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TRICARE
MANAGEMENT ACTIVITY

MB&RB

**CHANGE 56
6010.57-M
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**PUBLICATIONS SYSTEM CHANGE TRANSMITTAL
FOR
TRICARE POLICY MANUAL (TPM), FEBRUARY 2008**

The TRICARE Management Activity has authorized the following addition(s)/revision(s).

CHANGE TITLE: CODING AND CLARIFICATION UPDATES - OCTOBER 2010

CONREQ: 15093

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

SUMMARY OF CHANGE(S): See page 4 and 5.

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

This change is made in conjunction with Feb 2008 TRM, Change No. 57.

Ann N. Fazzini
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Chief, Medical Benefits and
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ATTACHMENT(S): 85 PAGE(S)
DISTRIBUTION: 6010.57-M

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

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SUMMARY OF CHANGES

CHAPTER 1

1. Section 12.1. Updates the list of CPT Procedure Codes. Deletes codes that are no longer valid. The codes that are now valid and that replaced the deleted codes are in the range of current published policy.
2. Section 13.1. Adds "S" code S0189 to list of reimbursable codes.

CHAPTER 4

3. Section 5.1. Updates the list of CPT Procedure Codes. Adds the HCPCS Procedure Code, S0189. Clarifies that testopel pellets are covered for FDA label indications for males. Clarifies that subcutaneous implantable pellets that are custom compounded of estradiol, estrogen, or testosterone in combination with estrogen or estradiol and used for treatment of females are not covered. Adds 6.0 Effective Dates for dates removed from paragraphs in 4.0 Policy.
4. Section 6.1. Adds code for artificial intervertebral disc revision replacement for degenerative disc disease that was inadvertently deleted.
5. Section 15.1. Updates the list of CPT Procedure Codes.
6. Section 20.1. Updates the list of CPT Procedure Codes.

CHAPTER 5

7. Section 1.1. Updates the list of CPT Procedure Codes.

CHAPTER 7

8. Table of Contents. Administrative edit.
9. Section 2.1. Revises the age at which breast cancer screenings are covered and the frequency of which these screenings are covered. It also revises the risk factors that are considered to put women at greater than average risk of breast cancer. Administrative corrections, 4. Policy, to maintain consistency in document format.
10. Section 2.2. Revises the age at which breast cancer screenings are covered and the frequency of which these screenings are covered. It also revises the risk factors that are considered to put women at greater than average risk of breast cancer. Administrative corrections to table.

SUMMARY OF CHANGES (Continued)

CHAPTER 7 (Continued)

11. Section 7.1. 32 CFR (Part 199) change allowing non-physician referral for physical therapy, occupational therapy and speech therapy.
12. Section 18.2. 32 CFR (Part 199) change allowing non-physician referral for physical therapy, occupational therapy and speech therapy.
13. Section 18.3. 32 CFR (Part 199) change allowing non-physician referral for physical therapy, occupational therapy and speech therapy.
14. Section 27.1. Updates list of HCPCS Procedure Codes. Adds the specific names for Botox A & B to existing policy language. Clarifies that Botox use for cosmetic indications is excluded from coverage.

CHAPTER 9

15. Section 15.1. Clarifies the restrictions regarding use of the ECHO Home Health Care-Respite Care.

CHAPTER 11

16. Section 3.1. Updates the list of providers.
17. Section 12.1. Administrative correction to text regarding TED record coding.

APPENDIX A

18. Appendix A. Administrative updates.

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19. Administrative updates.

Category III Codes

Issue Date: March 6, 2002

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

1.0 CPT¹ PROCEDURE CODES

0073T, 0075T, 0076T, 0099T, 0184T

2.0 DESCRIPTION

Category III codes are a set of temporary codes for emerging technology, services, and procedures. These codes are used to track new and emerging technology to determine applicability to clinical practice. When a Category III code receives a Category I code from the American Medical Association (AMA) it does not automatically become a benefit under TRICARE. However, the codes that may have moved from unproven to proven must be forwarded to the Office of Medical Benefits and Reimbursement Branch (MB&RB) for coverage determination/policy clarification.

3.0 POLICY

3.1 Category III codes are to be used instead of unlisted codes to allow the collection of specific data. TRICARE has not opted to track Category III codes at this time.

3.2 Category III codes are excluded from coverage since clinical safety and efficacy or applicability to clinical practice has not been established.

