evaluation of complex congenital anomaly of coronary circulation or of the great vessels.

**4.13.7** Presurgical evaluation prior to biventricular pacemaker placement.

**4.13.8** Presurgical evaluation of coronary anatomy prior to non-coronary surgery (valve placement or repair; repair of aortic aneurysm or dissection).

**4.13.9** Presurgical cardiovascular evaluation for patients with equivocal stress study prior to kidney or liver transplantation.

**4.13.10** Presurgical evaluation prior to electrophysiologic procedure to isolate pulmonary veins for radiofrequency ablation of arrhythmia focus.

## **5.0 EXCLUSIONS**

**5.1** Bone density studies for the routine screening of osteoporosis.

**5.2** Ultrafast CT (electron beam CT (HCPCS code S8092)) to predict asymptomatic heart disease is preventive.

- 5.3** MRIs (CPT<sup>4</sup> procedure codes 77058 and 77059) to screen for breast cancer in asymptomatic women considered to be at low or average risk of developing breast cancer; for diagnosis of suspicious lesions to avoid biopsy, to evaluate response to neoadjuvant chemotherapy, to differentiate cysts from solid lesions.
- 5.4** MRIs (CPT<sup>4</sup> procedure codes 76058 and 77059) to assess implant integrity or confirm implant rupture, if implants were not originally covered or coverable.
- 5.5** 3D rendering (CPT<sup>4</sup> procedure codes 76376 and 76377) for monitoring coronary artery stenosis activity in patients with angiographically confirmed Coronary Artery Disease (CAD) is unproven.
- 5.6** 3D rendering (CPT<sup>4</sup> procedure codes 76376 and 76377) for evaluating graft patency in individuals who have undergone revascularization procedures is unproven.
- 5.7** 3D rendering (CPT<sup>4</sup> procedure codes 76376 and 76377) for use as a screening test for CAD in healthy individuals or in asymptomatic patients who have one or more traditional risk factors for CAD is unproven.
- 5.8** CT angiography (CPT<sup>4</sup> procedure codes 76376 and 76377) for acute ischemic stroke is unproven.
- 5.9** CT angiography (CPT<sup>4</sup> procedure codes 76376 and 76377) for intracerebral aneurysm and subarachnoid hemorrhage is unproven.
- 5.10** CT, heart, without contrast, including image post processing and quantitative evaluation of coronary calcium (ultra fast or electron beam CT) (CPT<sup>4</sup> procedure code 0144T, HCPCS code S8092) is excluded for symptomatic patients and for screening asymptomatic patients for CAD.
- 5.11** CT, heart, without contrast material followed by contrast, material(s) and further sections, including cardiac gating and 3D image post processing; cardiac structure and morphology (CPT<sup>4</sup> procedure code 0145T) is excluded for patients with typical anginal chest pain with high suspicion for CAD; patients with acute Myocardial Infarction (MI); and for screening asymptomatic patients for CAD.
- 5.12** Computed tomographic angiography of coronary arteries (including native and anomalous coronary arteries, coronary bypass grafts) without quantitative evaluation of coronary calcium (CPT<sup>4</sup> procedure code 0146T) is excluded for patients with typical anginal chest pain with high suspicion for CAD; patients with acute MI; and for screening asymptomatic patients for CAD.
- 5.13** Computed tomographic angiography of coronary arteries (including native and anomalous coronary arteries, coronary bypass grafts) with quantitative evaluation of coronary calcium (CPT<sup>4</sup> procedure code 0147T) is excluded for patients with typical anginal chest pain with high suspicion for CAD; patients with acute MI; and for screening asymptomatic patients for CAD.
- 5.14** Cardiac structure and morphology and computed tomographic angiography of coronary arteries (including native and anomalous coronary arteries, coronary bypass grafts) without

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quantitative evaluation of coronary calcium (CPT<sup>5</sup> procedure code 0148T) is excluded for patients with typical anginal chest pain with high suspicion for CAD; patients with acute MI; and for screening asymptomatic patients for CAD.

**5.15** Cardiac structure and morphology and computed tomographic angiography of coronary arteries (including native and anomalous coronary arteries, coronary bypass grafts) with quantitative evaluation of coronary calcium (CPT<sup>5</sup> procedure code 0149T) is excluded for patients with typical anginal chest pain with high suspicion for CAD; patients with acute MI; and for screening asymptomatic patients for CAD.

**5.16** Cardiac structure and morphology in congenital heart disease (CPT<sup>5</sup> procedure code 0150T) is excluded for patients with typical anginal chest pain with high suspicion for CAD; patients with acute MI; and for screening asymptomatic patients for CAD.

**5.17** CT, heart, without contrast material followed by contrast material(s) and further sections, including cardiac gating and 3D image post processing, function evaluation (left and right ventricular function, ejection fraction and segmental wall motion (CPT<sup>5</sup> procedure code 0152T)) is excluded for patients with typical anginal chest pain with high suspicion for CAD; patients with acute MI; and for screening asymptomatic patients for CAD.

**5.18** Multislice or multidetector row CT angiography of less than 16 slices per sec and 1mm or less resolution is excluded.

**5.19** Radiological supervision and interpretation of percutaneous vertebroplasty (CPT<sup>5</sup> procedure codes 72291 and 72292).

**5.20** Dual Energy X-Ray Absorptiometry (DXA) composition study (CPT<sup>5</sup> procedure code 0028T) is unproven.

## 6.0 EFFECTIVE DATES

**6.1** The effective date for MRIs with contrast media is dependent on the U.S. Food and Drug Administration (FDA) approval of the contrast media and a determination by the contractor of whether the labeled or unlabeled use of the contrast media is medically necessary and a proven indication.

**6.2** March 31, 2006, for breast MRI.

**6.3** March 31, 2006, for coverage of multislice or multidetector row CT angiography.

**6.4** March 1, 2007, for CPT<sup>5</sup> procedure codes 72291 and 72292.

**6.5** January 1, 2007, for coverage of multislice of multidetector row CT angiography performed for presurgical evaluation prior to electrophysiological procedure to isolate pulmonary veins for radiofrequency ablation of arrhythmia focus.

- END -

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## Radiologic Guidance

Issue Date: January 1, 2007

Authority: 21 CFR 199.4(b)(c), (e)(14), and [32 CFR 199.6\(a\)\(2\)](#)

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

Fluoroscopic Guidance: 77001 - 77003

Computed Tomography Guidance: 77011 - 77014

Magnetic Resonance Guidance: 77021 and 77022

Radiologic Other: 77031 and 77032

### 2.0 DESCRIPTION

**2.1** Use of a fluoroscopy to examine deep structures by means of x-ray; it consists of a fluorescent screen covered with crystals of calcium tungstate on which are projected the shadows of x-rays passing through the body placed between the screen and the source of radiation.

**2.2** Fluoroscopic guidance (CPT<sup>1</sup> procedure code 77001) for central venous placement, replacement or removal may be considered for cost-sharing. Fluoroscopic guidance (CPT<sup>1</sup> procedure code 77002) for needle placement (e.g., biopsy, aspiration, injection, localization device) may be considered for cost-sharing. Fluoroscopic guidance (CPT<sup>1</sup> procedure code 77003) and localization of needle or catheter tip for spine or paraspinal diagnostic or therapeutic injection procedures may be considered for cost-sharing.

**2.3** Computed tomography guidance (CPT<sup>1</sup> procedure code 77011) for stereotactic localization, for guidance of needle placement (CPT<sup>1</sup> procedure code 77012); for guidance and monitoring of parenchymal tissue ablation (CPT<sup>1</sup> procedure code 77013); for guidance for placement of radiation therapy field (CPT<sup>1</sup> procedure code 77014) may be considered for cost-sharing.

**2.4** Magnetic resonance guidance for needle placement (CPT<sup>1</sup> procedure code 77021); for guidance and monitoring of parenchymal tissue ablation (CPT<sup>1</sup> procedure code 77022) may be considered for cost-sharing.

**2.5** Stereotactic localization guidance for breast biopsy or needle placement (CPT<sup>1</sup> procedure code 77031) may be considered for cost-sharing.

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

Chapter 5, Section 2.2

Radiologic Guidance

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**2.6** Mammographic guidance for needle placement for wire localization or for injection, breast may be considered for cost-sharing (CPT<sup>2</sup> procedure code 77032).

- END -

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**3.6** Extracranial stereotactic radiosurgery/radiotherapy is covered for the following indication. This list of indications is not all inclusive. Other indications are covered when documented by reliable evidence as safe, effective, and comparable or superior to standard care (proven).

- Primary and metastatic lung carcinoma.

**3.7** Frameless stereotaxy (neuronavigation) is covered for the following indications. This list of indications is not all inclusive. Other indications are covered when documented by reliable evidence as safe, effective, and comparable or superior to standard care (proven).

- Localization, surgical planning and guidance for intracranial tumors, skull base tumors, metastatic brain tumors, AVMs, cavernomas, chordomas, and pituitary adenomas.
- Biopsy guidance.
- Cerebrospinal fluid shunt placement.
- Surgery for intractable epilepsy.
- Spinal surgery.

**3.8** The frameless stereotaxy device must be U.S. Food and Drug Administration (FDA) approved. The following devices are FDA approved: StealthStation System, The Operating Arm, ISG Viewing Wand, MKM System, and Philips Easyguide. Other systems which are FDA approved are also covered.

#### **4.0 EXCLUSIONS**

**4.1** Helium ion beam radiosurgery/radiotherapy for AVMs and ependymoma is unproven.

**4.2** Intra-Operative Radiation Therapy (IORT) is unproven.

**4.3** High energy neutron radiation treatment delivery, single treatment area using a single port or parallel-opposed ports with no blocks or simple blocking (CPT<sup>2</sup> procedure code 77422) is unproven.

**4.4** High energy neutron radiation treatment delivery, single treatment area using a single port or parallel-opposed ports with no blocks or simple blocking one or more isocenter(s) with coplanar or non-coplanar geometry with blocking and/or wedge, and/or compensator(s) (CPT<sup>2</sup> procedure code 77423) is unproven.

**4.5** Compensator-based Intensity Modulated Radiation Therapy (IMRT) beam modulation treatment delivery of inverse planned treatment (0073T) is unproven.

#### **5.0 EFFECTIVE DATES**

**5.1** February 26, 1986, for proton beam radiosurgery/radiotherapy for AVMs.

**5.2** March 1, 1988, for proton beam radiosurgery/radiotherapy for patients with Cushing's disease or acromegaly caused by pituitary microadenoma.

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

Chapter 5, Section 3.1

Radiation Oncology

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- 5.3** October 6, 1988, for gamma beam (gamma knife) radiosurgery/radiotherapy for treatment of AVM, benign brain tumors, acoustic neuromas, pituitary adenomas, craniopharyngiomas, other tumors of the posterior fossa and pineal region tumors.
- 5.4** January 1, 1990, for proton beam radiosurgery/radiotherapy for soft tissue sarcoma (liposarcoma).
- 5.5** June 18, 1990, for proton beam radiosurgery/radiotherapy for chordomas or chondrosarcomas.
- 5.6** January 1, 1994, for gamma beam (gamma knife) and linear accelerator radiosurgery/radiotherapy for metastatic brain tumors.
- 5.7** January 1, 1996, for proton beam radiosurgery/radiotherapy for uveal melanoma.
- 5.8** January 1, 1996, for helium ion beam radiosurgery/radiotherapy for uveal melanoma and chordomas or chondrosarcomas.
- 5.9** April 1, 1996, for linear accelerator radiosurgery/radiotherapy for AVMs and acoustic neuromas.
- 5.10** April 26, 1996, for proton beam radiosurgery/radiotherapy for prostate cancer.
- 5.11** October 1, 1997, for gamma knife radiosurgery/radiotherapy for high grade gliomas (glioblastoma multiforme, anaplastic astrocytomas).
- 5.12** January 1, 1998, for extracranial stereotactic radiosurgery/radiotherapy for lung carcinoma.
- 5.13** The date of FDA approval for frameless stereotaxy.

- END -

## Chapter 5

## Section 4.1

# Nuclear Medicine

Issue Date: June 30, 1993

Authority: [32 CFR 199.4\(b\)\(2\)\(vii\)](#) and [\(c\)\(2\)\(ix\)](#)

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### 1.0 CPT<sup>1</sup> PROCEDURE CODE RANGE

78000 - 79999

### 2.0 DESCRIPTION

Nuclear Medicine uses very small amounts of radioactive materials or radiopharmaceuticals to diagnose and treat disease. Radiopharmaceuticals are substances that are attracted to specific organs, bones, or tissues. The radiopharmaceutical used in nuclear medicine emit gamma rays that can be detected externally by gamma or Positron Emission Tomography (PET) cameras. These cameras work in conjunction with computers used to form images that provide data and information about the area of body being imaged. The following techniques are used in the diagnosis, management, treatment, and prevention of disease:

- Planar, Single Photon Emission Computed Tomography (SPECT);
- Positron Emission Tomography (PET);
- Tomography;
- Nuclear Medicine Scan;
- Radiopharmaceutical;
- Gamma Camera;
- In Vitro Fertilization (IVF) done in test tubes; and
- IVF done in patients.

### 3.0 POLICY

#### 3.1 PET is covered for:

**3.1.1** The diagnosis and management of seizure disorders.

**3.1.2** Evaluation of ischemic heart disease.

**3.1.3** **The diagnosis, staging, restaging, and monitoring of treatment of pancreatic cancer.**

**3.1.4** The diagnosis and management of lung cancer when documented by reliable evidence as safe, effective, and comparable or superior to standard care (proven).

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**3.2** SPECT is covered for:

**3.2.1** Myocardial perfusion imaging utilizing SPECT.

**3.2.2** Brain imaging utilizing SPECT for the evaluation of seizure disorder.

**3.2.3** Prostatic radioimmunoscinigraphy imaging utilizing SPECT for the following indications:

**3.2.3.1** Metastatic spread of prostate cancer and for use in post-prostatectomy patients in whom there is a high suspicion of undetected cancer recurrence.

**3.2.3.2** Newly diagnosed patients with biopsy-proven prostate cancer at high risk for spread of their disease to pelvic lymph nodes.

**3.2.4** Indium<sup>111</sup> - for detecting the presence and location of myocardial injury in patients with suspected myocardial infarction.

**3.2.5** Indium<sup>111</sup>- labeled anti-TAG72 for tumor recurrence in colorectal and ovarian cancer.

**3.2.6** SPECT for other indications is covered when documented by reliable evidence as safe, effective, and comparable or superior to standard care (proven).

**3.3** Indium<sup>111</sup> Pentetreotide (Octreoscan) Scintigraphy is covered for:

**3.3.1** The localization and monitoring of treatment of primary and metastatic neuroendocrine tumors.

**3.3.2** Other indications when documented by reliable evidence as safe, effective, and comparable or superior to standard care (proven).

**3.4** Bone Density Studies (CPT<sup>2</sup> procedure codes 78350 and 78351) are covered for:

**3.4.1** The diagnosis and monitoring of osteoporosis.

**3.4.2** The diagnosis and monitoring of osteopenia.

**3.4.3** Patients must present with signs and symptoms of bone disease or be considered at high-risk for developing osteoporosis. High-risk factors which have been identified as the standard of care by the American College of Obstetricians and Gynecologists (ACOG) include:

**3.4.3.1** Women who are estrogen-deficient and at a clinical risk of or osteoporosis. Naturally or surgically post-menopausal women who have not been on **long-term** Hormone Replacement Therapy (HRT). However, **current** use of HRT does not preclude estrogen deficiency.

**3.4.3.2** Individuals who have vertebral abnormalities.

**3.4.3.3** Individuals receiving long-term glucocorticoid (steroid) therapy.

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**3.4.3.4** Individuals with primary hyperparathyroidism.

**3.4.3.5** Individuals with positive family history of osteoporosis.

**3.4.3.6** Any other high-risk factor identified by ACOG as the standard of care.

#### **4.0 EXCLUSIONS**

**4.1** Bone density studies for the routine screening of osteoporosis.

**4.2** PET for the diagnosis and monitoring of treatment of Alzheimer's disease, fronto-temporal dementia or other forms of dementia is unproven.

#### **5.0 EFFECTIVE DATES**

**5.1** January 1, 1995, for PET for ischemic heart disease.

**5.2** December 1, 1996, for PET for lung cancer.

**5.3** October 14, 1990, for SPECT for myocardial perfusion imaging.

**5.4** January 1, 1991, for SPECT for brain imaging.

**5.5** October 28, 1996, for <sup>111</sup>In-Capromab Pendetide, CyT 356 (ProstaScint™).

**5.6** June 1, 1994, for Octreoscan Scintigraphy.

**5.7** May 26, 1994, for bone density studies.

**5.8** January 1, 2006, for PET and PET/CT for pancreatic cancer.

- END -



## Chapter 6

## Section 1.1

### General

Issue Date:

Authority: 32 CFR 199.4(a)(1)(i), (b)(2)(ix), (b)(2)(xviii), (b)(3)(vi), (b)(3)(xv), (c)(2)(ix), (c)(2)(x), and (g)(60)

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

80048 - 87622, 87640, 87641, 87650 - 87999, 88104 - 89264, 89330 - 89399

#### 2.0 DESCRIPTION

**2.1** Pathology is the medical science and specialty practice that deals with all aspects of disease, but with special reference to the essential nature, the causes, and development of abnormal conditions, as well as the structural and functional changes that result from disease processes.