4.0 EXCEPTIONS

4.1 **U.S. Food and Drug Administration (FDA) Investigational Device Exemption (IDE)** (Category B) clinical trial. See [Chapter 8, Section 5.1](#).

4.2 Category III code 0073T is a covered service as listed in [Chapter 5, Section 3.1](#).

4.3 Category III codes 0075T and 0076T are covered codes as outlined in [Chapter 4, Section 9.1](#).

4.4 **Category III code 0099T is a covered code as outlined in Chapter 4, Section 21.1.**

4.5 Category III code 0184T is a covered service as listed in [Chapter 4, Section 13.1](#).

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5.0 EXCLUSIONS

5.1 Unlisted codes for Category III codes. Effective January 1, 2002.

5.2 Ultrasound ablation (destruction of uterine fibroids) with Magnetic Resonance Imaging (MRI) guidance (CPT² procedure code 0071T) in the treatment of uterine leiomyomata is unproven.

5.3 Computer-Aided Detection (CAD) with breast MRI (CPT² procedure code 0159T) is unproven.

5.4 XSTOP Interspinous Process Decompression System (CPT² procedure codes 0171T and 0172T, HCPCS code C1821) is unproven.

- END -

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

Issue Date: November 6, 2007
Authority:

1.0 HCPCS "C" AND "S" CODES

C1000 - C9999; S0000 - S9999

2.0 DESCRIPTION

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

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

3.0 POLICY

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

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

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

3.2.2 S0812, S1030, S1031, S1040, S2066, S2067, S2068, S2075, S2076, S2077, S2083, S2202, S2235, **S2325**, S2360, S2361, S2401, S2402, S2403, S2405, S2411, S3620, S3818, S3819, S3820, S3822, S3823, S8030, S8185, S8265, S8270, and S9430 for all beneficiaries; and

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

TRICARE Policy Manual 6010.57-M, February 1, 2008

Chapter 1, Section 13.1

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

3.2.4 S2400 for prenatal surgical intervention of temporary tracheal occlusion of Congenital Diaphragmatic Hernia (CDH) for fetuses with prenatal diagnosis of CDH shall be determined on a case-by-case basis, based on the Rare Disease policy, effective October 1, 2009. Procedural guidelines for review of rare disease are contained in [Section 3.1](#).

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

3.3 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 -

Integumentary System

Issue Date: August 26, 1985

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

1.0 CPT¹ PROCEDURE CODES

10021, 10022, 10040 - 11977, **11980** - 11983, 12001 - 15366, 15400 - 15431, 15570 - 15776, 15840 - 15845, 15851 - 19499, 97601, and 97602

2.0 HCPCS PROCEDURE CODE

S0189

3.0 DESCRIPTION

Integumentary system pertains to the skin, subcutaneous tissue and areolar tissue and other accessory structures of the skin such as the lips, nails, etc.

4.0 POLICY

4.1 Services and supplies required in the diagnosis and treatment of illness or injury involving the integumentary system are covered.

4.2 Topical Treatment of Skin Ulcers Caused by Venous Insufficiency. Topical application of Alpigraf by a physician for the treatment of skin ulcers caused by venous insufficiency is a covered benefit.

4.3 Topical Treatment of Diabetic Foot Ulcers.

4.3.1 Application of tissue cultured skin grafts for diabetic foot ulcers is a covered benefit.

4.3.2 Application of Becaplermine Gel (Regranex) is a covered treatment of lower extremity diabetic neuropathic foot ulcers that extend into the subcutaneous tissue or beyond.

4.4 Negative Pressure Wound Therapy (NPWT) may be covered when certain criteria are met. See [Section 5.8](#).

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4.5 Testopel pellets (Testosterone pellets) are covered for one of the following U. S. Food and Drug Administration (FDA) label indications:

4.5.1 As second-line testosterone replacement therapy in males with congenital or acquired endogenous androgen absence or deficiency associated with primary or secondary hypogonadism when neither oral nor intramuscular testosterone replacement therapy is effective or appropriate; or

4.5.2 For treatment of delayed male puberty.

5.0 EXCLUSIONS

5.1 Removal of corns or calluses or trimming of toenails and other routine podiatry services, except those required as a result of diagnosed systemic medical disease affecting the lower limbs, such as severe diabetes.

5.2 Services performed for cosmetic purposes.

5.3 Subcutaneous implantable pellets (CPT² procedure code 11980, HCPCS J3490 and S0189) for Hormone Replacement Therapy (HRT) in females that are made up of estradiol, estrogen, or testosterone in combination with estrogen or estradiol have been custom-compounded by pharmacists are not covered, as these pellets are not approved by the FDA.