**2.2** The surgical pathology services include accession, examination, and reporting for a specimen which is defined as tissue that is submitted for individual and separate attention, requiring individual examination and pathologic diagnosis. These codes require gross and microscopic examination.

#### 3.0 POLICY

**3.1** Pathology and laboratory services are covered except as indicated.

**3.2** Surgical pathology procedures, billed by a pathologist, are covered services.

**3.3** If the operating surgeon bills for surgical pathology procedures, they will be denied as incidental, since the definitive (microscopic) examination will be performed later, after fixation of the specimen, by the pathologist who will bill separately.

**3.4** Dermatologists are qualified to perform surgical pathology services. Therefore, if a dermatologist bills for both the surgical procedure (e.g., CPT<sup>1</sup> procedure code 11100, skin biopsy) as well as the surgical pathology, both procedures are covered in full.

**3.5** Human papillomavirus testing (CPT<sup>1</sup> procedure codes 87620 - 87622) is covered for the assessment of women with Atypical Squamous Cells of Undetermined Significance (ASCUS) cells detected upon initial pap smear.

**3.6** For transfusion services, refer to [Section 2.1](#).

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## 4.0 EXCLUSIONS

- 4.1** Autopsy and postmortem (CPT<sup>2</sup> procedure codes 88000 - 88099).
- 4.2** Sperm penetration assay (hamster oocyte penetration test or the zona-free hamster egg test) is excluded for In vitro Fertilization (IVF) (CPT<sup>2</sup> procedure code 89329).
- 4.3** In-vitro chemoresistance and chemosensitivity assays (stem cell assay, differential staining cytotoxicity assay and thymidine incorporation assay) are unproven.
- 4.4** Hair analysis to identify mineral deficiencies from the chemical composition of hair is unproven. Hair analysis testing (CPT<sup>2</sup> procedure code 96902) may be reimbursed when necessary to determine lead poisoning.
- 4.5** Insemination of oocytes (CPT<sup>2</sup> procedure code 89268).
- 4.6** Extended culture of oocyte(s) embryo(s) four to seven days (CPT<sup>2</sup> procedure code 89272).
- 4.7** Assisted oocyte fertilization, microtechnique; less than or equal to 10 oocytes (CPT<sup>2</sup> procedure code 89280). Assisted oocyte fertilization, microtechnique; greater than 10 oocytes (CPT<sup>2</sup> procedure code 89281).
- 4.8** Biopsy oocyte polar body or embryo blastomere (CPT<sup>2</sup> procedure code 89290). Biopsy oocyte polar body or embryo blastomere; greater than four embryos (CPT<sup>2</sup> procedure code 89291).
- 4.9** Cryopreservation reproductive tissue, testicular (CPT<sup>2</sup> procedure code 89335).
- 4.10** Storage (per year) embryo(s) (CPT<sup>2</sup> procedure code 89342). Storage (per year) sperm/semens (CPT<sup>2</sup> procedure code 89343). Storage (per year) reproductive tissue, testicular/ovarian (CPT<sup>2</sup> procedure code 89344). Storage (per year) oocyte (CPT<sup>2</sup> procedure code 89346).
- 4.11** Thawing of cryopreserved, embryo(s) (CPT<sup>2</sup> procedure code 89352). Thawing of cryopreserved, sperm/semens, each aliquot (CPT<sup>2</sup> procedure code 89353). Thawing of cryopreserved, reproductive tissue, testicular/ovarian (CPT<sup>2</sup> procedure code 89354). Thawing of cryopreserved, oocytes, each aliquot (CPT<sup>2</sup> procedure code 89356).
- 4.12** CPT<sup>2</sup> procedure codes 83701 and 83704 and not covered for Low Density Lipoprotein (LDL) subclass testing.
- 4.13** Allo Map™ for molecular testing is unproven for use in cardiac transplant rejection surveillance.

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## Diagnostic Genetic Testing And Counseling

Issue Date: March 10, 2000

Authority: [32 CFR 199.4\(a\)\(1\)\(i\)](#)

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

96040

### 2.0 DESCRIPTION

Genetic testing intended to be confirmatory of a clinical diagnosis which is already suspected based on the patient's symptoms or risk status. Under the family planning benefit, genetic testing may also be performed in certain high risk individuals and pregnancies. For the purposes of the TRICARE benefit, genetic testing includes specific tests to detect developmental abnormalities as well as tests for specific genetic defects.

### 3.0 POLICY

**3.1** Genetic counseling provided by an otherwise authorized provider is covered and must precede the actual diagnostic genetic testing.

**3.2** Diagnostic genetic testing when medically proven and appropriate and when the results of the test will influence the medical management of the individual or pregnancy is a TRICARE benefit.

**3.3** The following diagnostic tests are covered. This is not an all inclusive list, but provides examples of covered diagnostic tests.

**3.3.1** Chromosome analysis (to include karyotyping and/or high resolution chromosome analysis) in some cases of habitual abortion or infertility.

**3.3.2** Testing for Marfan Syndrome and chromosome analysis (to include karyotyping and/or high resolution chromosome analysis) of children. Common indications for chromosome analysis in children to include ambiguity of external genitalia, small-for-gestational age infants, multiple anomalies and failure to thrive.

**3.3.3** Other medically necessary genetic diagnostic tests.

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**4.0 EXCLUSION**

Routine genetic testing that does not influence the beneficiary's medical management.

- END -

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Chapter 7, Medicine

<b>Section/Addendum</b>	<b>Subject/Addendum Title</b>
22.1	Telemedicine/Telehealth Figure 7.22.1-1 Telehealth Originating Site Facility Fee
23.1	Augmentative Communication Devices (ACDs)
24.1	Phase II And Phase III Cancer Clinical Trials
<b>25.1</b>	<b>Dermoscopy</b>



## Clinical Preventive Services - TRICARE Standard

Issue Date: April 19, 1983

Authority: [32 CFR 199.4\(e\)\(3\)\(ii\)](#), [\(g\)\(37\)](#), and 10 USC 1079(a)

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

45300 - 45339, 45355 - 45385, **77052, 77057** - 77059, 80061, 82270, 82274, 84153, 86580, 86762, 87340, 88141 - 88155, 88160 - 88162, 88164 - 88167, 88174, 88175, 90281 - 90396, 99172, 99173, 99201 - 99215, 99381 - 99387, 99391 - 99397

### 2.0 HCPCS PROCEDURE CODES

Level II Codes **G0008 - G0010**, G0104, G0105, G0121, G0202

### 3.0 BACKGROUND

**3.1** The National Defense Authorization Act for Fiscal Year (NDAA FY) 1996 (Public Law (PL) 104-106, Section 701) signed into effect on February 10, 1996, expands well-baby visits and immunizations to family members under the age of six and establishes immunizations and comprehensive preventive benefits for family members age six and above to include health promotion and disease preventive visits provided in connection with immunizations, Papanicolaou (PAP) smears, and mammograms. The NDAA FY 1997 (PL 104-201, Section 701) signed into effect on September 23, 1996, further expands health care preventive services for colon and prostate cancer examinations. Periodic health examinations that include risk assessment, physical examination, laboratory tests, x-rays, and risk specific counseling will allow for the prevention, early detection and treatment of diseases before they manifest themselves as major health problems. Prior to these Acts, preventive services were quite limited. In addition to PAP smears, mammograms, and well-baby care up to the age of two, the only related services authorized under Extra and Standard plans in the absence of symptoms were immunizations for family members accompanying an active duty member on overseas duty. The expanded preventive services will generally be reflective of those currently being offered to Prime enrollees under the Uniform Health Maintenance Organization (HMO) Benefit (see [32 CFR 199.18\(b\)\(2\)](#)), except for the application of appropriate cost-sharing and deductibles under Extra and Standard plans.

**3.2** While immunizations are provided as a specific exception to the general preventive care exclusion under the Regulation ([32 CFR 199.4\(g\)\(37\)](#)) and can be provided independently of other preventive services for those age six and older, the other expanded services (i.e., preventive services reflective of those currently being offered to Prime enrollees under Uniform HMO Benefit) must be provided in connection with immunizations, PAP smears, mammograms, and other cancer screening authorized by 10 United States Code (USC) 1079. For example, if a eligible female goes in

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for a routine PAP smear, she is also eligible to receive a wide variety of other preventive services such as tuberculosis screening, rubella antibody screening, blood pressure screening, cholesterol screening test and preventive counseling services, to name a few. However, the same coverage will not be extended if she simply makes an appointment for a routine health promotion visit, where one or more of the associated preventive services (i.e., PAP smear, mammogram, immunization and/or other cancer screening authorized by 10 USC 1079) are not performed.

**3.3** Preventive physical examinations (for example, oral cavity examinations for pharyngeal cancer, palpation for thyroid nodules, skin cancer screening, and examinations for testicular cancer) are paid under the same comprehensive health promotion and disease prevention examination office visit code (CPT<sup>2</sup> procedure codes 99381 - 99387 and 99391 - 99397) as the associated PAP smear, mammogram, immunization or other cancer screening examination authorized by 10 USC 1079. In other words, these additional physical examinations are being performed during the same office visit as required to perform the associated PAP smear, mammogram, immunization or other cancer screening authorized by 10 USC 1079.

#### **4.0 POLICY**

Preventive care is not directly related to specific illness, injury, a definitive set of symptoms, or obstetrical care, but rather is performed as a periodic health screening, health assessment, or periodic health maintenance. The following services may be provided during acute and chronic care visits or during preventive care visits for asymptomatic individuals to maintain and promote good health:

#### **4.1 Health Promotion and Disease Prevention Examinations**

The following prevention services are specific exceptions to the general preventive care exclusion under the Regulation. The contractor shall apply all appropriate claims processing and rebundling edits before determining if the following preventive services are individually reimbursable. The contractor need not establish additional edits to identify claims within the age, sex, race, or clinical history parameters included below:

#### **4.1.1 Cancer Screening Examinations and Services**

##### **4.1.1.1 Breast Cancer**

**4.1.1.1.1** Physical Examination. For women under age 40, physicians may elect to perform clinical breast examination for those who are at high risk, especially those whose first-degree relatives have had breast cancer diagnosed before menopause. For women age 40 and older, annual clinical examinations should be performed.

**4.1.1.1.2** X-ray mammography. Mammography (CPT<sup>2</sup> procedure codes 77052 and 77057) is recommended as a routine screening procedure (i.e., performed in the absence of any signs or

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symptoms of breast disease) when ordered by a physician, or upon self-referral as outlined below for:

**4.1.1.1.2.1** An asymptomatic woman over the age of 39, for one screening mammography every 12 months.

**4.1.1.1.2.2** An asymptomatic woman 35 years of age for a baseline mammogram and one screening mammogram every 12 months thereafter if the woman is considered to be at high risk of developing breast cancer. Acceptable indicators for high risk are:

**4.1.1.1.2.2.1** A personal history of breast cancer;

**4.1.1.1.2.2.2** A personal history of biopsy-proven benign breast disease;

**4.1.1.1.2.2.3** A mother, sister, or daughter who has had breast cancer;

**4.1.1.1.2.2.4** Not given birth prior to age 30; or

**4.1.1.1.2.2.5** Other acceptable high risk factors as may be recommended by major authorities (e.g., the American Academy of Family Physicians, American Cancer Society, American College of Obstetricians and Gynecologists (ACOG), American College of Physicians, and U.S. Preventive Services Task Force (USPSTF)).

**Note:** Screening mammography procedures should be billed using CPT<sup>3</sup> procedure code 77057 except when performed in connection with other preventive services, in which case a comprehensive health promotion and disease prevention examination office visit code (CPT<sup>3</sup> procedure codes 99381 - 99387 and 99391 - 99397) should be used.

**4.1.1.1.2.3** A 30 day administrative tolerance will be allowed for internal requirements between mammograms; e.g., if an asymptomatic woman 39 years of age or older received a screening mammography on September 15, coverage for another screening mammography would be allowed on or after August 17, of the following year.

**4.1.1.1.2.4** The effective date for cancer screening mammography is November 5, 1990.

**4.1.1.1.3** Breast Magnetic Resonance Imaging (MRI) (CPT<sup>3</sup> procedure codes 77058 and 77059). Breast MRI is recommended as an annual screening procedure for asymptomatic women age 35 or older considered to be at high risk of developing breast cancer per the guidelines published by the American Cancer Society (ACS) as follows:

- Women with a BRCA1 or BRCA2 gene mutation.
- Women with a first degree relative (parent, child, sibling) with a BRCA1 or BRCA2 mutation, even if untested.
- Lifetime risk approximately 20-25% or greater as defined by BRCAPRO or other models that are largely dependent on family history.

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- History of chest radiation between the ages of 10 and 30.
- History of LiFraumeni, Cowden, or Bannayan-Riley-Ruvalcaba syndromes or first degree relative with the syndrome.
- The effective date for breast cancer screening MRI is March 1, 2007.

#### **4.1.1.2 Cancer of Female Reproductive Organs**

**4.1.1.2.1** Physical examination. Pelvic examination should be performed in conjunction with PAP smear testing for cervical neoplasms and premalignant lesions.

**4.1.1.2.2** PAP smears. Cancer screening PAP tests should be performed for women who are at risk for sexually transmissible diseases, women who have or have had multiple sexual partners (or if their partner has or has had multiple sexual partners), women who smoke cigarettes, and women 18 years of age and older when provided under the terms and conditions contained in the guidelines adopted by the Deputy Director, TRICARE Management Activity (TMA). The frequency of the PAP tests will be at the discretion of the patient and clinician but not less frequent than every three years.

**4.1.1.2.2.1** Reimbursement for screening PAP smears shall not exceed the reimbursement for the intermediate office level visit except when performed in connection with other preventive services, in which case reimbursement will be allowed for the appropriate comprehensive health promotion and disease prevention examination office visit (CPT<sup>4</sup> procedure codes 99381 - 99387 and 99391 - 99397).

**4.1.1.2.2.2** Claims for screening PAP smears which are coded at a level greater than the intermediate level office visit and for which no additional preventive services have been provided will be reimbursed at the allowable charge for either CPT<sup>4</sup> procedure code 99203 or 99213 using the EOB message: "Charge reimbursed at the intermediate office visit level." Separate charges for the preparation, handling, and collection of the screening cervical PAP test are considered to be an integral part of the routine office examination visit and will not be allowed.

**4.1.1.2.2.3** Reimbursement for the cytopathology laboratory procedure associated with screening PAP tests should be billed using CPT<sup>4</sup> procedure codes 88141 - 88155, 88164 - 88167, 88174, and 88175. Reimbursement of these procedures is limited to the total CHAMPUS Maximum Allowable Charge (CMAC) and will only be paid once regardless of whether the attending physician or the laboratory bills for the services.

**4.1.1.2.2.4** Extra and Standard plans may cost-share services that are rendered during the same office visit of a screening PAP test as long as the services are considered medically necessary and are documented as such, and would not otherwise be considered integral to the office visit.

**4.1.1.2.2.5** A 30 day administrative tolerance will be allowed for interval requirements between screening PAP tests.

**4.1.1.2.2.6** The effective date for cancer screening for PAP smears is November 5, 1990.

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#### 4.1.1.3 Colorectal Cancer

**4.1.1.3.1** Physical Examination. Digital rectal examination should be performed on individuals 40 years of age and older. The effective date for coverage of a digital rectal exam is October 6, 1997.

**4.1.1.3.2** Fecal Occult Blood Testing. Once every 12 months (either guaiac-based testing or immunochemical-based testing) for beneficiaries who have attained age 50 (i.e., at least 11 months have passed following the month in which the last covered screening fecal-occult blood test was done). The effective date for coverage of guaiac-based testing is October 6, 1997. The effective date for coverage of immunochemical-based testing is August 20, 2003.

**4.1.1.3.3** Proctosigmoidoscopy or Sigmoidoscopy. Once every three to five years beginning at age 50. The effective date for coverage of proctosigmoidoscopy or sigmoidoscopy is October 6, 1997.

**4.1.1.3.4** Optical (Conventional) Colonoscopy. Once every 10 years beginning at age 50 for individuals at average risk for colon cancer. The effective date for coverage of colonoscopy for individuals at average risk is March 15, 2006.

**4.1.1.3.4.1** The following age ranges and frequencies are recommended for individuals at **increased** risk for colon cancer:

**4.1.1.3.4.1.1** Hereditary non-polyposis colorectal cancer syndrome. Colonoscopy should be performed every two years beginning at age 25, or five years younger than the earliest age of diagnosis of colorectal cancer, whichever is earlier. Annual screening after age 40.

**4.1.1.3.4.1.2** Familial risk of sporadic colorectal cancer. Familial risk means the individual has a first degree relative with sporadic colorectal cancer or adenomas before the age of 60 or multiple first degree relatives with colorectal cancer or adenomas. Colonoscopy should be performed every three to five years beginning 10 years earlier than the youngest affected relative.

**4.1.1.3.4.2** The effective date for coverage of colonoscopy for individuals at **increased** risk is October 6, 1997.

#### **4.1.1.3.5** Computed Tomographic Colonography (CTC)

**4.1.1.3.5.1** The effective date for coverage of CTC as indicated above is March 15, 2006.

**4.1.1.3.5.2** CTC is **NOT** covered as a colorectal cancer screening for any other indication or reason.

#### 4.1.1.4 Prostate Cancer

**4.1.1.4.1** Physical examination. Digital rectal examination will be offered annually for all men beginning at age 50 who have at least a 10 year life expectancy. It should also be offered to begin for men age 45 and over with a family history of prostate cancer in at least one other first degree relative (father, brother, or son) diagnosed with prostate cancer at an early age (younger than age 65) and to all African American men aged 45 and over regardless of family history. Testing should

be offered to start at age 40 for men with a family history of prostate cancer in two or more other family members.

**4.1.1.4.2** Prostate-Specific Antigen.

**4.1.1.4.2.1** Annual testing for the following categories of males:

- All men aged 50 years and older.
- Men aged 45 years and over with a family history of prostate cancer in at least one other family member.
- All African American men aged 45 and over regardless of family history.
- Men aged 40 and over with a family history of prostate cancer in two or more other family members.

**4.1.1.4.2.2** Screening will continue to be offered as long as the individual has a 10 year life expectancy.

**4.1.1.4.3** The effective date for prostate cancer screening is October 6, 1997.

**4.1.2 Infectious Diseases**

**4.1.2.1** Hepatitis B screening. The effective date for screening pregnant women for HBsAG during the prenatal period was March 1, 1992.

**4.1.2.2** Human Immunodeficiency Virus (HIV) testing.

**4.1.2.2.1** Effective July 7, 1995, TRICARE may share the cost of routine HIV screening tests for pregnant women, and

**4.1.2.2.2** Extra and Standard plans may share the cost of HIV testing when medically necessary; i.e., when performed on individuals with verified exposure to HIV or who exhibit symptoms of HIV infection (persistent generalized lymphadenopathy). Claims for HIV testing must include documentation by the attending physician verifying medical necessity. Claims that meet the criteria for coverage are to be reimbursed following the reimbursement methodology applicable to the provider's geographic location.

**4.1.2.2.3** HIV testing is covered when done in conjunction with routine pre-operative services by an independent laboratory or clinic. If the HIV testing is done while the patient is in an inpatient setting, the testing should be included in the Diagnostic Related Group (DRG).

**4.1.2.3** Prophylaxis. The following preventive therapy may be provided to those who are at risk for developing active disease:

**4.1.2.3.1** Tetanus immune globulin (human) and tetanus toxoid administered following an injury.

**4.1.2.3.2** Services provided following an animal bite:

**4.1.2.3.2.1** Extra and Standard plans may cost-share the administration of anti-rabies serum or human rabies immune globulin and rabies vaccine.

**Note:** Pre-exposure prophylaxis for persons with a high risk of exposure to rabies is not covered.

**4.1.2.3.2.2** Extra and Standard plans may also cost-share the laboratory examination of the brain of an animal suspected of having rabies if performed by a laboratory which is an authorized provider and if the laboratory customarily charges for such examinations. In order for the examination charges to be paid, the animal must have bitten a beneficiary, the charges for the examination must be submitted under the beneficiary's name, and the beneficiary must be responsible for the cost-share on the claim.

**Note:** Charges by any source for boarding, observing, or destroying animals, or for the collection of brain specimens are not covered.

**4.1.2.3.3** Rh immune globulin when administered to an Rh negative woman during pregnancy and following the birth of an Rh positive child or following a spontaneous or induced abortion.

**4.1.2.3.4** For treatment provided to individuals with verified exposure to a potentially life-threatening medical condition (i.e., hepatitis A, hepatitis B, meningococcal meningitis, etc.), claims must include documentation by the attending physician verifying exposure.

**4.1.2.3.5** Isoniazid therapy for individuals at high risk for tuberculosis to include those:

**4.1.2.3.5.1** With a positive Mantoux test without active disease;

**4.1.2.3.5.2** Who have had close contact with an infectious case of Tuberculosis (TB) in the past three months regardless of their skin test reaction; or

**4.1.2.3.5.3** Who are members of populations in which the prevalence of TB is greater than 10% regardless of their skin test reaction - including injection drug users, homeless individuals, migrant workers, and those born in Asia, Africa, or Latin America.

**Note:** In general, isoniazid prophylaxis should be continued for at least six months up to a maximum of 12 months.

**4.1.2.3.6** Immunizations.

**4.1.2.3.6.1** Coverage is extended for the age appropriate dose of vaccines that meet the following requirements:

- The vaccine has been recommended and adopted by the Advisory Committee on Immunization Practices (ACIP); and
- The ACIP adopted recommendations have been accepted by the Director of the Centers for Disease Control and Prevention (CDC) and the Secretary of Health and Human Services (HHS) and published in a CDC **Morbidity and Mortality Weekly**

**Report** (MMWR).

- Refer to the CDC's web site (<http://www.cdc.gov>) for a current schedule of CDC recommended vaccines. The effective date of coverage for the Human Papilloma Virus (HPV) vaccine is October 13, 2006. The effective date of coverage for the zoster vaccine is October 19, 2007.

**4.1.2.3.6.2** Coverage is extended for immunizations required by dependents of active duty military personnel who are traveling outside the United States as a result of an active duty member's duty assignment, and such travel is being performed under orders issued by a Uniformed Service are covered.

**4.1.3 Genetic Testing**

**4.1.3.1** Genetic testing and counseling is covered during pregnancy under any of the following circumstances:

**4.1.3.1.1** The pregnant woman is 35 years of age or older;

**4.1.3.1.2** One of the parents of the fetus has had a previous child born with a congenital abnormality;

**4.1.3.1.3** One of the parents of the fetus has a history (personal or family) of congenital abnormality; or

**4.1.3.1.4** The pregnant woman contracted rubella during the first trimester of the pregnancy.

**4.1.3.1.5** There is a history of three or more spontaneous abortions in the current marriage or in previous mating of either spouse; or

**4.1.3.1.6** The fetus is at an increased risk for a hereditary error of metabolism detectable in vitro; or

**4.1.3.1.7** The fetus is at an increased risk for neural tube defect (family history or elevated maternal serum alpha-fetoprotein level); or

**4.1.3.1.8** There is a history of sex-linked conditions (i.e., Duchenne muscular dystrophy, hemophilia, x-linked mental retardation, etc.).

**Note:** Extra and Standard plans may not cost-share routine or demand genetic testing or genetic tests performed to establish the paternity or sex of an unborn child.

**4.1.4 School Physicals**

**4.1.4.1** Physical examinations are covered for beneficiaries ages five through 11 that are required in connection with school enrollment. The effective date for coverage of school enrollment physicals is October 30, 2000.

**4.1.4.2** Cost-sharing and deductibles are to be applied as prescribed under the beneficiary's respective coverage plan (i.e., in accordance with the cost-sharing and deductible guidelines and either TRICARE Standard or Extra coverage plans).

**4.1.4.3** Standard office visit evaluation and management CPT<sup>5</sup> codes (i.e., CPT<sup>5</sup> procedure code ranges 99201 - 99205 and 99211 - 99214) may be used in billing for school physicals; however, payment may not exceed what would have otherwise been reimbursed under the comprehensive Preventive Medicine Service codes for beneficiaries ages five through 11 (CPT<sup>5</sup> procedure codes 99383 and 99393).

#### **4.1.5 Other**

**4.1.5.1** Physical examinations and immunizations provided to the spouse and children of Active Duty Service Members (ADSMs) in conjunction with official travel outside the United States. Claims must include a copy of the travel orders or other official documentation verifying the official travel requirement.

**4.1.5.2** Routine chest x-rays and electrocardiograms required for admission when a patient is scheduled to receive general anesthesia on an inpatient or outpatient basis.

**Note:** Extra and Standard plans may not cost-share routine chest x-rays or electrocardiograms for admissions not involving services that require general anesthesia.

## **4.2 Health Promotion and Disease Prevention Services Covered in Connection with Immunizations, PAP Smears, Mammograms, or Examinations for Colon and Prostate Cancer**

The following health prevention services are only covered in connection with immunizations, PAP smears, mammograms, or screening examinations for colon and prostate cancer; i.e., preventive services provided during the same comprehensive preventative office visit as the associated immunization, PAP smear, mammogram, or colon and prostate examination or preventive services provided as a result of a referral made during that same office visit. The contractor shall apply all appropriate claims processing and rebundling edits before determining if the following preventive services are individually reimbursable. The contractor need not establish additional edits to identify claims within the age, sex, race, or clinical history parameters included below, or research claims history to ensure that an association exists between the following preventive services and an immunization, PAP smear, mammogram, or colon and prostate cancer examination:

### **4.2.1 Cancer Screening Examinations**

**4.2.1.1** Testicular Cancer. Physical examination annually for males age 13 to 39 with history of cryptorchidism, orchipexy, or testicular atrophy.

**4.2.1.2** Skin Cancer. Physical skin examination should be performed for individuals with family or personal history of skin cancer, increased occupational or recreational exposure to sunlight, or clinical evidence of precursor lesions.

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**4.2.1.3** Oral Cavity and Pharyngeal Cancer. A complete oral cavity examination should be part of routine preventive care for adults at high risk due to exposure to tobacco or excessive amounts of alcohol. Oral examination should also be part of a recommended annual dental check-up.

**4.2.1.4** Thyroid Cancer. Palpation for thyroid nodules should be performed in adults with a history of upper body irradiation.

#### **4.2.2 Infectious Diseases**

**4.2.2.1** Tuberculosis screening. Screening annually, regardless of age, all individuals at high risk for tuberculosis (as defined by CDC) using Mantoux tests.

**4.2.2.2** Rubella antibodies. Females, once during age 12 through 18, unless documented history of adequate rubella vaccination with at least one dose of rubella vaccine on or after the first birthday.

#### **4.2.3 Cardiovascular Disease**

**4.2.3.1** Cholesterol. A lipid panel at least once every five years, beginning age 18.

**4.2.3.2** Blood pressure screening. Blood pressure screening at least every two years after age six.

#### **4.2.4 Body Measurements**

Height and weight should be measured periodically. The optimal frequency is a matter of clinical discretion. Those individuals who are 20% or more above desirable weight should receive appropriate nutritional and exercise counseling.

#### **4.2.5 Vision Screening**

Vision screening continues to be excluded from coverage under the Extra and Standard plans except for the one routine eye examination per calendar year per person for family members of active duty members and vision screening allowed under the well-child benefit.

#### **4.2.6 Audiology Screening**

Preventive hearing examinations are only allowed under the well-child care benefit.

#### **4.2.7 Counseling Services**

**4.2.7.1** Patient and parent education counseling for:

- Dietary assessment and nutrition;
- Physical activity and exercise;
- Cancer surveillance;
- Safe sexual practices;
- Tobacco, alcohol and substance abuse;
- Promoting dental health;
- Accident and injury prevention; and

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- Stress, bereavement and suicide risk assessment.

**4.2.7.2** These are expected components of good clinical practice that are integrated into the appropriate office visit at no additional charge.

**5.0 EFFECTIVE DATE**

Unless otherwise stated, the effective date of health promotion and disease prevention services covered in connection with immunizations, PAP smears, mammograms, or examinations for colon and prostate cancer is October 6, 1997.

- END -



## Clinical Preventive Services - TRICARE Prime

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

### 1.0 POLICY

**1.1** TRICARE Prime enrollees may receive Prime Clinical Preventive Services from any network provider without referral or authorization. If a Prime Clinical Preventive Service is not available from a network provider (e.g., a network provider is not available within prescribed access parameters), an enrollee may receive the service from a non-network provider with a referral from the Primary Care Manager (PCM) and authorization from the contractor. If an enrollee uses a non-network provider without first obtaining a referral from the PCM and authorization from the contractor payment is made under the Point of Service (POS) option only for services that are otherwise covered under TRICARE Standard. Payment will not be made under the POS option for clinical preventive services that are not otherwise covered under TRICARE Standard.

**1.2** There shall be no copayments associated with the individually TRICARE reimbursable services listed below. The contractor shall apply all appropriate claims processing and rebundling edits before determining if the below listed Current Procedural Terminology (CPT) procedure code is individually reimbursable. The contractor need not establish additional edits to identify claims within the age, sex, race, or clinical history perimeters included below. However, a 30 day administrative tolerance will be allowed for any time interval requirements imposed on screening mammographies and Papanicolaou (PAP) smears; e.g., if an asymptomatic woman 50 years of age or older received a screening mammography on September 15, coverage for another screening mammography would be allowed on or after August 17 of the following year.

SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT PROCEDURE CODE
<b>SCREENING EXAMINATIONS:</b>		
<b>COMPREHENSIVE HEALTH PROMOTION AND DISEASE PREVENTION EXAMINATIONS</b>	<b>For ages 24 months or older: One comprehensive disease prevention clinical evaluation and follow up during age intervals: 2-4; 5-11; 12-17; 18-39; 40-64.</b>	<b>CPT<sup>1</sup> codes 99382 - 99386 and 99392 - 99396.</b>
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SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT PROCEDURE CODE
<b>TARGETED HEALTH PROMOTION AND DISEASE PREVENTION EXAMINATIONS</b>	The following screening examinations may be performed during either the above periodic comprehensive health promotion examination or as part of other patient encounters. The intent is to maximize preventive care.	
<b>School Physicals:</b>	<b>Physical Examinations:</b> For beneficiaries ages five through 11 that are required in connection with school enrollment. The effective date for coverage of school enrollment physicals is October 30, 2000.	CPT <sup>1</sup> codes 99201 - 99205*, 99211 - 99214*, 99383, and 99393
	*Standard office visit evaluation and management CPT <sup>1</sup> procedure codes (i.e., code ranges 99201 - 99205 and 99211 - 99214) may be used in billing for school physicals; however, payment may not exceed what would have otherwise been reimbursed under the comprehensive preventive medicine service codes for beneficiaries ages five through 11 (CPT <sup>1</sup> procedure codes 99383 and 99393).	
<b>Breast Cancer:</b>	<b>Physical Examination:</b> For women under age 40, physicians may elect to perform clinical breast examination for those who are at high risk, especially those whose first-degree relatives have had breast cancer diagnosed before menopause. For women age 40 and older, annual clinical examinations should be performed.	See appropriate level evaluation and management codes.
	<b>Mammography:</b> Annual screening mammograms for women over age 39; For high risk women (family history of breast cancer in a first degree relative), baseline mammogram age 35, then annually.	CPT <sup>1</sup> codes 77052 and 77057. HCPCS codes G0202, G0204, and G0206.
	<b>Magnetic Resonance Imaging (MRI):</b> Annual screening breast MRI for asymptomatic women age 30 or older considered to be at high risk of developing breast cancer per the guidelines of the American Cancer Society (ACS) as follows: 1) Women with a BRCA1 or BRCA2 gene mutation; 2) Women with a first degree relative (parent, child, sibling) with a BRCA1 or BRCA2 mutation, even if untested; 3) Lifetime risk approximately 20-25% or greater as defined by BRCAPRO or other models that are largely dependent on family history; 4) History of chest radiation between the ages of 10 and 30; 5) History of LiFraumeni, Cowden, or Bannayan-Riley-Ruvalcaba syndromes or first degree relative with the syndrome. The effective date for breast cancer screening MRI is March 1, 2007.	CPT <sup>1</sup> codes 77058 and 77059.
<b>Cancer of Female Reproductive Organs:</b>	<b>Physical Examination:</b> Pelvic examination should be performed in conjunction with Pap smear testing for cervical neoplasms and premalignant lesions.	See appropriate level evaluation and management codes.
	<b>Papanicolaou (PAP) Smears:</b> Annually starting at age 18 (or younger, if sexually active) until three consecutive satisfactory normal annual examinations. Frequency may then be less often at the discretion of the patient and clinician but not less frequently than every three years.	CPT <sup>1</sup> codes 88141 - 88155, 88164 - 88167, 88174, 88175, 99201 - 99215, or 99301 - 99313.