6.0 EFFECTIVE DATES

6.1 Effective May 26, 1998, for topical treatment of skin ulcers caused by venous insufficiency.

6.2 Effective May 8, 2000, for topical treatment of diabetic foot ulcers.

6.3 Effective December 16, 1997, for topical treatment of diabetic foot ulcers application of Becaplermine Gel (Regranex).

6.4 Effective November 9, 2007, for NPWT.

- END -

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Musculoskeletal System

Issue Date: August 26, 1985

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

1.0 CPT¹ PROCEDURE CODES

20000 - 22505, 22520 - 22525, 22532 - 22534, 22548 - 28825, 28899 - 29863, 29866, 29867, 29870 - 29999

2.0 HCPCS CODES

S2325, S2360, S2361

3.0 DESCRIPTION

The musculoskeletal system pertains to or comprises the skeleton and the muscles.

4.0 POLICY

4.1 Services and supplies required in the diagnosis and treatment of illness or injury involving the musculoskeletal system are covered. U.S. Food and Drug Administration (FDA) approved surgically implanted devices are also covered.

4.2 Effective August 25, 1997, Autologous Chondrocyte Implantation (ACI) surgery for the repair of clinically significant, symptomatic, cartilaginous defects of the femoral condyle (medial, lateral or trochlear) caused by acute or repetitive trauma is a covered procedure. The autologous cultured chondrocytes must be approved by the FDA.

4.3 Single or multilevel anterior cervical microdiscectomy with allogeneic or autogeneic iliac crest grafting and anterior plating is covered for the treatment of cervical spondylosis.

4.4 Percutaneous vertebroplasty (CPT¹ procedure codes 22520-22522, S2360, S2361) and balloon kyphoplasty (CPT¹ procedure codes 22523-22525) are covered for the treatment of painful osteolytic lesions and osteoporotic compression fractures refractory to conservative medical treatment.

4.5 Total Ankle Replacement (TAR) (CPT¹ procedure codes 27702 and 27703) surgery is covered if the device is FDA approved and the use is for an FDA approved indication. However, a medical necessity review is required in case of marked varus or valgus deformity.

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4.6 Core decompression of the femoral head (hip) for early (precollapse stage I or II) avascular necrosis may be considered for cost-sharing.

5.0 EXCLUSIONS

5.1 Meniscal transplant (CPT² procedure code 29868) for meniscal injury is unproven.

5.2 Ligament replacement with absorbable copolymer carbon fiber scaffold is unproven.

5.3 Prolotherapy, joint sclerotherapy and ligamentous injections with sclerosing agents (HCPCS procedure code M0076) are unproven.

5.4 Trigger point injection (CPT² procedure codes 20552 and 20553) for migraine headaches.

5.5 Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace, cervical; single interspace (CPT² procedure code 22856) each additional interspace (CPT² procedure code 0092T) is unproven.

5.6 Removal of total disc arthroplasty anterior approach cervical; single interspace (CPT² procedure code 22864) each additional interspace (CPT² procedure code 0095T) is unproven. Also, see [Section 1.1](#).

5.7 Lumbar total disc arthroplasty (lumbar artificial intervertebral disc revision including replacement, lumbar total disc replacement) for degenerative disc disease is unproven (CPT² procedure codes 22857, **22862**, 0163T, 0164T, and 0165T).

5.8 Extracorporeal Shock Wave Therapy (ESWT) for the treatment of plant fasciitis or lateral epicondylitis is unproven.

5.9 XSTOP Interspinous Process Decompression System (CPT² procedure codes 0171T and 0172T, HCPCS code C1821) for the treatment of neurogenic intermittent claudication secondary to lumbar spinal stenosis is unproven.

5.10 Femoroacetabular Impingement (FAI) open surgery, surgical dislocation (CPT² procedure codes 27140 and 27179), for the treatment of hip impingement syndrome or labral tear is unproven.

5.11 Hip arthroscopy with debridement of articular cartilage (CPT² procedure code 29862) for the treatment of FAI is unproven.

5.12 Femoroplasty (CPT² procedure code 29999) for the treatment of FAI syndrome is unproven.

5.13 Osteochondral allograft of the humeral head with meniscal transplant and glenoid microfracture in the treatment of shoulder pain and instability is unproven.

5.14 Thermal Intradiscal Procedures (TIPs) (CPT² procedure codes 22526, 22527, 62287, and Healthcare Common Procedure Coding System (HCPCS) code S2348) are unproven. TIPs are also

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Male Genital System

Issue Date: August 26, 1985

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

1.0 CPT¹ PROCEDURE CODES

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

2.0 DESCRIPTION

The male genital system includes the male organs of reproduction.

3.0 POLICY

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

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

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

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

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

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

3.6.1 Penile Implant.

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

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

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

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

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

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

3.6.6 Testicular prostheses.

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

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

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

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

4.0 EXCLUSIONS

4.1 Penile implants and related services when performed for psychological impotence, transsexualism, or such other conditions as gender dysphoria.

4.2 Testicular prosthesis and related services when performed for transsexualism or such other conditions as gender dysphoria.

4.3 Therapy for sexual dysfunctions or inadequacies (see [Chapter 7, Section 1.1](#)).

Chapter 4

Section 20.1

Nervous System

Issue Date: August 29, 1985

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

1.0 CPT¹ PROCEDURE CODES

61000 - 61626, 61680 - 62264, 62268 - 62284, 62290 - 63048, 63055 - 64484, 64505 - 64560, 64565 - 64580, 64595, 64600 - 64650, 64680 - 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 (CPT¹ 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.

2.6 Thoracic epidural steroid injections for the treatment of pain due to symptomatic thoracic disc herniations may be considered for cost-sharing when a patient meets all of the following criteria:

- Pain is radicular; and
- Pain is unresponsive to conservative treatment.

2.7 Non-pulsed Radiofrequency (RF) denervation (CPT² procedure codes 64622, 64623, 64626, 64627) for the treatment of chronic cervical and lumbar facet pain is covered when the following criteria are met:

2.7.1 No prior spinal fusion surgery in the vertebral level being treated, and

2.7.2 Low back (lumbosacral) or neck (cervical) pain, suggestive of facet joint origin as evidenced by absence of nerve root compression as documented in the medical record on history, physical and radiographic evaluations; and the pain is not radicular, and

2.7.3 Pain has failed to respond to three months of conservative management which may consist of therapies such as nonsteroidal anti-inflammatory medications, acetaminophen, manipulation, physical therapy, and a home exercise program, and

2.7.4 A trial of controlled diagnostic medial branch blocks under fluoroscopic guidance has resulted in at least a 50% reduction in pain; and

2.7.5 If there has been a prior successful RF denervation, a minimum time of six months has elapsed since prior RF treatment (per side, per anatomical level of the spine).

2.8 Endoscopic laminotomy (CPT² procedure code 63030) is covered for the treatment of lumbar spinal stenosis. The endoscopic spinal system used in the procedure must be FDA approved.

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.

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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\(d\)\(2\)](#)

1.0 CPT¹ PROCEDURE CODES

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

2.0 HCPCS PROCEDURE CODES

G0204, G0206

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. (CPT² 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 (CPT² procedure codes 77058 and 77059) is covered for the following indications. This list of indications is not all inclusive. Other indications may be covered when documented by reliable evidence as safe, effective and comparable to conventional technology (proven):

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 localized or locally advanced breast 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.

4.2.7 For guidance of interventional procedures such as vacuum assisted biopsy and preoperative wire localization for lesions that are occult on mammography or sonography and are demonstrable only with MRI.

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 Cardiovascular Magnetic Resonance (CMR) (CPT² procedure codes 75557, 75559, 75561, 75563, and 75565) is covered for the following indications:

4.4.1 Detection Of Coronary Artery Disease (CAD). Symptomatic--evaluation of chest pain syndrome (use of vasodilator perfusion CMR or dobutamine stress function CMR).

- Intermediate pre-test probability of CAD.
- Electrocardiogram (ECG) uninterpretable OR unable to exercise.

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5.7 3D rendering (CPT⁶ 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 (CPT⁶ procedure codes 76376 and 76377) for acute ischemic stroke is unproven.

5.9 CT angiography (CPT⁶ procedure codes 76376 and 76377) for intracerebral aneurysm and subarachnoid hemorrhage is unproven.

5.10 CT, heart, without contrast material, with quantitative evaluation of coronary calcium (CPT⁶ procedure code 75571) is excluded for patients with typical anginal chest pain with high suspicion of CAD; patients with acute MI; and for screening asymptomatic patients for CAD.