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SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT PROCEDURE CODE
<b>Testicular Cancer:</b>	<b>Physical Examination:</b> Clinical testicular exam annually for males age 13 through 39 with a history of cryptorchidism, orchiopexy, or testicular atrophy.	See appropriate level evaluation and management codes.
<b>Prostate Cancer:</b>	<b>Physical Examinations:</b> Digital rectal examination should be offered annually for all men aged 50 years and over; men aged 45 and over with a family history of prostate cancer in at least one other family member; all African American men aged 45 and over regardless of family history; and men aged 40 and over with a family history of prostate cancer in two or more other family members.	See appropriate level evaluation and management codes.
	<b>Prostate Specific Antigen (PSA):</b> Annually for the following categories of males: all men aged 50 years and older; men aged 45 years and over with a family history of prostate cancer in at least one other family member; all African American men aged 45 and over regardless of family history; and men aged 40 and over with a family history of prostate cancer in two or more other family members.	CPT <sup>1</sup> code 84153.
<b>Colorectal Cancer:</b>	<b>Physical Examination:</b> Digital rectal examination should be included in the periodic health examination of individuals 40 years of age and older.	See appropriate level evaluation and management codes.
	<b>Fecal Occult Blood Testing (FOBT):</b> Once every 12 months (either guaiac-based testing or immunochemical-based testing) for beneficiaries who have attained age 50 (i.e., at least 11 months have passed following the month in which the last covered screening fecal-occult blood test was done). The effective date for coverage of immunochemical-based testing is August 20, 2003.	CPT <sup>1</sup> codes 82270 and 82274.
	<b>Proctosigmoidoscopy or Sigmoidoscopy:</b> Once every three to five years beginning at age 50.	CPT <sup>1</sup> codes 45300 - 45321, 45327, and 45330 - 45339. HCPCS code G0104.
	<b>Optical (Conventional) Colonoscopy for Individuals at Average Risk for Colon Cancer:</b> Once every 10 years for individuals age 50 or above. The effective date for coverage of colonoscopy for individuals at average risk is March 15, 2006.	CPT <sup>1</sup> codes 45355 and 45378 - 45385. HCPCS codes G0105 and G0121.
	<b>Optical (Conventional) Colonoscopy for Individuals at Increased Risk for Colon Cancer:</b> Performed every two years beginning at age 25, or five years younger than the earliest age of diagnosis of colorectal cancer, whichever is earlier and then annually after age 40 for individuals with hereditary non-polyposis colorectal cancer syndrome. Individuals with familial risk of sporadic colorectal cancer (i.e., individuals with first degree relatives with sporadic colorectal cancer or adenomas before the age 60 or multiple first degree relatives with colorectal cancer or adenomas) may receive a colonoscopy every three to five years beginning at age 10 years earlier than the youngest affected relative.	

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Clinical Preventive Services - TRICARE Prime

SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT PROCEDURE CODE
<b>Colorectal Cancer (Continued):</b>	<b>Computed Tomographic Colonography (CTC) for Individuals in whom an Optical Colonoscopy is Medically Contraindicated or Incomplete:</b> CTC is covered as a colorectal cancer screening <b>ONLY</b> when an optical colonoscopy is medically contraindicated OR cannot be completed due to a known colonic lesion, structural abnormality, or other technical difficulty is encountered that prevents adequate visualization of the entire colon. The effective date for coverage of CTC for this indication is March 15, 2006. CTC is <b>NOT</b> covered as a colorectal cancer screening for any other indication or reason.	CPT <sup>1</sup> Level III codes 0066T or 0067T.
<b>Skin Cancer:</b>	<b>Physical Examination:</b> Skin examination should be performed for individuals with a family or personal history of skin cancer, increased occupational or recreational exposure to sunlight, or clinical evidence of precursor lesions.	See appropriate level evaluation and management codes.
<b>Oral Cavity and Pharyngeal Cancer:</b>	<b>Physical Examination:</b> A complete oral cavity examination should be part of routine preventive care for adults at high risk due to exposure to tobacco or excessive amounts of alcohol. Oral examination should also be part of a recommended annual dental check-up.	See appropriate level evaluation and management codes.
<b>Thyroid Cancer:</b>	<b>Physical Examination:</b> Palpation for thyroid nodules should be performed in adults with a history of upper body irradiation.	See appropriate level evaluation and management codes.
<b>Infectious Diseases:</b>	<b>Tuberculosis Screening:</b> Screen annually, regardless of age, all individuals at high risk for tuberculosis (as defined by CDC) using Mantoux tests.	CPT <sup>1</sup> codes 86580 and 86585.
	<b>Rubella Antibodies:</b> females, once, age 12-18, unless documented history of adequate rubella vaccination with at least one dose of rubella vaccine on or after the first birthday.	CPT <sup>1</sup> code 86762.
	<b>Hepatitis B Screening:</b> Screen pregnant women for HBsAG during prenatal period.	CPT <sup>1</sup> code 87340.
<b>Cardiovascular Diseases:</b>	<b>Cholesterol:</b> A lipid panel at least once every five years, beginning age 18.	CPT <sup>1</sup> code 80061.
	<b>Blood Pressure Screening:</b> For children: annually between three and six years of age, and every two years thereafter. For adults: a minimum frequency of every two years.	See appropriate level evaluation and management codes.
	<b>Abdominal Aortic Aneurysm (AAA):</b> One time AAA screening by ultrasonography for men, age 65 - 75, who have ever smoked.	CPT <sup>1</sup> code 76999.

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SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT PROCEDURE CODE
<b>Other:</b>	<b>Body Measurement:</b> For children: Height and weight should be measured regularly throughout infancy and childhood. Head circumference should be measured through age 24 months. For adults: Height and weight should be measured periodically. The optimal frequency is a matter of clinical discretion. Those individuals who are 20% or more above desirable weight should receive appropriate nutritional and exercise counseling.	See appropriate level evaluation and management codes.
	<b>Vision Care:</b> Pediatric vision screening at birth and approximately 6 months of age to include determination of vision on visual acuity, ocular alignment and red reflex, along with external examination of ocular abnormalities. Routine eye examination once every two years for retirees and eligible family members age three and older who are enrolled in Prime. Active Duty Family Member (ADFM) age three and older who are enrolled in Prime may receive a routine eye exam annually (see Section 6.1). Diabetic patients, at any age, should have routine eye examinations at least yearly.	CPT <sup>1</sup> codes 92002, 92004, 92012, 92014, 92015, 99172, and 99173.
	<b>Note:</b> Routine eye examinations are meant to be more than the standard visual acuity screening test conducted by the member's primary care physician through the use of a standard Snellen wall chart. Self-referral will be allowed for routine eye examinations since PCMs are incapable of providing this service; i.e., a prime beneficiary will be allowed to set up his or her own appointment for a routine eye examination with any network optometrist or ophthalmologist.	
	<b>Hearing Screening:</b> For children: All high risk neonates (as defined by the Joint Committee on Infant Hearing) audiology screening before leaving the hospital. If not tested at birth, high-risk children should be screened before three months of age. Evaluate hearing of all children as part of routine examinations and refer those with possible hearing impairment as appropriate.	CPT <sup>1</sup> codes 92551, 92587, and 92588.
	<b>Pediatric Blood Lead:</b> Assessment of risk for lead exposure by structured questionnaire based on Centers for Disease Control and Prevention (CDC) Preventing Lead Poisoning in Young Children (October 1991) during each well child visit from age six months through six years. Screening by blood lead level determination for all children at high risk for lead exposure per CDC guidelines.	CPT <sup>1</sup> code 83655.

**COUNSELING SERVICES:**

<b>These are expected components of good clinical practice that are integrated into the appropriate office visit at no additional charge.</b>	<b>Patient &amp; Parent Education Counseling:</b> Dietary Assessment & Nutrition; Physical Activity & Exercise; Cancer Surveillance; Safe Sexual Practices; Tobacco, Alcohol and Substance Abuse; Accident & Injury Prevention; Promoting Dental Health; Stress, Bereavement, & Suicide Risk Assessment.	These are expected components of good clinical practice that are integrated into the appropriate office visit at no additional charge.
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Clinical Preventive Services - TRICARE Prime

SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT PROCEDURE CODE
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**IMMUNIZATIONS:**

Age appropriate dose of vaccines that have been recommended and adopted by the Advisory Committee on Immunization Practices (ACIP) and accepted by the Director of the CDC and the Secretary of Health and Human Services (HHS) and published in a CDC **Morbidity and Mortality Weekly Report** (MMWR). Refer to the CDC's home page (<http://www.cdc.gov>) for current schedule of CDC recommended vaccines. The effective date of coverage for the Human Papilloma Virus (HPV) vaccine is October 13, 2006.

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- END -

## Preauthorization Requirements For Substance Use Disorder Detoxification And Rehabilitation

Issue Date: March 13, 1992

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

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### 1.0 BACKGROUND

In the National Defense Authorization Act for Fiscal Year 1991 (NDAA FY 1991), Public Law (PL) 101-510 and the Defense Appropriations Act for 1991, PL 101-511, Congress addressed the problem of spiraling costs for mental health services under TRICARE. These statutes made two principal changes. First, they established new day limits for inpatient mental health services and secondly, they mandated prior authorization for all nonemergency inpatient mental health admissions, with required certification of emergency admissions within 72 hours.

### 2.0 POLICY

Effective October 1, 1991, preadmission and continued stay authorization is required before services for substance use disorders may be cost-shared. Preadmission and continued stay authorization is required for both detoxification and rehabilitation services. To comply with the statutory requirements and to avoid denial, requests for preadmission authorization on weekends and holidays are discouraged. All admissions for rehabilitation are elective and must be certified as medically/psychologically necessary prior to admission. The admission criteria shall not be considered satisfied unless the patient has been personally evaluated by a physician or other authorized health care professional with admitting privileges to the facility to which the patient is being admitted prior to the admission.

### 3.0 POLICY CONSIDERATIONS

#### 3.1 Treatment of Mental Disorders

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

condition.

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

**3.2.1** Detoxification. Stays for detoxification are covered if preauthorized as medically/psychologically necessary. Days of detoxification must be counted toward the statutory day limit which went into effect October 1, 1991, limiting care for adults (age 19 and over) to 30 days in a fiscal year or 30 days in an admission and to 45 days for children (age 18 and under). In determining the medical or psychological necessity of detoxification and rehabilitation for substance use disorder, the evaluation conducted by the contractor shall consider the appropriate level of care for the patient and the intensity of services required by the patient. Emergency and inpatient hospital services are covered when medically necessary for the active medical stabilization, and for treatment of medical complications of substance use disorder. Authorization prior to admission is not required in the case of an emergency requiring an inpatient acute level of care, but authorization for a continuation of services must be obtained promptly. Admissions resulting from a bona fide emergency should be reported within 24 hours of the admission or the next business day after the admission, but must be reported to the contractor within 72 hours of the admission. Emergency and inpatient hospital services are considered medically necessary only when the patient's condition is such that the personnel and facilities of a hospital are required. Stays for detoxification in a substance use disorder facility are limited to **seven** days unless the limit is waived by the contractor and must be provided under general medical supervision.

**3.2.2** Rehabilitative care. The patient's condition must be such that rehabilitation for substance use disorder must be provided in a hospital or in an organized inpatient substance use disorder treatment program. Rehabilitation stays are covered if preauthorized as medically/psychologically necessary. Coverage during a single benefit period is limited to no more than one inpatient stay (**prior to October 1, 2008**, exclusive of stays classified in DRG 433; **and on or after October 1, 2008**, exclusive of stays classified in DRG 894) in hospitals subject to the DRG-based payment system or 21 days in a DRG-exempt facility for rehabilitative care unless the limit is waived by the contractor. Days of rehabilitation must be counted toward the statutory day limit, restricting care for adults (age 19 and over) to 30 days in a fiscal year or 30 days in an admission and to 45 days for children (aged 18 and under). The concept of an emergency admission does not apply to rehabilitative care.

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

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

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

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

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

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

**3.2.5** Preadmission authorization is required even when the beneficiary has other health insurance because the statutory requirement is applicable to every case in which payment is sought, regardless of whether it is first payer or second payer basis.

### **3.3 Payment Responsibility**

**3.3.1** Any inpatient mental health care obtained without requesting preadmission authorization or rendered in excess of the 30/45 day limit (or beyond the DRG long-stay outlier) without following concurrent review requirements, in which the services are determined excluded by reason of being not medically necessary, is not the responsibility of the patient or the patient's family until:

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

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

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

### **3.4 Concurrent Review**

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

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

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**Preauthorization Requirements For Substance Use Disorder Detoxification And Rehabilitation**

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establish that coordination for the move existed between the two facilities, then the intent to transfer cannot be established and the move should be considered a discharge.

**4.0 EXCEPTION**

For Dual Eligible beneficiaries, these requirements apply when TRICARE is primary payer. As secondary payer, TRICARE will rely on and not replicate Medicare's determination of medical necessity and appropriateness in all circumstances where Medicare is primary payer. In the event that TRICARE is primary payer for these services and preauthorization was not obtained, the contractor will obtain the necessary information and perform a retrospective review.

- END -

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

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

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

## **5.0 EXCEPTIONS**

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

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

**5.2** The clinician responsible for the patient's care is responsible for documenting the need for additional days and must establish an estimated length-of-stay (LOS) beyond the date of the 60-day limit. There must be evidence of a coherent and specific plan for assessment, intervention and reassessment that reasonably can be accomplished within the time frame of the additional days of coverage requested under the waiver provisions.

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

## **6.0 EXCEPTION**

Effective October 1, 2003, TRICARE's preadmission and continued stay authorization is not required for inpatient mental health care for Medicare-TRICARE dual eligibles for the period when

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

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Medicare is primary payer and has authorized the care. **In the event that TRICARE is primary payer for these services and preauthorization was not obtained, the contractor shall obtain the necessary information and perform a retrospective review.**

- END -

## Substance Use Disorders

Issue Date: June 26, 1995

Authority: [32 CFR 199.4\(e\)\(4\)](#) and (h)

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### 1.0 DESCRIPTION

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

### 2.0 POLICY

Coverage may be extended for the treatment of substance use disorders including detoxification, rehabilitation, and outpatient care provided in authorized substance use disorder rehabilitation facilities in accordance with the [paragraph 3.0](#).

### 3.0 POLICY CONSIDERATIONS

#### 3.1 Emergency And Inpatient Hospital Services

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

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

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

**3.1.4** Inpatient hospital services are subject to the provisions regarding the limit on inpatient mental health services.

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

#### 3.2 Authorized Substance Use Disorder Treatment

**3.2.1** Only those services provided by an authorized institutional providers are covered. Such a provider must be either an authorized hospital, or an organized substance use disorder treatment program in an authorized freestanding or hospital-based substance use disorder rehabilitation facility.

**3.2.2** A qualified mental health provider (physicians, clinical psychologists, Clinical Social Workers (CSWs), and psychiatric nurse specialists) shall prescribe the particular level of treatment.

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

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

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

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

### **3.3 Covered Services**

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

**3.3.1.1** Residential Care is subject to the following:

**3.3.1.1.1** Care must be preauthorized.

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

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

**3.3.1.1.4** The medical and psychological necessity of the detoxification must be documented. Any detoxification services provided in the substance use disorder rehabilitation facility must be under general medical supervision.

**3.3.1.2** Partial care is subject to the following:

**3.3.1.2.1** Care must be preauthorized

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

## Special Otorhinolarygologic Services

Issue Date: April 19, 1983

Authority: [32 CFR 199.4\(c\)\(3\)\(iv\)](#), [\(g\)\(47\)](#), [32 CFR 199.5\(c\)](#), and 10 USC 1079(e)

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

92502 - 92512, 92516, 92520, 92526, 92551 - 92597, 92601 - 92617, 92626, 92627, 92630, 92633, **92640**, 92700

### 2.0 DESCRIPTION

**2.1** Otolaryngology is that branch of medicine concerned with the screening, diagnosis and management of medical and surgical disorders of the ear, the upper respiratory and upper alimentary systems and related structures and the head and neck.

**2.2** Audiology is the discipline involved in the prevention, identification and the evaluation of hearing disorders, the selection and evaluation of hearing aids, and the rehabilitation of individuals with hearing impairment. Audiological services, including function tests, performed to provide medical diagnosis and treatment of the auditory system.

### 3.0 POLICY

**3.1** Otorhinolaryngology services, including audiological services are covered for the diagnosis and treatment of a covered medical condition.

**3.2** **Prior to September 1, 2005**, hearing aid services and supplies may be cost-shared only for **eligible** beneficiaries through the Program **for Persons with Disabilities (PPWD) on the basis of a hearing disability or of multiple disabilities, one of which involves a hearing disability.**

**3.3** **On or after September 1, 2005**, hearing aid services and supplies may be cost-shared only for Active Duty Family Members (ADFM) with a profound hearing loss through the TRICARE Basic Program. See [Section 8.2](#).

**3.4** Diagnostic analysis of cochlear implant with programming is covered for patients under seven years of age (CPT<sup>1</sup> procedure codes 92601 and 92602), and age seven years or older with programming (CPT<sup>1</sup> procedure codes 92603 and 92604). See [Chapter 4, Section 22.2](#).