5.11 CT, heart, without contrast material, for evaluation of cardiac structure and morphology (including 3D image postprocessing, assessment of cardiac function, and evaluation of venous structures, if performed) (CPT⁶ procedure code 75572) 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.

5.12 CT, heart, with contrast material, for evaluation of cardiac structure and morphology in the setting of congenital heart disease (including 3D image postprocessing, assessment of LV cardiac function, RV structure and function and evaluation of venous structures, if performed) (CPT⁶ procedure code 75573) 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 heart, coronary arteries and bypass (when present), with contrast material, including 3D image postprocessing (including evaluation of cardiac structure and morphology, assessment of cardiac function, and evaluation of venous structures, if performed) (CPT⁶ procedure code 75574) 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 Multislice or multidetector row CT angiography of less than 16 slices per sec and 1mm or less resolution is excluded.

5.15 Radiological supervision and interpretation of percutaneous vertebroplasty (CPT⁶ procedure codes 72291 and 72292).

5.16 Dual Energy X-Ray Absorptiometry (DXA) composition study (CPT⁶ procedure code 0028T) is unproven.

5.17 Computer-Aided Detection with breast MRI (CPT⁶ 0159T) is unproven.

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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 January 1, 2007, for CPT⁷ 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.

6.6 October 1, 2008, for breast MRI for guidance of interventional procedures such as vacuum assisted biopsy and preoperative wire localization for lesions that are occult on mammography or sonography and are demonstrable only with MRI.

6.7 October 3, 2006, for CMR.

- END -

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TRICARE Policy Manual 6010.57-M, February 1, 2008
Chapter 7, Medicine

Section/Addendum	Subject/Addendum Title
24.1	Phase I, Phase II, And Phase III Cancer Clinical Trials
25.1	Dermoscopy
26.1	Forensic Examinations Following Sexual Assault or Domestic Violence
27.1	Botulinum Toxin Injections

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)

1.0 CPT¹ 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, **G0101** - G0105, G0121, G0202

3.0 BACKGROUND

3.1 The National Defense Authorization Act (**NDAA**) for Fiscal Year (FY) 1996 (Public Law 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 (**Public Law** 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\(b\)\(2\)](#)). **The NDAA FY 2009 (Public Law 110-417, Section 711) signed into effect October 14, 2008, waives copayment requirements for certain TRICARE beneficiaries for those preventive services as described in the TRICARE Reimbursement Manual (TRM), Chapter 2, Section 1, paragraphs 1.3.3.10 and 1.4.3. Appropriate cost-sharing and deductibles will apply for all other preventive services 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

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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 for a routine PAP smear, she is also eligible to receive a wide variety of other preventive services such as Tuberculosis (TB) 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 (CPT² 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 Clinical Breast Examination (CBE)

For women under age 40, CBE may be performed during a covered periodic preventive health exam. For women age 40 and older, CBE should be performed annually.

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4.1.1.1.2 Screening Mammography

4.1.1.1.2.1 Screening mammography (CPT³ procedure codes 77052 and 77057) is covered annually for all women beginning at age 40.

4.1.1.1.2.2 Screening mammography is covered annually beginning at age 30 for services rendered on or after September 7, 2010, and at age 35 for services rendered prior to September 7, 2010, for women who have a 15% or greater lifetime risk of breast cancer (according to risk assessment tools based on family history such as the Gail model, the Claus model, and the Tyrer-Cuzick model), or who have any of the following risk factors:

4.1.1.1.2.2.1 History of breast cancer, Ductal Carcinoma In Situ (DCIS), Lobular Carcinoma In Situ (LCIS), Atypical Ductal Hyperplasia (ADH), or Atypical Lobular Hyperplasia (ALH);

4.1.1.1.2.2.2 Extremely dense breasts when viewed by mammogram;

4.1.1.1.2.2.3 Known BRCA1 or BRCA2 gene mutation;

4.1.1.1.2.2.4 First-degree relative (parent, child, sibling) with a BRCA1 or BRCA2 gene mutation, and have not had genetic testing themselves;

Note: Listing of the BRCA1 and BRCA2 gene mutations as additional risk factors here does not imply or constitute TRICARE coverage of BRCA1 or BRCA2 genetic testing as a clinical preventive service.

4.1.1.1.2.2.5 Radiation therapy to the chest between the ages of 10 and 30 years; or

4.1.1.1.2.2.6 History of Li-Fraumeni, Cowden, or hereditary diffuse gastric cancer syndrome, or a first-degree relative with a history of one of these syndromes.