**3.5** Evaluation for prescription of non-speech-generating augmentative and alternative communication device, including programming and modification, may be cost-shared only for eligible beneficiaries through the Extended Care Health Option (ECHO) on the basis of a speech

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disability or of multiple disabilities, one of which involves a speech disability (CPT<sup>2</sup> procedure codes 92605 - 92609).

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## Pulmonary Services

Issue Date: April 19, 1983

Authority: [32 CFR 199.4\(b\)\(2\)\(xviii\)](#)

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

94002 - 94004, 94010 - 94799

### 2.0 DESCRIPTION

Services provided for the diagnosis or treatment of conditions involving the lungs.

### 3.0 POLICY

**3.1** Pulmonary services including pulmonary services provided as part of a treatment program on an inpatient or outpatient basis are covered.

**3.2** For an indication to be covered the efficacy of the pulmonary services must be proven.

**Note:** Examples of proven indications are: cardiopulmonary or pulmonary rehabilitation for pre- and post-lung transplant patients when preauthorized by the appropriate preauthorizing authority as outlined in the Policy on heart-lung and lung transplantation; effective September 13, 1999, severe Chronic Obstructive Pulmonary Disease (COPD) on an inpatient basis; and moderate and severe COPD on an outpatient basis.

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## Dermoscopy

Issue Date: June 19, 2008

Authority: [32 CFR 199.4\(c\)\(2\)\(iv\)](#) and [\(c\)\(2\)\(xiv\)](#)

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

96904

### 2.0 DESCRIPTION

Early phases of malignant melanoma can be difficult to detect. Surgery (i.e., biopsy) to remove the melanoma is the standard treatment for this disease. However, a number of surveillance technologies have been developed in an attempt to improve accuracy in diagnosing malignancies in pigmented skin lesions without using a biopsy or excision (removal) of the lesion itself.

Dermoscopy (also known as Digital Epiluminescence Microscopy (DELM), dermatoscopy, melanomography, in vivo cutaneous surface microscopy, mole mapping, and magnified oil immersion diascopy) is one of technologies designed for detecting and monitoring dysplastic and atypical nevi for early detection of malignant cutaneous melanomas. The dermoscope allows 10x or higher magnification by using high intensity light. Oil placed between the skin and the lens makes the skin more transparent and enables visualization of skin structures to the bottom of the outermost layer of the skin. This technology offers the physician the ability to have a baseline image to refer to so he or she can examine each suspicious lesion, and then compare them year after year, by re-imaging.

### 3.0 POLICY

The Dermoscopy technique for diagnosing and monitoring dysplastic and atypical nevi for early detection of malignant cutaneous melanoma in patients with suspicious pigmented skin lesions is not covered because it is considered unproven.

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## Chapter 8

## Section 3.1

# Orthotics

Issue Date: September 20, 1990  
Authority: [32 CFR 199.4\(d\)\(3\)\(viii\)](#)

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### 1.0 DESCRIPTION

Orthotics is the field of knowledge relating to the making of an appliance or apparatus used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body.

### 2.0 POLICY

**2.1** Orthotic devices are covered.

**2.2** For individuals with diabetes, extra-depth shoes with inserts or custom molded shoes with inserts are covered.

**2.3** Orthopedic braces including shoes which are an integral part of the brace--neither the shoe nor the brace is usable separately--are covered.

### 3.0 EXCLUSIONS

The following types of orthoses are excluded from TRICARE coverage:

**3.1** Orthopedic shoes (except for orthopedic shoes which are an integral part of a brace).

**3.2** Arch supports.

**3.3** Shoe inserts.

**3.4** Other supportive devices of the feet, such as, wedges, specialized fillers, heels straps, pads, shanks, etc.

**3.5** Cranial orthosis (Dynamic Orthotic Cranioplasty Band) and cranial molding helmets for nonsynostotic positional plagiocephaly (deformational plagiocephaly, plagiocephaly without synostosis) (HCPCS S1040). The use of this device for all other indications is excluded on the basis that this is off-label use of a device. For policy provisions on the use of this device for Extended Care Health Option (ECHO) beneficiaries, see [Chapter 9, Section 14.1](#).

- END -



## Chapter 8

## Section 7.1

# Nutritional Therapy

Issue Date: April 19, 1983

Authority: [32 CFR 199.4\(a\)\(1\)\(i\)](#), [\(d\)\(3\)\(iii\)](#), [\(g\)\(57\)](#), and [32 CFR 199.5\(c\)](#)

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### 1.0 HCPCS PROCEDURE CODES

B4034 - B9999

### 2.0 DESCRIPTION

Nutritional therapy provides medically necessary nutrient intake for individuals with inborn errors of metabolism, medical conditions of malabsorption, pathologies of the alimentary or gastrointestinal tract, and neurological or physiological conditions which require enteral tube feedings.

### 3.0 POLICY

**3.1** When used as the primary source of calories or as the primary source or a required macronutrient (i.e., protein), TRICARE may cost-share medically necessary supplies and nutritional products for:

**3.1.1** Enteral nutritional therapy.

**3.1.2** Parenteral nutritional therapy.

**3.1.3** Oral nutritional therapy.

**3.1.4** Medically necessary vitamins and minerals added to the nutritional solution.

**3.1.5** Intraperitoneal Nutrition (IPN) therapy when determined to be medically necessary treatment for individuals suffering from malnutrition as a result of end stage renal disease.

**3.1.6** Ketogenic diet if it is part of a medically necessary admission for epilepsy. Services and supplies will be reimbursed under the **Diagnosis Related Group (DRG)** payment methodology.

**3.2** Medically necessary nutritional products which are provided under [paragraph 3.1](#) and which are on the "Enteral Nutrition Product Classification List" are eligible for TRICARE cost-sharing. The list is maintained by **Noridian Administrative Services** and is currently available online at: <http://www.dmepdac.com/dmecsapp/do/search>.

**3.3** Medical supplies and equipment required to provide the therapy are covered.

**3.4** Nutritional therapy may be provided in the inpatient or outpatient setting.

**4.0 EXCLUSIONS**

**4.1** Food and food substitutes.

**4.2** Vitamins or mineral preparations, except as provided in [paragraph 3.0](#) or by [Section 9.1](#).

**4.3** Nutritional supplements administered solely to boost protein or caloric intake or in the absence of a medical condition for which the accepted treatment consists of or includes administration of nutritional supplements.

**4.4** The above exclusions apply also to prenatal care.

**4.5** For children less than one year of age who require enteral nutritional therapy, formulas that are readily available in a retail environment and are marketed for use by infants without medical conditions as described in [paragraph 2.0](#) are excluded from coverage.

**4.6** Except as provided in [paragraph 3.1.6](#), services and supplies related to a ketogenic diet, including nutritional counseling, calculation of a ketogenic formula, and food substitutes.

- END -

## Dental Anesthesia And Institutional Benefit

Issue Date: May 23, 2007  
Authority: [32 CFR 199.4\(e\)\(10\)](#)

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### 1.0 BACKGROUND

Section 702 of the John Warner National Defense Authorization Act for Fiscal Year 2007, (NDAA-07), Public Law 109-364, amended paragraph (1) of section 1079(a) of title 10, United States Code (USC) and provided that "in connection with dental treatment for patients with developmental, mental, or physical disabilities or for pediatric patients age five or under, only institutional and anesthesia services may be provided". The NDAA-07 was signed into law on October 17, 2006

### 2.0 POLICY

**2.1** Medically necessary institutional and general anesthesia services may be covered in conjunction with non-covered or non-adjunctive dental treatment for patients with developmental, mental, or physical disabilities or for pediatric patients age five or under. Also, see [paragraph 2.2](#), on additional hospital services benefit.

**2.2** Patients with diagnosed developmental, mental, or physical disabilities are those patients with conditions that prohibit dental treatment in a safe and effective manner. Therefore, it is medically or psychologically necessary for these patients to require general anesthesia for dental treatment.

**2.3** The general anesthesia cannot be performed by the attending dentist, but rather must be administered by a separate anesthesiology provider.

**2.4** Coverage of institutional services will include institutional benefits associated with both hospital and in-out surgery settings.

**2.5** **No referrals are required for the above services.** Preauthorization is required for above outpatient care or inpatient stays to be covered in the same manner as required for adjunctive dental care as provided in [Section 13.1](#). No preauthorization will be required for care obtained during the period from October 17, 2006 to the implementation date of this policy.

**2.6** When the Managed Care Support Contractor (MCSC) receives a claim for reimbursement for general anesthesia services in conjunction with dental care that is covered under this section, the MCSC shall check with the appropriate TRICARE dental contractor to determine if the general anesthesia charges have already been covered for claims involving services during the period October 17, 2006 to the implementation date of this policy. If the general anesthesia services were

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Dental Anesthesia And Institutional Benefit

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provided in an institutional or in-out surgery setting, then the MCSC shall advise the sponsor of the right to file a claim for the difference in the amount authorized under TRICARE and the appropriate TRICARE Dental Plan (TDP), as well as the difference in the amount of the anesthesia cost-share under the TDP, and the cost-share the beneficiary has under the TRICARE plan in which they were participating at the time, TRICARE Prime, Standard, or Extra.

**3.0 EXCLUSION**

The professional services related to non-adjunctive dental care are not covered with the exception of coverage for general anesthesia services.

**4.0 EFFECTIVE DATE**

October 17, 2006.

- END -

## Chapter 9

## Section 3.1

# Registration

Issue Date: February 14, 2004

Authority: [32 CFR 199.5\(h\)\(2\)](#), 10 USC 1079(d)

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### 1.0 ISSUE

Section 1079(d)(1) of Title 10 United States Code (USC) requires that TRICARE beneficiaries must be “registered” in order to receive the benefits provided under Section 1079(d)-(f) of Title 10, United States Code (USC). This registration policy will enhance the efforts to provide an integrated set of services and supplies to eligible TRICARE beneficiaries and insure effective utilization of program resources.

### 2.0 POLICY

**2.1** The active duty sponsor (or other authorized individual acting on behalf of the beneficiary) will submit the following to the Managed Care Support Contractor (MCSC) or TRICARE Area Office (TAO) Director responsible for administering the Extended Care Health Option (ECHO) in the geographic area where the beneficiary resides:

**2.1.1** Evidence that the sponsor is an Active Duty Service Member (ADSM) in one of the Uniformed Services.

**2.1.2** Medical records, as determined necessary by the MCSC or TAO Director which demonstrate that the Active Duty Family Member (ADFM) has a qualifying condition in accordance with [Sections 2.2](#) through [2.4](#), and who otherwise meets all applicable ECHO requirements.

**2.1.3** Evidence, as provided by the sponsor’s branch of service, that the family, or family member seeking ECHO registration, is enrolled in the Exceptional Family Member Program (EFMP) provided by the sponsor’s branch of service.

**2.1.3.1** This requirement is waived when either:

**2.1.3.1.1** The sponsor’s branch of service does not provide the EFMP; or

**2.1.3.1.2** The beneficiary seeks ECHO eligibility based on the “deceased sponsor” provisions listed in [Section 2.1](#), or

**2.1.3.1.3** Other circumstances exist that make enrollment in the EFMP unnecessary or inappropriate, such as when an individual resides with the custodial parent who is not the active duty sponsor.

**2.1.3.2** To avoid delaying receipt of ECHO services while completing the ECHO registration process, in particular awaiting completion of enrollment in the EFMP of the sponsor's service, the MCSC or TAO Director may grant otherwise ECHO-eligible beneficiaries a provisional eligibility status for a period of not more than 90 days during which ECHO benefits will be authorized and payable. This provisional status is portable across managed care support contract regions and, except for the ECHO Home Health Care (EHC) benefit, it applies to the TRICARE Overseas Program (TOP).

**Note:** The provisional status will terminate upon completion of the registration process or at the end of the 90 day period, whichever occurs first. The government liability for ECHO benefits will terminate at the end of the 90 day period. The government will not recoup claims paid for ECHO benefits provided during the provisional period.

**2.1.4** Such other information as may be required by the MCSC or TAO Director in order to determine whether or not the requesting beneficiary is eligible for the ECHO.

**2.1.5** In locations outside the 50 United States and the District of Columbia, the TAO Director shall advise the TOP contractor of all ECHO eligibility determinations.

**2.2** Upon determination that an ADFM is eligible for the ECHO, the MCSC or the TOP contractor will use the Defense Online Enrollment System (DOES) to annotate the beneficiary's Defense Enrollment Eligibility Reporting System (DEERS) record to reflect ECHO eligibility.

**2.2.1** The MCSC or TOP contractor will provide the sponsor/beneficiary with written notification of the eligibility determination and that the beneficiary is registered in ECHO. Except as otherwise provided in [paragraph 2.1.3.2](#), the beneficiary is eligible to receive ECHO benefits as of the date of registration.

**Note:** Upon query through the Composite Health Care System (CHCS), the DEERS Eligibility Response will return the Health Care Delivery Plan (HCDP) code "400", which indicates the beneficiary is registered and eligible to receive ECHO benefits.

**2.2.2** Determination that a beneficiary is not eligible for the ECHO is factual, therefore, such determination can not be appealed.

**2.3** At the time of registration, the MCSC or TOP contractor will also provide the sponsor/beneficiary with informational materials that, at a minimum, emphasize the ECHO is an optional program for ADFMs only and has unique qualifying and cost-sharing requirements.

**2.4** The eligibility determination will remain in effect until such time as the MCSC or the TAO Director determines the beneficiary is no longer eligible for the ECHO. This may result from a loss of TRICARE eligibility, remediation of the qualifying condition, or a determination that the beneficiary does not otherwise meet the eligibility requirements of the ECHO.

**2.5** TRICARE does not charge a fee for registering in the ECHO, however, the sponsor/beneficiary may incur costs associated with the determination of eligibility for the ECHO. For example, the sponsor of a beneficiary who uses TRICARE Standard or Extra to receive diagnostic services that result in a diagnosis that is an ECHO qualifying condition, is liable for all relevant cost-shares associated with receipt of those diagnostic services through TRICARE Standard or Extra. Those cost-

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Registration

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shares are not reimbursable under the ECHO. Additionally, TRICARE does not provide separate or additional reimbursement to providers for completion of forms, such as the DoD form DD 2792, **Exceptional Family Member Medical Summary**, or for reproducing, copying or transmitting records necessary to register in the ECHO. TRICARE will deny claims for such services.

**3.0 EFFECTIVE DATE**

September 1, 2005.

- END -



individuals providing such services. The totals will be entered on separate lines of the CMS 1500 (08/2005).

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

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

## 6.8 Reimbursement

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

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

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

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

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

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

**6.8.2.1.2** From the "Table 6. RUG-53 Case-Mix Adjusted Federal Rates for Urban SNFs by Labor and Non-Labor Component", determine the highest cost RUG-III category;

**6.8.2.1.3** Multiply the labor component obtained in (2) by the "Table 8. FY 2008 Wage Index for Urban Areas Based on CBSA Labor Market Areas" value corresponding to the beneficiary's location;

**6.8.2.1.4** Sum the non-labor component from (2) and the adjusted labor component from (3); the result is the beneficiary's EHC per diem in that location;

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#### ECHO Home Health Care (EHC)

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**6.8.2.1.5** Multiply the per diem obtained in (4) by 365 (366 in leap year); the result is the beneficiary's fiscal year cap for EHC in that location.

**6.8.2.1.6** For beneficiary's residing in areas not listed in Table 8, use "Table 7. RUG-53 Case-Mix Adjusted Federal Rates for Rural SNFs by Labor and Non-Labor Component" and "Table 9. FY 2008 Wage Index Based on CBSA Labor Market Areas for Rural Areas" and adjust similarly to steps (3) through (5) to determine the EHC cap for beneficiaries residing in rural areas.

**Note:** See [Addendum A](#) for an example of the EHC cap based on the FY 2008 rates published in the **Federal Register** on [August 31, 2007 \(72 FR 43412\)](#).

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

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

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

**6.8.2.5** The cost for EHC services does not accrue to the \$2,500 maximum monthly Government cost-share indicated in [Section 16.1](#).

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

## 7.0 EXCLUSIONS

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

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

**7.3** EHC respite care services are not available for the purpose of covering primary caregiver(s) absences due to deployment, employment, seeking employment, or to pursue education.

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

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

## ECHO Home Health Care (EHC) Benefit

The following example illustrates the process of calculating the maximum fiscal year benefit for Extended Care Health Option (ECHO) Home Health Care (EHC) as described in [Section 15.1, paragraph 6.8](#).

This example is based on the Fiscal Year 2008 rates for the Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for Fiscal Year (FY) 2008; Final Rule published by the Centers for Medicare and Medicaid Services (CMS) in the **Federal Register** on August 31, 2007 (72 FR 43412).