Note: Screening mammography procedures should be billed using CPT³ procedure code 77057 except when performed in connection with other preventive services, in which case an appropriate comprehensive health promotion and disease prevention examination office visit code (CPT³ 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 a woman meeting the above coverage criteria 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)

4.1.1.1.3.1 Breast screening MRI (CPT³ procedure codes 77058 and 77059) is covered annually, in addition to the annual screening mammogram, beginning at age 30 for services rendered on or after September 7, 2010, and at age 35 for services rendered prior to September 7, 2010, for women

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who have a 20% or greater lifetime risk of breast cancer (according to risk assessment tools based on family history such as the Gail model, the Claus model, and the Tyrer-Cuzick model), or who have any of the following risk factors:

4.1.1.1.3.1.1 Known BRCA1 or BRCA2 gene mutation;

4.1.1.1.3.1.2 First-degree relative (parent, child, sibling) with a BRCA1 or BRCA2 gene mutation, and have not had genetic testing themselves;

Note: Listing of the BRCA1 and BRCA2 gene mutations as additional risk factors here does not imply or constitute TRICARE coverage of BRCA1 or BRCA2 genetic testing as a clinical preventive service.

4.1.1.1.3.1.3 Radiation therapy to the chest between the ages of 10 and 30; or

4.1.1.1.3.1.4 History of LiFraumeni, Cowden, or hereditary diffuse gastric cancer syndrome, or first-degree relative with a history of one of these syndromes.

4.1.1.1.3.2 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 Pelvic 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 (CPT⁴ 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 CPT⁴ procedure code 99203 or 99213 using the EOB message: "Charge reimbursed at the intermediate office visit level." Separate charges for

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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 CPT⁵ 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.

4.1.1.2.3 Human Papillomavirus (HPV) Deoxyribonucleic Acid (DNA) Testing

HPV DNA testing is covered as a cervical cancer screening only when performed in conjunction with a PAP smear, and only for women aged 30 and older.

4.1.1.2.3.1 To be eligible for reimbursement as a cervical cancer screening, HPV DNA testing (CPT⁵ procedure codes 87620 - 87622) must be billed in conjunction with a PAP smear (CPT⁵ procedure codes 88141 - 88155, 88164 - 88167, 88174, and 88175) that is provided to a woman aged 30 or older.

4.1.1.2.3.2 The effective date for coverage of HPV DNA testing as a cervical cancer screening is September 7, 2010.

4.1.1.3 Colorectal Cancer

4.1.1.3.1 The following cancer screenings and frequencies are covered for individuals at **average risk** for colon cancer:

- Fecal Occult Blood Testing (FOBT). Either guaiac-based or immunochemical-based testing of three consecutive stool samples once every 12 months for beneficiaries who have attained age 50 (i.e., at least 11 months have passed following the month in which the last covered screening FOBT 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.
- Proctosigmoidoscopy or Flexible Sigmoidoscopy. Once every three to five years beginning at age 50. The effective date for coverage of proctosigmoidoscopy or sigmoidoscopy for individuals at **average risk** is October 6, 1997.

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- 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 optical colonoscopy for individuals at **average risk** is March 15, 2006.

4.1.1.3.2 A family history of colorectal cancer or adenomatous polyps increases an individual's risk of colon cancer. The following identifies these risk factors and the cancer screenings and frequencies covered for individuals at **increased risk** for colon cancer:

- One or more first-degree relatives diagnosed with sporadic colorectal cancer or an adenomatous polyp before the age of 60 or in two or more first-degree relatives at any age. Optical colonoscopy should be performed every three to five years beginning at age 40 or 10 years earlier than the youngest affected relative, whichever is earlier.
- One or more first-degree relatives diagnosed with sporadic colorectal cancer or an adenomatous polyp at age 60 or older, or two second-degree relatives diagnosed with colon cancer. Either flexible sigmoidoscopy (once every five years) or optical colonoscopy (once every 10 years) should be performed beginning at age 40.