STEP	DESCRIPTION	URBAN <sup>1</sup>	RURAL <sup>2</sup>
1	Tables 6 and 7 Highest RUG-III Category	RUX	RUX
2	Tables 6 and 7 Labor Component of RUX	442.24	441.19
3	Tables 8 and 9 Wage Index	1.6122	1.1644
4	Adjusted Labor Component (Step 2 x Step 3)	680.71	513.72
5	Tables 6 and 7 Non-Labor Component	179.66	187.71
6	Total RUX Daily Rate (Step 4 + Step 5)	860.40	701.43
7	Total Fiscal Year EHC Benefit (Step 6 x 365) <sup>3</sup>	314,906.40	256,723.38

<sup>1</sup> Beneficiary resides in Santa Cruz, CA.  
<sup>2</sup> Beneficiary resides in rural Massachusetts.  
<sup>3</sup> 366 in Leap Year.

- END -



## State Licensure And Certification

Issue Date: September 20, 1990

Authority: [32 CFR 199.6\(c\)\(2\)\(i\)](#) and [\(c\)\(2\)\(ii\)](#)

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### 1.0 ISSUE

TRICARE requirement for state licensure and certification.

### 2.0 POLICY

**2.1 State Licensure/Certification.** Otherwise covered services shall be cost-shared only if the individual professional provider holds a current, valid license or certification to practice his or her profession in the state where the service is rendered. Licensure/certification in a profession other than that for which the provider is seeking authorization is not acceptable. The licensure/certification must be at the full clinical level of practice. Full clinical practice level is defined as an unrestricted license that is not subject to limitations on the scope of practice ordinarily granted all other applicants for similar specialty in the granting jurisdiction. Individuals placed on probation or whose license has otherwise been restricted are not considered to be practicing at a full clinical practice level. The services provided must be within the scope of the license, certification, or other legal authorization. Licensure or certification is required to be an authorized provider when offered in the state where the service is rendered, even if such licensure or certification is not required by the state where the service is rendered. Providers who practice in a state where licensure or certification is optional are required to obtain that licensure or certification to become an authorized provider. A temporary professional state license which allows full and unrestricted scope of practice fully satisfies any Individual Professional Provider certification requirement for the period during which the temporary license is valid. The authorized status of the provider expires when the temporary license expires unless the temporary license is renewed or a regular license is issued to the provider.

**2.2 Certified Membership in National or Professional Association that Sets Standards for the Profession.** If the state does not offer licensure or certification, the provider must have membership in or certification by (or be eligible to have membership in or certification by) the appropriate national or professional association that sets standards for the specific profession. Associate, provisional, or student membership is not acceptable. Membership or certification must be at the full clinical level. If the provider does not have membership in or certification by the standard setting national or professional association, acceptable proof of eligibility is a letter or other written documentation from the appropriate association stating that the provider meets the requirements to be a member of or certified by the association.

**2.3 Time Period for Obtaining Licensure or Certification.** When a new State law is enacted that requires or provides for a certain category of provider to be in possession of licensure or

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State Licensure And Certification

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certification, authorized providers must obtain the license as soon as the State begins issuance. A period of time, not to exceed a maximum of six months, will be authorized to obtain the license.

- END -

## Outside The 50 United States And The District Of Columbia Locality-Based Reimbursement Rate Waiver

Issue Date: April 7, 2008

Authority: [32 CFR 199.14\(n\)](#) and [\(o\)](#)

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### 1.0 APPLICABILITY

**1.1** This policy is mandatory for waiver of TRICARE established reimbursement schedules for professional providers outside the 50 United States and the District of Columbia locations. Reimbursement rate waivers are available to TRICARE eligible beneficiaries in specified locations outside the 50 United States and the District of Columbia where the government has established reimbursement rate schedules. Please reference the TRICARE Reimbursement Manual (TRM), [Chapter 1, Section 35](#).

**1.2** As the commonwealth of Puerto Rico adheres to reimbursement rates used for the 50 United States and the District of Columbia (which align with Medicare's prospective payment systems) please refer the TRM, [Chapter 5, Section 2](#) for the applicable waiver process for Puerto Rico.

### 2.0 POLICY

**2.1** Under this reimbursement rate waiver process, a locality-based waivers may be submitted for consideration in the waiver of professional providers receiving TRICARE established reimbursement rates:

**2.1.1** If it is determined that access to specific health care services is impaired, higher payment rates may be authorized or established, by the Director, TRICARE Management Activity (TMA), for specific services that are covered under TRICARE. For specified areas outside the 50 United States and the District of Columbia, locality waivers are defined geographically as a city or country.

**2.1.2** When the Director, TMA, or designee, determines beneficiary access to health care services in a locality is impaired, the Director, TMA, or designee, may establish rates, as deemed appropriate and cost efficient by the following methodologies to assure adequate access to health care services.

**2.1.2.1** A percent factor may be applied or added to the allowed and established by TRICARE under the TRM, [Chapter 1, Section 35](#).

**2.1.2.2** A prevailing charge for a specified location outside the 50 United States and the District of Columbia may be applied. TRICARE may use any appropriate methodology to substantiate and establish prevailing charges.

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Outside The 50 United States And The District Of Columbia Locality-  
Based Reimbursement Rate Waiver

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**2.1.2.3** Other appropriate payment schedules, if applicable.

**2.2** All waiver requests for specified locations outside the 50 United States and the District of Columbia shall be submitted to the Director, TRICARE Area Offices (TAOs), to ensure that the TAO agrees with such request and that all available evidence in support of the locality-based waiver request has been submitted for consideration.

**2.3** The procedure to be followed for specified locations outside the 50 United States and the District of Columbia is as follows:

**2.3.1** The Director, TAO shall validate that the access to care is impaired in localities where the government has established reimbursement schedules.

**2.3.2** Who can apply:

- Director, TAO.
- Providers in the affected specified localities outside the 50 United States and the District of Columbia.
- Overseas claims processing contractor.
- TRICARE beneficiaries in the locality.

**2.3.3** How to apply:

**2.3.3.1** Applicant must submit a written waiver request to the Director, TAO. The request must specify the type of waiver the application is for and justify that access to health care services is impaired due to low TRICARE reimbursement rates.

**2.3.3.2** Justification for the waiver must include at the minimum:

**2.3.3.2.1** Total number of providers (primary care, specialty, or other) in a designated locality.

**2.3.3.2.2** Mix of primary/specialty providers needed to meet patient access standards (refer to the Department of Defense (DoD) access standards. Example, DoD access standards require one Primary Care Physician (PCP) per 1,000 beneficiaries).

**2.3.3.2.3** Current number of providers who accept or work with TRICARE.

**2.3.3.2.4** Number of eligible beneficiaries in the locality.

**2.3.3.2.5** A description of any efforts that have been attempted to locate alternative providers of service, as well as the results of those efforts.

**2.3.3.2.6** Availability of Military Treatment Facilities (MTFs) and MTF providers, if applicable.

## Acronyms And Abbreviations

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3D	Three Dimensional
AA	Anesthesiologist Assistant
AA&E	Arms, Ammunition and Explosives
AAA	Abdominal Aortic Aneurysm
AAAH	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 Behavioral Analysis
ABMT	Autologous Bone Marrow Transplant
ABPM	Ambulatory Blood Pressure Monitoring
ABR	Auditory Brainstem Response
<b>AC</b>	<b>Active Component</b>
ACD	Augmentative Communication Devices
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
ACS	American Cancer Society
<b>ACSP</b>	<b>Autism Demonstration Corporate Services Provider</b>
ACTUR	Automated Central Tumor Registry
AD	Active Duty
ADA	American Dental Association American Diabetes Association Americans with Disabilities Act
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
ADFM	Active Duty Family Member

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## Appendix A

### Acronyms And Abbreviations

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ADL	Activities of Daily Living
ADP	Automated Data Processing
ADSM	Active Duty Service Member
<b>AF</b>	<b>Atrial Fibrillation</b>
AFOSI	Air Force Office of Special Investigations
AGR	Active Guard/Reserve
AHA	American Hospital Association
AHLTA	Armed Forces Health Longitudinal Technology Application
AHRQ	Agency for Healthcare Research and Quality
AI	Administrative Instruction
AIDS	Acquired Immune Deficiency Syndrome
AIIM	Association for Information and Image Management
AIS	Automated Information Systems
AIX	Advanced IBM Unix
AJ	Administrative Judge
ALA	Annual Letter of Assurance
ALB	All Lines Busy
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
AMH	Accreditation Manual for Hospitals
AMHCA	American Mental Health Counselor Association
AML	Acute Myelogenous Leukemia
ANSI	American National Standards Institute
AOA	American Osteopathic Association
APA	American Psychiatric Association American Podiatry Association
APC	Ambulatory Payment Classification
API	Application Program Interface
APN	Assigned Provider Number
APO	Army Post Office
ART	Assisted Reproductive Technology
ARU	Automated Response Unit
ASA	Adjusted Standardized Amount American Society of Anesthesiologists
ASAP	Automated Standard Application for Payment
ASC	Accredited Standards Committee Ambulatory Surgical Center

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### Appendix A

#### Acronyms And Abbreviations

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ASCA	Administrative Simplification Compliance Act
ASCUS	Atypical Squamous Cells of Undetermined Significance
ASD	Assistant Secretary of Defense Atrial Septal Defect Autism Spectrum Disorder
ASD(C3I)	Assistant Secretary of Defense for Command, Control, Communications, and Intelligence
ASD(HA)	Assistant Secretary of Defense (Health Affairs)
ASD (MRA&L)	Assistant Secretary of Defense for Manpower, Reserve Affairs, and Logistics
ASP	Average Sale Price
ATB	All Trunks Busy
ATO	Approval to Operate
AVM	Arteriovenous Malformation
AWOL	Absent Without Leave
AWP	Average Wholesale Price
B&PS	Benefits and Provider Services
B2B	Business to Business
BACB	Behavioral Analyst Certification Board
BBA	Balanced Budget Act
BBP	Bloodborne Pathogen
BBRA	Balanced Budget Refinement Act
BCABA	Board Certified Associate Behavior Analyst
BCAC	Beneficiary Counseling and Assistance Coordinator
BCBA	Board Certified Behavior Analyst
BCBS	Blue Cross Blue Shield
BC	Birth Center
BCC	Biostatistics Center
BI	Background Investigation
BIPA	Benefits Improvement Protection Act
BL	Black Lung
BLS	Basic Life Support
BMT	Bone Marrow Transplantation
BP	Behavioral Plan
BPC	Beneficiary Publication Committee
BPS	Beneficiary and Provider Services
BRAC	Base Realignment and Closure
BRCA	BReast CAncer
BS	Bachelor of Science
BSID	Bayley Scales of Infant Development
BSR	Beneficiary Service Representative
BWE	Beneficiary Web Enrollment
C&A	Certification and Accreditation
C&CS	Communications and Customer Service

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### Appendix A

#### Acronyms And Abbreviations

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C/S	Client/Server
CA	Care Authorization
CA/NAS	Care Authorization/Non-Availability Statement
CABG	Coronary Artery Bypass Craft
CAC	Common Access Card
CAD	Coronary Artery Disease
CAF	Central Adjudication Facility
CAH	Critical Access Hospital
CAP/DME	Capital and Direct Medical Education
CAPD	Continuous Ambulatory Peritoneal Dialysis
CAPP	Controlled Access Protection Profile
CAT	Computerized Axial Tomography
CB	Consolidated Billing
CBC	Cypher Block Chaining
CBHCO	Community-Based Health Care Organizations
CBSA	Core Based Statistical Area
CC	Common Criteria Criminal Control (Act)
CC&D	Catastrophic Cap and Deductible
CCDD	Catastrophic Cap and Deductible Data
CCEP	Comprehensive Clinical Evaluation Program
CCMHC	Certified Clinical Mental Health Counselor
CCN	Case Control Number
CCPD	Continuous Cycling Peritoneal Dialysis
CCR	Cost-To-Charge Ratio
CCTP	Custodial Care Transitional Policy
CD	Compact Disc
CDC	Centers for Disease Control and Prevention
CDCF	Central Deductible and Catastrophic Cap File
CDD	Childhood Disintegrative Disorder
CDH	Congenital Diaphragmatic Hernia
CD-I	Compact Disc - Interactive
CDR	Clinical Data Repository
CDRL	Contract Data Requirements List
CD-ROM	Compact Disc - Read Only Memory
CDT	Current Dental Terminology
CEIS	Corporate Executive Information System
CEO	Chief Executive Officer
CEOB	CHAMPUS Explanation of Benefits
CFO	Chief Financial Officer
CFR	Code of Federal Regulations
CFS	Chronic Fatigue Syndrome

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## Appendix A

### Acronyms And Abbreviations

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CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CHAMPVA	Civilian Health and Medical Program of the Department of Veteran Affairs
CHBC	Criminal History Background Check
CHBR	Criminal History Background Review
CHC	Civilian Health Care
CHCBP	Continued Health Care Benefits Program
CHCS	Composite Health Care System
CHEA	Council on Higher Education Accreditation
CHKT	Combined Heart-Kidney Transplant
CHOP	Children's Hospital of Philadelphia
CI	Counterintelligence
CIA	Central Intelligence Agency
<b>CIF</b>	<b>Central Issuing Facility</b>
CIO	Chief Information Officer
CIPA	Classified Information Procedures Act
CJCSM	Chairman of the Joint Chiefs of Staff Manual
CL	Confidentiality Level (Classified, Public, Sensitive)
CLIA	Clinical Laboratory Improvement Amendment
CLIN	Contract Line Item Number
CLKT	Combined Liver-Kidney Transplant
CLL	Chronic Lymphocytic Leukemia
CMAC	CHAMPUS Maximum Allowable Charge
CMHC	Community Mental Health Center
CML	Chronic Myelogenous Leukemia
CMN	Certificate(s) of Medical Necessity
CMO	Chief Medical Officer
CMP	Civil Money Penalty
CMS	Centers for Medicare and Medicaid Services
CMVP	Cryptographic Module Validation Program
CNM	Certified Nurse Midwife
CNS	Central Nervous System Clinical Nurse Specialist
CO	Contracting Officer
COB	Close of Business Coordination of Benefits
COBC	Coordination of Benefits Contractor
COBRA	Consolidated Omnibus Budget Reconciliation Act
CoCC	Certificate of Creditable Coverage
COCO	Contractor Owned-Contractor Operated
COE	Common Operating Environment
CONUS	Continental United States
COO	Chief Operating Officer

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COOP	Continuity of Operations Plan
COPA	Council on Postsecondary Accreditation
COPD	Chronic Obstructive Pulmonary Disease
COR	Contracting Officer's Representative
CORF	Comprehensive Outpatient Rehabilitation Facility
CORPA	Commission on Recognition of Postsecondary Accreditation
COTS	Commercial-off-the-shelf
CPA	Certified Public Accountant
CPE	Contract Performance Evaluation
CPI	Consumer Price Index
CPI-U	Consumer Price Index - Urban (Wage Earner)
CPNS	Certified Psychiatric Nurse Specialists
CPR	CAC PIN Reset
CPT	Chest Physiotherapy Current Procedural Terminology
CPT-4	Current Procedural Terminology, 4th Edition
CQMP	Clinical Quality Management Program
CQMP AR	Clinical Quality Management Program Annual Report
CQS	Clinical Quality Studies
CRM	Contract Resource Management (Directorate)
CRNA	Certified Registered Nurse Anesthetist
CRT	Computer Remote Terminal
CSA	Clinical Support Agreement
CSE	Communications Security Establishment (of the Government of Canada)
CSP	Corporate Service Provider Critical Security Parameter
CST	Central Standard Time
CSU	Channel Sending Unit
CSV	Comma-Separated Value
CSW	Clinical Social Worker
CT	Central Time Computerized Tomography
<b>CTC</b>	<b>Computed Tomographic Colonography</b>
CTCL	Cutaneous T-Cell Lymphoma
CTEP	Cancer Therapy Evaluation Program
CVAC	CHAMPVA Center
CVS	Contractor Verification System
CY	Calendar Year
DAA	Designated Approving Authority
DAO	Defense Attache Offices
DBA	Doing Business As
DC	Direct Care
DCAA	Defense Contract Audit Agency