4.1.1.3.3 Certain other risk factors put an individual at **high risk** for colon cancer. The following identifies these risk factors and the cancer screenings and frequencies covered for individuals at **high risk** for colon cancer:

- Individuals with known or suspected Familial Adenomatous Polyposis (FAP). Annual flexible sigmoidoscopy beginning at age 10 to 12.
- Family history of Hereditary Non-Polyposis Colorectal Cancer (HNPCC) syndrome. Optical colonoscopy should be performed once every one to two years beginning at age 20 to 25, or 10 years younger than the earliest age of diagnosis of colorectal cancer, whichever is earlier.
- Individuals diagnosed with Inflammatory Bowel Disease (IBD), Chronic Ulcerative Colitis (CUC), or Crohn's disease. For these individuals, cancer risk begins to be significant eight years after the onset of pancolitis or 10 to 12 years after the onset of left-sided colitis. For individuals meeting these risk parameters, optical colonoscopy should be performed every one to two years with biopsies for dysplasia.

4.1.1.3.4 The effective date for coverage of flexible sigmoidoscopy or optical colonoscopy for individuals at **increased** or **high risk** for colon cancer is October 6, 1997.

4.1.1.3.5 Computed Tomographic Colonography (CTC).

- The effective date for coverage of CTC as indicated above is March 15, 2006.
- 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 Rectal 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 (PSA)

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 Diagnosis 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.

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 TB 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 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) for use in the United States; 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 for use in the United States.
- The effective date of coverage for CDC recommended vaccines is October 6, 1997, OR the date ACIP recommendation for the vaccine were published in a MMWR, whichever date is LATER.

4.1.2.3.6.2 Immunizations recommended specifically for travel outside the United States are NOT covered, EXCEPT 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 CPT⁶ codes (i.e., CPT⁶ 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 (CPT⁶ 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

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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. Examination of the testis annually for males between the ages of 13 through 39 with history of cryptorchidism, orchipexy, or testicular atrophy.

4.2.1.2 Skin Cancer. Examination of the skin 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.

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 TB Screening. Screen annually, regardless of age, for all individuals at **high risk** for TB (as defined by CDC) using Mantoux tests.

4.2.2.2 Rubella Antibodies. Test females once, between the ages 12 through 18, unless documented history of adequate rubella vaccination with at least one dose of rubella vaccine on or after the first birthday is documented.

4.2.3 Cardiovascular Disease

4.2.3.1 Cholesterol. A lipid panel at least once every five years, beginning at 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
- 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

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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 **mammography** 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
COMPREHENSIVE HEALTH PROMOTION AND DISEASE PREVENTION EXAMINATIONS	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.	CPT ¹ codes 99382 - 99386 and 99392 - 99396.

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SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT PROCEDURE CODE
TARGETED HEALTH PROMOTION AND DISEASE PREVENTION EXAMINATIONS	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.	
School Physicals:	Physical Examinations: 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 ¹ codes 99201 - 99205*, 99211 - 99214*, 99383, and 99393
	*Standard office visit evaluation and management CPT ¹ 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 ¹ procedure codes 99383 and 99393).	
Breast Cancer:	Clinical Breast Examination (CBE): For women under age 40, CBE may be performed during a covered periodic preventive health exam. For women age 40 and older, CBE should be performed annually.	See appropriate level evaluation and management codes.
	Screening Mammography: Covered annually for all women over beginning at age 40. Covered annually beginning at age 30 for women who have a 15% or greater lifetime risk of breast cancer (according to risk assessment tools based on family history such as the Gail model, the Claus model, and the Tyrer-Cuzick model), or who have any of the following risk factors: <ol style="list-style-type: none"> 1. History of breast cancer, Ductal Carcinoma In Situ (DCIS), Lobular Carcinoma In Situ (LCIS), Atypical Ductal Hyperplasia (ADH), or Atypical Lobular Hyperplasia (ALH); 2. Extremely dense breasts when viewed by mammogram; 3. *Known BRCA1 or BRCA2 gene mutation; 4. *First-degree relative (parent, child, sibling) with a BRCA1 or BRCA2 gene mutation, and have not had genetic testing themselves; 5. Radiation therapy to the chest between the ages of 10 and 30 years; or 6. History of Li-Fraumeni, Cowden, or hereditary diffuse gastric cancer syndrome, or a first-degree relative with a history of one of these syndromes. 	CPT ¹ codes 77052 and 77057. HCPCS codes G0202, G0204, and G0206.
	* Listing of the BRCA1 and BRCA2 gene mutations as additional risk factors here does not imply or constitute TRICARE coverage of BRCA1 or BRCA2 genetic testing as a clinical preventive service.	
	Breast Screening Magnetic Resonance Imaging (MRI): Covered annually, in addition to the annual screening mammogram, beginning at age 30 for women who have a 20% or greater lifetime risk of breast cancer (according to risk assessment tools based on family history such as the Gail model, the Claus model, and the Tyrer-Cuzick model), or who have any of the following risk factors: <ol style="list-style-type: none"> 1. *Known BRCA1 or BRCA2 gene mutation; 	CPT ¹ codes 77058 and 77059.