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DCAO	Debt Collection Assistance Officer
DCID	Director of Central Intelligence Directive
DCII	Defense Clearance and Investigation Index
DCIS	Defense Criminal Investigating Service
DCN	Document Control Number
DCP	Data Collection Period
DCR	Developed Character Reference
DCS	Duplicate Claims System
DCSI	Defense Central Security Index
DD (Form)	Department of Defense (Form)
DDAS	DCII Disclosure Accounting System
DDP	Dependent Dental Plan
DDS	DEERS Dependent Suffix
DE	Durable Equipment
DECC	Defense Enterprise Computing Center
DED	Dedicated Emergency Department
DEERS	Defense Enrollment Eligibility Reporting System
<b>DELM</b>	<b>Digital Epiluminescence Microscopy</b>
DENC	Detailed Explanation of Non-Concurrence
DepSecDef	Deputy Secretary of Defense
DES	Data Encryption Standard
DFAS	Defense Finance and Accounting Service
DG	Diagnostic Group
DGH	Denver General Hospital
DHHS	Department of Health and Human Services
DHP	Defense Health Program
DIA	Defense Intelligence Agency
DIACAP	DoD Information Assurance Certification And Accreditation Process
DII	Defense Information Infrastructure
DIS	Defense Investigative Service
DISA	Defense Information System Agency
DISCO	Defense Industrial Security Clearance Office
DISN	Defense Information Systems Network
DISP	Defense Industrial Security Program
DITSCAP	DoD Information Technology Security Certification and Accreditation Process
DLAR	Defense Logistics Agency Regulation
DLE	Dialyzable Leukocyte Extract
DM	Disease Management
DMDC	Defense Manpower Data Center
DME	Durable Medical Equipment
DMEPOS	Durable medical equipment, prosthetics, orthotics, and supplies
DMI	DMDC Medical Interface

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DMIS	Defense Medical Information System
DMIS-ID	Defense Medical Information System Identification (Code)
DMLSS	Defense Medical Logistics Support System
DMZ	Demilitarized Zone
DNA	Deoxyribonucleic Acid
DNA-HLA	Deoxyribonucleic Acid - Human Leucocyte Antigen
DNACI	DoD National Agency Check Plus Written Inquiries
DO	Doctor of Osteopathy Operations Directorate
DOB	Date of Birth
DoD	Department of Defense
DoD AI	Department of Defense Administrative Instruction
DoDD	Department of Defense Directive
DoDI	Department of Defense Instruction
DoDIG	Department of Defense Inspector General
DoD P&T	Department of Defense Pharmacy and Therapeutics (Committee)
DOE	Department of Energy
DOEBA	Date of Earliest Billing Action
DOES	DEERS Online Enrollment System
DOHA	Defense Office of Hearings and Appeals
DOJ	Department of Justice
DOLBA	Date of Latest Billing Action
<b>DOS</b>	<b>Date Of Service</b>
DP	Designated Provider
DPA	Differential Power Analysis
DPI	Designated Providers Integrator
DPO	DEERS Program Office
DRA	Deficit Reduction Act
DREZ	Dorsal Root Entry Zone
<b>DRG</b>	<b>Diagnosis</b> Related Group
DRPO	DEERS RAPIDS Program Office
DSAA	Defense Security Assistance Agency
DSC	DMDC Support Center
DSCC	Data and Study Coordinating Center
DSM	Diagnostic and Statistical Manual of Mental Disorders
DSM-III	Diagnostic and Statistical Manual of Mental Disorders, Third Edition
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition
DSMC	Data and Safety Monitoring Committee
DSMO	Designated Standards Maintenance Organization
DSO	DMDC Support Office
DSU	Data Sending Unit
DTF	Dental Treatment Facility

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DTR	Derived Test Requirements
DTRO	Director, TRICARE Regional Office
DUA	Data Use Agreement
DVA	Department of Veterans Affairs
DVAHCF	Department of Veterans Affairs Health Care Finder
DVD	Digital Video Disc
DWR	DSO Web Request
Dx	Diagnosis
<b>DXA</b>	<b>Dual Energy X-Ray Absorptiometry</b>
<b>ECAS</b>	<b>European Cardiac Arrhythmia Society</b>
<b>EHRA</b>	<b>European Heart Rhythm Association</b>
E-ID	Early Identification
E-NAS	Electronic Non-Availability Statement
E&M	Evaluation & Management
E2R	Enrollment Eligibility Reconciliation
EAL	Common Criteria Evaluation Assurance Level
EAP	Ethandamine phosphate
EBC	Enrollment Based Capitation
ECA	External Certification Authority
ECG	Electrocardiogram
ECHO	Extended Care Health Option
ECT	Electroconvulsive Therapy
ED	Emergency Department
EDC	Error Detection Code
EDI	Electronic Data Information Electronic Data Interchange
EDIPI	Electronic Data Interchange Person Identifier
EDIPN	Electronic Data Interchange Person Number
EDI_PN	Electronic Data Interchange Patient Number
EEG	Electroencephalogram
EEPROM	Erasable Programmable Read-Only Memory
EFM	Electronic Fetal Monitoring
EFMP	Exceptional Family Member Program
EFP	Environmental Failure Protection
EFT	Electronic Funds Transfer Environmental Failure Testing
EGHP	Employer Group Health Plan
E/HPC	Enrollment/Health Plan Code
EHHC	ECHO Home Health Care Extended Care Health Option Home Health Care
EHP	Employee Health Program
EIA	Educational Interventions for Autism Spectrum Disorders
EIDS	Executive Information and Decision Support

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EIN	Employer Identification Number
EIP	External Infusion Pump
EKG	Electrocardiogram
ELN	Element Locator Number
ELISA	Enzyme-Linked Immunoabsorbent Assay
E/M	Evaluation and Management
EMC	Electronic Media Claim Enrollment Management Contractor
EMDR	Eye Movement Desensitization and Reprocessing
EMG	Electromyogram
EMTALA	Emergency Medical Treatment & Active Labor Act
ENTNAC	Entrance National Agency Check
EOE	Evoked Otoacoustic Emission
EOB	Explanation of Benefits
EOBs	Explanations of Benefits
EOC	Episode of Care
EOG	Electro-oculogram
EOMB	Explanation of Medicare Benefits
ePHI	electronic Protected Health Information
EPO	Erythropoietin Exclusive Provider Organization
EPR	EIA Program Report
EPROM	Erasable Programmable Read-Only Memory
ER	Emergency Room
ERISA	Employee Retirement Income and Security Act of 1974
ESRD	End Stage Renal Disease
EST	Eastern Standard Time
ESWT	Extracorporeal Shock Wave Therapy
ET	Eastern Time
ETIN	Electronic Transmitter Identification Number
EWPS	Enterprise Wide Provider System
EWRAS	Enterprise Wide Referral and Authorization System
F&AO	Finance and Accounting Office(r)
FAR	Federal Acquisition Regulations
FASB	Federal Accounting Standards Board
FBI	Federal Bureau of Investigation
FCC	Federal Communications Commission
FCCA	Federal Claims Collection Act
FDA	Food and Drug Administration
FDB	First Data Bank
FDL	Fixed Dollar Loss
Fed	Federal Reserve Bank

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FEHBP	Federal Employee Health Benefit Program
FEL	Familial Erythrophagocytic Lymphohistiocytosis
FEV <sub>1</sub>	Forced Expiratory Volume
FFM	Foreign Force Member
FHL	Familial Hemophagocytic Lymphohistiocytosis
FI	Fiscal Intermediary
FIPS	Federal Information Processing Standards (or System)
FIPS PUB	FIPS Publication
FISH	Fluorescence In Situ Hybridization
FISMA	Federal Information Security Management Act
FL	Form Locator
FMCRA	Federal Medical Care Recovery Act
<b>FOBT</b>	<b>Fecal Occult Blood Testing</b>
FOC	Full Operational Capability
FOIA	Freedom of Information Act
FPO	Fleet Post Office
FQHC	Federally Qualified Health Center
FR	Federal Register Frozen Records
FRC	Federal Records Center
FTE	Full Time Equivalent
FTP	File Transfer Protocol
FX	Foreign Exchange (lines)
FY	Fiscal Year
GAAP	Generally Accepted Accounting Principles
GAO	General Accounting Office
GBL	Government Bill of Lading
GDC	Guglielmi Detachable Coil
GFE	Government Furnished Equipment
GHz	Gigahertz
GIFT	Gamete Intrafallopian Transfer
GIQD	Government Inquiry of DEERS
GP	General Practitioner
GPCI	Geographic Practice Cost Index
H/E	Health and Environment
HAC	Health Administration Center <b>Hospital Acquired Condition</b>
HAVEN	Home Assessment Validation and Entry
HBA	Health Benefits Advisor
HBO	Hyperbaric Oxygen Therapy
HCC	Health Care Coverage
HCDP	Health Care Delivery Program

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HCF	Health Care Finder
HCFA	Health Care Financing Administration
HCG	Human Chorionic Gonadotropin
HCIL	Health Care Information Line
HCP	Health Care Provider
HCPC	Healthcare Common Procedure Code (formerly HCFA Common Procedure Code)
HCPCS	Healthcare Common Procedure Coding System (formerly Healthcare Common Procedure Coding System)
HCPR	Health Care Provider Record
HCSR	Health Care Service Record
HDC	High Dose Chemotherapy
HDC/SCR	High Dose Chemotherapy with Stem Cell Rescue
HDL	Hardware Description Language
HEAR	Health Enrollment Assessment Review
HEDIS	Health Plan Employer Data and Information Set
HepB-Hib	Hepatitis B and Hemophilus influenza B
HHA	Home Health Agency
HHA PPS	Home Health Agency Prospective Payment System
HHC	Home Health Care
HHC/CM	Home Health Care/Case Management
HHRG	Home Health Resource Group
HHS	Health and Human Services
HI	Health Insurance
HIC	Health Insurance Carrier
HICN	Health Insurance Claim Number
HINN	Hospital-Issued Notice Of Noncoverage
HIPAA	Health Insurance Portability and Accountability Act (of 1996)
HIPPS	Health Insurance Prospective Payment System
HIQH	Health Insurance Query for Health Agency
HIV	Human Immunodeficiency Virus
HL7	Health Level 7
HLA	Human Leukocyte Antigen
HMAC	Hash-Based Message Authentication Code
HMO	Health Maintenance Organization
HNPCC	Hereditary Nonpolposis Colorectal Cancer
HPA&E	Health Program Analysis & Evaluation
HPSA	Health Professional Shortage Area
HPV	Human Papilloma Virus
HRG	Health Resource Group
<b>HRS</b>	<b>Heart Rhythm Society</b>
HRT	Heidelberg Retina Tomograph Hormone Replacement Therapy

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HSCRC	Health Services Cost Review Commission
HTML	HyperText Markup Language
HTTP	HyperText Transfer (Transport) Protocol
HTTPS	Hypertext Transfer (Transport) Protocol Secure
HUAM	Home Uterine Activity Monitoring
<b>HUD</b>	<b>Humanitarian Use Device</b>
HUS	Hemolytic Uremic Syndrome
HVPT	Hyperventilation Provocation Test
IA	Information Assurance
IATO	Interim Approval to Operate
IAVA	Information Assurance Vulnerability Alert
IAVB	Information Assurance Vulnerability Bulletin
IAVM	Information Assurance Vulnerability Management
IAW	In accordance with
IC	Individual Consideration Integrated Circuit
ICASS	International Cooperative Administrative Support Services
ICD-9-CM	International Classification of Diseases, 9th Revision, Clinical Modification
ICF	Intermediate Care Facility
ICMP	Individual Case Management Program
ICMP-PEC	Individual Case Management Program For Persons With Extraordinary Conditions
ICN	Internal Control Number
ICSP	Individual Corporate Services Provider
ID	Identification Identifier
IDE	Investigational Device Exemption Investigational Device
IDEA	Individuals with Disabilities Education Act
IDET	Intradiscal Electrothermal Therapy
IDME	Indirect Medical Education
IdP	Identity Protection
IE	Interface Engine Internet Explorer
IEP	Individualized Educational Program
IFSP	Individualized Family Service Plan
IG	Implementation Guidance
IGCE	Independent Government Cost Estimate
IHI	Institute for Healthcare Improvement
IHS	Indian Health Service
IIHI	Individually Identifiable Health Information
IIP	Implantable Infusion Pump
IM	Information Management Intramuscular

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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
IORT	Intra-Operative Radiation Therapy
IP	Inpatient
IPC	Information Processing Center (outdated term, see SMC)
IPN	Intraperitoneal Nutrition
IPPS	Inpatient Prospective Payment System
IPS	Individual Pricing Summary
IPSEC	Secure Internet Protocol
IQ	Intelligence Quotient
IQM	Internal Quality Management
IRB	Institutional Review Board
IRR	Individual Ready Reserve
IRS	Internal Revenue Service
IRTS	Integration and Runtime Specification
IS	Information System
ISN	Investigation Schedule Notice
ISO	International Standard Organization
ISP	Internet Service Provider
IT	Information Technology
ITSEC	Information Technology Security Evaluation Criteria
IV	Initialization Vector Intravenous
IVF	In Vitro Fertilization
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
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

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LAC	Local Agency Check
LAK	Lymphokine-Activated Killer
LAN	Local Area Network
LASER	Light Amplification by Stimulated Emission of Radiation
LCF	Long-term Care Facility
LDL	Low Density Lipoprotein
LDLT	Living Donor Liver Transplantation
LOC	Letter of Consent
LOD	Letter of Denial/Revocation
LOI	Letter of Intent
LOS	Length-of-Stay
LOT	Life Orientation Test
LPN	Licensed Practical Nurse
LSIL	Low-grade Squamous Intraepithelial
LSN	Location Storage Number
LTC	Long-Term Care
LUPA	Low Utilization Payment Adjustment
LVEF	Left Ventricular Ejection Fraction
LVN	Licensed Vocational Nurse
LVRS	Lung Volume Reduction Surgery
MAC	Maximum Allowable Charge Maximum Allowable Cost
MAC III	Mission Assurance Category III
MAID	Maximum Allowable Inpatient Day
MB&RB	Medical Benefits and Reimbursement Branch
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
MDR	MHS Data Repository
MDS	Minimum Data Set
MEC	Marketing and Education Committee
MEI	Medicare Economic Index
MEPS	Military Entrance Processing Station
MEPRS	Medical Expense Performance Reporting System
MFCC	Marriage and Family Counseling Center
MGCRB	Medicare Geographic Classification Review Board
MGIB	Montgomery GI Bill
MHO	Medical Holdover

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MHS	Military Health System
MHSO	Managing Health Services Organization
MHSS	Military Health Services System
<b>MI</b>	<b>Myocardial Infarction</b>
MI&L	Manpower, Installations, and Logistics
MIA	Missing In Action
MIDCAB	Minimally Invasive Direct Coronary Artery Bypass
MIRE	Monochromatic Infrared Energy
MMA	Medicare Modernization Act
MMP	Medical Management Program
MMSO	Military Medical Support Office
MMWR	Morbidity and Mortality Weekly Report
MNR	Medical Necessity Report
MOA	Memorandum of Agreement
MOMS	Management of Myelomeningocele Study
MOP	Mail Order Pharmacy
MOU	Memorandum of Understanding
MPI	Master Patient Index
MR	Medical Review Mentally Retarded
MRA	Magnetic Resonance Angiography
MRI	Magnetic Resonance Imaging
MRPU	Medical Retention Processing Unit
MS	Microsoft®
MSA	Metropolitan Statistical Area
MSC	Military Sealift Command
MSIE	Microsoft® Internet Explorer
MSP	Medicare Secondary Payer
MST	Mountain Standard Time
MSUD	Maple Syrup Urine Disease
MSW	Masters of Social Work Medical Social Worker
MT	Mountain Time
MTF	Military Treatment Facility
MV	Multivisceral (transplant)
MVS	Multiple Virtual Storage
MWR	Morale, Welfare, and Recreation
N/A	Not Applicable
N/D	No Default
NAC	National Agency Check
NACI	National Agency Check Plus Written Inquiries
NACLCL	National Agency Check with Law Enforcement and Credit

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NADFM	Non-Active Duty Family Member
NARA	National Archives and Records Administration
NAS	Non-Availability Statement
NATO	North Atlantic Treaty Organization
NAVMED	Naval Medical (Form)
NBCC	National Board of Certified Counselors
NCCI	National Correct Coding Initiatives
NCF	National Conversion Factor
NCI	National Cancer Institute
NCPAP	Nasal Continuous Positive Airway Pressure
NCPDP	National Council of Prescription Drug Program
NCQA	National Committee for Quality Assurance
NCVHS	National Committee on Vital and Health Statistics
NDAA	National Defense Authorization Act
NDC	National Drug Code
NDMS	National Disaster Medical System
NED	National Enrollment Database
NETT	National Emphysema Treatment Trial
NF	Nursing Facility
NHLBI	National Heart, Lung and Blood Institute
NHSC	National Health Service Corps
NICHD	National Institute of Child Health and Human Development
NIH	National Institutes of Health
NII	Networks and Information Integration
NIPRNET	Nonsecure Internet Protocol Router Network
NIS	Naval Investigative Service
NISPOM	National Industrial Security Program Operating Manual
NIST	National Institute of Standards and Technology
NLT	No Later Than
NMES	Neuromuscular Electrical Stimulation
NMOP	National Mail Order Pharmacy
NMR	Nuclear Magnetic Resonance
NMT	Nurse Massage Therapist
NOAA	National Oceanic and Atmospheric Administration
NoPP	Notice of Private Practices
NOSCASTC	National Operating Standard Cost as a Share of Total Costs
NP	Nurse Practitioner
NPDB	National Practitioner Data Bank
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
NPR	Notice of Program Reimbursement
NPS	Naval Postgraduate School

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NQF	National Quality Forum
NRC	Nuclear Regulatory Commission
NTIS	National Technical Information Service
NUBC	National Uniform Billing Committee
NUCC	National Uniform Claims Committee
O/ATIC	Operations/Advanced Technology Integration Center
OASD(HA)	Office of the Assistant Secretary of Defense (Health Affairs)
OASD (H&E)	Office of the Assistant Secretary of Defense (Health and Environment)
OASD (MI&L)	Office of the Assistant Secretary of Defense (Manpower, Installations, and Logistics)
OASIS	Outcome and Assessment Information Set
OB/GYN	Obstetrician/Gynecologist
OBRA	Omnibus Budget Reconciliation Act
OCE	Outpatient Code Editor
OCHAMPUS	Office of Civilian Health and Medical Program of the Uniformed Services
OCONUS	Outside of the Continental United States
OCR	Office of Civil Rights
OCSP	Organizational Corporate Services Provider
OD	Optical Disk
OGC	Office of General Counsel
OGP	Other Government Program
OHI	Other Health Insurance
OHS	Office of Homeland Security
OIG	Office of Inspector General
OMB	Office of Management and Budget
OP/NSP	Operation/Non-Surgical Procedure
OPD	Outpatient Department
OPM	Office of Personnel Management
OPPS	Outpatient Prospective Payment System
OSA	Obstructive Sleep Apnea
OSAS	Obstructive Sleep Apnea Syndrome
OSD	Office of the Secretary of Defense
OSHA	Occupational Safety and Health Act
OSS	Office of Strategic Services
OT	Occupational Therapy (Therapist)
OTC	Over-The-Counter
OUSD	Office of the Undersecretary of Defense
OUSD (P&R)	Office of the Undersecretary of Defense (Personnel and Readiness)
P/O	Prosthetic and Orthotics
P&T	Pharmacy And Therapeutics (Committee)
PA	Physician Assistant
PACAB	Port Access Coronary Artery Bypass

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PACO <sub>2</sub>	Partial Pressure of Carbon Dioxide
PAO <sub>2</sub>	Partial Pressure of Oxygen
PAK	Pancreas After Kidney (transplant)
PAP	Papanicolaou
<b>PAT</b>	<b>Performance Assessment Tracking</b>
PatID	Patient Identifier
PAVM	Pulmonary Arteriovenous Malformation
PBM	Pharmacy Benefit Manager
PC	Personal Computer Professional Component
PCA	Patient Controlled Analgesia
PCDIS	Purchased Care Detail Information System
<b>PCI</b>	<b>Percutaneous Coronary Intervention</b>
PCM	Primary Care Manager
PCMBN	PCM By Name
PCMRA	PCM Research Application
PCMRS	PCM Panel Reassignment (Application) PCM Reassignment System
PCO	Procurement (Procuring) Contracting Officer
PCP	Primary Care Physician Primary Care Provider
PCS	Permanent Change of Station
PD	Passport Division
PDA	Patent Ductus Arteriosus Personal Digital Assistant
PDDBI	Pervasive Developmental Disorders Behavior Inventory
PDDNOS	Pervasive Developmental Disorder Not Otherwise Specified
PDF	Portable Document Format
PDQ	Physicians's Data Query
PDR	Person Data Repository
PDS	Person Demographics Service
PDTS	Pharmacy Data Transaction System
PE	Physical Examination
PEC	Pharmacoeconomic Center
PEP	Partial Episode Payment
PEPR	Patient Encounter Processing and Reporting
PERMS	Provider Education and Relations Management System
PET	Positron Emission Tomography
PFCRA	Program Fraud Civil Remedies Act
PFP	Partnership For Peace
PPFWD	Program for Persons with Disabilities
Phen-Fen	Pondimin and Redux
PHI	Protected Health Information

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PHIMT	Protected Health Information Management Tool
PHP	Partial Hospitalization Program
PHS	Public Health Service
PI	Program Integrity (Office)
PIA	Privacy Impact Assessment (Online)
PIC	Personnel Investigation Center
PIE	Pulsed Irrigation Evacuation
PIN	Personnel Identification Number
PIP	Personal Injury Protection Personnel Identity Protection
PIT	PCM Information Transfer
PIV	Personal Identity Verification
PK	Public Key
PKE	Public Key Enabling
PKI	Public Key Infrastructure
PKU	Phenylketonuria
PL	Public Law
PLS	Preschool Language Scales
PM-DRG	Pediatric Modified-Diagnosis Related Group
PMR	Percutaneous Myocardial Laser Revascularization
PNET	Primitive Neuroectodermal Tumors
PNT	Policy Notification Transaction
POA	Power of Attorney <b>Present On Admission</b>
POA&M	Plan of Action and Milestones
POC	Pharmacy Operations Center Plan of Care Point of Contact
POL	May 1996 TRICARE/CHAMPUS Policy Manual 6010.47-M
POS	Point of Sale (Pharmacy only) Point of Service Public Official's Statement
POV	Privately Owned Vehicle
PPD	Per Patient Day
PPN	Preferred Provider Network
PPO	Preferred Provider Organization
PPP	<b>Purchasing Power Parity</b>
PPS	Prospective Payment System Ports, Protocols and Services
PPSM	Ports, Protocols, and Service Management
PPV	Pneumococcal Polysaccharide Vaccine
PQI	Potential Quality Indicator Potential Quality Issue

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PR	Periodic Reinvestigation
PRC	Program Review Committee
PRG	Peer Review Group
PRO	Peer Review Organization
ProDUR	Prospective Drug Utilization Review
PROM	Programmable Read-Only Memory
PRP	Personnel Reliability Program
PRPP	Pharmacy Redesign Pilot Project
PSA	Prime Service Area Physician Scarcity Area
PSAB	Personnel Security Appeals Board
PSCT	Peripheral Stem Cell Transplantation
PSI	Personnel Security Investigation
PST	Pacific Standard Time
PT	Pacific Time Physical Therapist Physical Therapy Prothrombin Time
PTA	Pancreas Transplant Alone Percutaneous Transluminal Angioplasty
PTC	Processed To Completion
PTCA	Percutaneous Transluminal Coronary Angioplasty
PTK	Phototherapeutic Keratectomy
PVCs	Premature Ventricular Contractions
QA	Quality Assurance
QC	Quality Control
QI	Quality Improvement Quality Issue
QII	Quality Improvement Initiative
QIO	Quality Improvement Organization
QIP	Quality Improvement Program
QLE	Qualifying Life Event
QM	Quality Management
QUIG	Quality Indicator Group
RA	Remittance Advice
RAM	Random Access Memory
RAP	Request for Anticipated Payment
RAPIDS	Real-Time Automated Personnel Identification System
RC	Reserve Component
RCN	Recoupment Case Number Refund Control Number
RCS	Report Control Symbol
RD	Regional Director

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RDBMS	Relational Database Management System
RDDDB	Reportable Disease Database
REM	Rapid Eye Movement
RFI	Request For Information
RFP	Request For Proposal
RHC	Rural Health Clinic
RHHI	Regional Home Health Intermediary
RhoGAM	RRho (D) Immune Globulin
RN	Registered Nurse
RNG	Random Number Generator
RO	Regional Office
ROC	Resumption of Care
ROFR	Right of First Refusal
ROM	Read-Only Memory Rough Order of Magnitude
ROT	Read-Only Table
ROTC	Reserved Officer Training Corps
ROVER	RHHI Outcomes and Assessment Information Set Verification
RPM	Record Processing Mode
RRA	Regional Review Authority
RTC	Residential Treatment Center
RUG	Resource Utilization Group
RV	Residual Volume
RVU	Relative Value Unit
SAAR	System Authorization Access Request
SAD	Seasonal Affective Disorder
SADMERC	Statistical Analysis Durable Medical Equipment Regional Carrier
SAO	Security Assistant Organizations
SAP	Special Access Program
SAS	Sensory Afferent Stimulation
SAT	Service Assist Team
SBCC	Service Branch Classification Code
SBI	Special Background Investigation
SCH	Sole Community Hospital
SCHIP	State Children's Health Insurance Program
SCI	Sensitive Compartmented Information Spinal Cord Injury
SCIC	Significant Change in Condition
SCOO	Special Contracts and Operations Office
SCR	Stell Cell Rescue
S/D	Security Division
SD (Form)	Secretary of Defense (Form)

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## Appendix A

### Acronyms And Abbreviations

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SEP	Sensory Evoked Potentials
SES	Senior Executive Service
SelRes	Selected Reserve
SF	Standard Form
SGDs	Speech Generating Devices
SHCP	Supplemental Health Care Program
SI	Sensitive Information Small Intestine (transplant) <b>Special Indicator (code)</b> Status Indicator
SIDS	Sudden Infant Death Syndrome
SII	Special Investigative Inquiry
SI/L	Small Intestine-Live (transplant)
SIOP-ESI	Single Integrated Operational plan-Extremely Sensitive Information
SIP	System Identification Profile
SIT	Standard Insurance Table
SMC	System Management Center
SNF	Skilled Nursing Facility
SNS	Sacral Nerve Root Stimulation
SOC	Start of Care
SOFA	Status Of Forces Agreement
SOIC	Senior Officer of the Intelligence Community
SON	Submitting Office Number
SOR	Statement of Reasons
SPA	Simple Power Analysis
SPECT	Single Photon Emission Computed Tomography
SPK	Simultaneous Pancreas Kidney (transplant)
SPOC	Service Point of Contact
SPR	SECRET Periodic Reinvestigation
SQL	Structured Query Language
SRE	Serious Reportable Event
SSA	Social Security Act Social Security Administration
SSAA	Social Security Authorization Agreement
SSAN	Social Security Administration Number
SSBI	Single-Scope Background Investigation
SSL	Secure Socket Layer
SSM	Site Security Manager
SSN	Social Security Number
SSO	Short-Stay Outlier
STF	Specialized Treatment Facility
STS	Specialized Treatment Services

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### Acronyms And Abbreviations

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STSF	Specialized Treatment Service Facility
<b>SUBID</b>	<b>Sub-Identifier</b>
SUDRF	Substance Use Disorder Rehabilitation Facility
SVO	SIT Validation Office
SVT	Supraventricular Tachycardia
SWLS	Satisfaction With Life Scale
TAD	Temporary Additional Duty
TAFIM	Technical Architecture Framework for Information Management
TAMP	Transitional Assistance Management Program
TAO	TRICARE Alaska Office TRICARE Area Office
TARO	TRICARE Alaska Regional Office
TB	Tuberculosis
TBD	To Be Determined
TBE	Tick Borne Encephalitis
TBI	Traumatic Brain Injury
TC	Technical Component
TCP/IP	Transmission Control Protocol/Internet Protocol
TDEFIC	TRICARE Dual Eligible Fiscal Intermediary Contract
TDP	TRICARE Dental Plan
TDY	Temporary Duty
TED	TRICARE Encounter Data
TEFRA	Tax Equity and Fiscal Responsibility Act
TEOB	TRICARE Explanation of Benefits
TEPRC	TRICARE Encounter Pricing (Record)
TEPRV	TRICARE Encounter Provider (Record)
TET	Tubal Embryo Transfer
TF	Transfer Factor
TFL	TRICARE For Life
TFMDP	TRICARE (Active Duty) Family Member Dental Plan
TGRO	TRICARE Global Remote Overseas
TGROHC	TGRO Host Country
TIFF	Tagged Imaged File Format
TIL	Tumor-Infiltrating Lymphocytes
TIMPO	Tri-Service Information Management Program Office
TIN	Taxpayer Identification Number
TIPS	Transjugular Intrahepatic Portosystemic Shunt
TIS	TRICARE Information Service
TLAC	TRICARE Latin America/Canada
TLC	Total Lung Capacity
TMA	TRICARE Management Activity
TMA-A	TRICARE Management Activity - Aurora

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TMAC	TRICARE Maximum Allowable Charge
TMI&S	Technology Management Integration & Standards
TMOP	TRICARE Mail Order Pharmacy
TMR	Transmyocardial Revascularization
TNEX	TRICARE Next Generation (MHS Systems)
TOB	Type of Bill
TOE	Target of Evaluation
TOL	TRICARE Online
TOM	August 2002 TRICARE Operations Manual 6010.51-M February 2008 TRICARE Operations Manual 6010.56-M
TOP	TRICARE Overseas Program
TPA	Third Party Administrator
TPC	Third Party Collections
TPharm	TRICARE Pharmacy
TPL	Third Party Liability
TPM	August 2002 TRICARE Policy Manual 6010.54-M February 2008 TRICARE Policy Manual 6010.57-M
TPN	Total Parenteral Nutrition
TPOCS	Third Party Outpatient Collections System
TPR	TRICARE Prime Remote
TPRADFM	TRICARE Prime Remote Active Duty Family Member
TPRADSM	TRICARE Prime Remote Active Duty Service Member
TPRC	TRICARE Puerto Rico Contract(or)
TQMC	TRICARE Quality Monitoring Contractor
TRDP	TRICARE Retiree Dental Program
TRI	TED Record Indicator
TRM	August 2002 TRICARE Reimbursement Manual 6010.55-M February 2008 TRICARE Reimbursement Manual 6010.58-M
TRO	TRICARE Regional Office
TRPB	TRICARE Retail Pharmacy Benefits
TRRx	TRICARE Retail Pharmacy
TRS	TRICARE Reserve Select
TRSA	TRICARE Reserve Select Application
TSC	TRICARE Service Center
TSF	Target of Evaluation Security Functions
TSM	August 2002 TRICARE Systems Manual 7950.1-M February 2008 TRICARE Systems Manual 7950.2-M
TSP	Target of Evaluation Security Policy
TSR	TRICARE Select Reserve
TSRDP	TRICARE Select Reserve Dental Program
TSRx	TRICARE Senior Pharmacy
TSS	TRICARE Senior Supplement
TSSD	TRICARE Senior Supplement Demonstration

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#### Acronyms And Abbreviations

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TTY	Teletypewriter
TUNA	Transurethral Needle Ablation
UAE	Uterine Artery Embolization
UB	Uniform Bill
UBO	Uniform Business Office
UCBT	Umbilical Cord Blood Stem Cell Transplantation
UCC	Uniform Commercial Code
UCCI	United Concordia Companies, Inc.
UCSF	University of California San Francisco
UIC	Unit Identification Code
UIN	Unit Identifier Number
UM	Utilization Management
UMO	Utilization Management Organization
UMP	User Maintenance Portal
UPIN	Unique Physician Identification Number
URF	Unremarried Former Spouses
URL	Universal Resource Locator
US	United States
USA	United States of America
USACID	United States Army Criminal Investigation Division
USAF	United States Air Force
USAO	United States Attorneys' Office
USC	United States Code
USCG	United States Coast Guard
USCO	Uniformed Services Claim Office
USD	Undersecretary of Defense
USD (P&R)	Undersecretary of Defense (Personnel and Readiness)
USDI	Undersecretary of Defense for Intelligence
USFHP	Uniformed Services Family Health Plan
USHBP	Uniformed Services Health Benefit Plan
USMC	United States Marine Corps
USMTF	Uniformed Services Medical Treatment Facility
USN	United States Navy
USPDI	United States Pharmacopoeia Drug Information
USPHS	United States Public Health Service
USPS	United States Postal Service
USPSTF	U.S. Preventive Services Task Force
USS	United Seaman's Service
USTF	Uniformed Services Treatment Facility
UV	Ultraviolet
VA	Veterans Affairs (hospital) Veterans Administration

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VAD	Ventricular Assist Device
VAMC	VA Medical Center
VATS	Video-Assisted Thoroscopic Surgery
VAX-D	Vertebral Axial Decompression
VD	Venereal Disease
VO	Verifying Office (Official)
VPN	Virtual Private Network
VPOC	Verification Point of Contact
VSAM	Virtual Storage Access Method
VSD	Ventricular Septal Defect
WAC	Wholesale Acquisition Cost
WAN	Wide Area Network
WATS	Wide Area Telephone Service
WC	Worker's Compensation
WEDI	Workgroup for Electronic Data Interchange
WIC	Women, Infants, and Children (Program)
<b>WII</b>	<b>Wounded, Ill, and Injured</b>
WLAN	Wireless Local Area Network
WORM	Write Once Read Many
WRAMC	Walter Reed Army Medical Center
WTC	World Trade Center
WTRR	Wire Transfer Reconciliation Report
<b>WTU</b>	<b>Warrior Transition Unit</b>
X-Linked SCID	X-Linked Severe Combined Immunodeficiency Syndrome
XML	eXtensible Markup Language
ZIFT	Zygote Intrafallopian Transfer

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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	3.10			
TRICARE For Life (TFL)	10	6.1			
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			

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