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SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT PROCEDURE CODE
Breast Cancer (Continued):	<p>Breast Screening Magnetic Resonance Imaging (MRI) (Continued):</p> <p>2. First-degree relative (parent, child, sibling) with a BRCA1 or BRCA2 gene mutation, and have not had genetic testing themselves;</p> <p>3. Radiation to the chest between the ages of 10 and 30; or</p> <p>4. History of LiFraumeni, Cowden, or hereditary diffuse gastric cancer syndrome, or a first-degree relative with a history of one of these syndromes.</p> <p>The effective date for breast cancer screening MRI is March 1, 2007.</p>	
	* Listing of the BRCA1 and BRCA2 gene mutations as additional risk factors here does not imply or constitute TRICARE coverage of BRCA1 or BRCA2 genetic testing as a clinical preventive service.	
Cancer of Female Reproductive Organs:	Pelvic Examination: Pelvic examination should be performed in conjunction with Pap smear testing for cervical neoplasms and premalignant lesions.	See appropriate level evaluation and management codes.
	PAP Smears: 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 ¹ codes 88141 - 88155, 88164 - 88167, 88174, 88175, 99201 - 99215, or 99301 - 99313.
	<p>Human Papillomavirus (HPV) Deoxyribonucleic Acid (DNA) Testing: HPV DNA testing is covered as a cervical cancer screening only when performed in conjunction with a PAP smear, and only for women aged 30 and older.</p> <p>To be eligible for reimbursement as a cervical cancer screening, HPV DNA testing must be billed in conjunction with a PAP smear that is provided to a woman aged 30 or older.</p> <p>The effective date for coverage of HPV DNA testing as a cervical cancer screening is September 7, 2010.</p>	CPT ¹ codes 87620 - 87622.
Testicular Cancer:	Testicular Examination: 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.
Prostate Cancer:	Rectal Examination: 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.

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SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT PROCEDURE CODE
Prostate Cancer (Continued):	Prostate-Specific Antigen (PSA): 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 ¹ code 84153.
Colorectal Cancer:	Fecal Occult Blood Testing (FOBT): For Individuals at Average Risk for Colon Cancer: Either guaiac-based or immunochemical-based testing of three consecutive stool samples once every 12 months for beneficiaries who have attained age 50 (i.e., at least 11 months must 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.	CPT ¹ codes 82270 and 82274.
	Proctosigmoidoscopy or Flexible Sigmoidoscopy for Individuals at Average, Increased, or High Risk for Colon Cancer: Average Risk: Once every three to five years beginning at age 50. Increased Risk (Individuals with a family history): Once every five years, beginning at age 40, for individuals with a first degree relative diagnosed with a colorectal cancer or an adenomatous polyp at age 60 or older, or two second degree relatives diagnosed with colorectal cancer. High Risk: Annual flexible sigmoidoscopy, beginning at age 10 through 12, for individuals with known or suspected Familial Adenomatous Polyposis (FAP). The effective date for coverage of proctosigmoidoscopy or flexible sigmoidoscopy, regardless of risk, is October 6, 1997.	CPT ¹ codes 45300 - 45321, 45327, and 45330 - 45339. HCPCS code G0104.
	Optical (Conventional) Colonoscopy for Individuals at Average, Increased, or High Risk for Colon Cancer: Average Risk: Once every 10 years for individuals age 50 or above. The effective date for coverage of optical colonoscopy for individuals at average risk is March 15, 2006.	CPT ¹ codes 45355 and 45378 - 45385. HCPCS codes G0105 and G0121.

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SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT PROCEDURE CODE
Colorectal Cancer (Continued):	<p>Optical (Conventional) Colonoscopy for Individuals at Average, Increased, or High Risk for Colon Cancer (Continued):</p> <p>Increased Risk (Individuals with a family history):</p> <ol style="list-style-type: none"> 1. Once every five years for individuals with a first degree relative diagnosed with a colorectal cancer or an adenomatous polyp at age 60 or older, or in two or more first degree relatives at any age. Optical colonoscopy should be performed beginning at age 40 or 10 years younger than the earliest affected relative, whichever is earlier. 2. Once every 10 years, beginning at age 40, for individuals with a first degree relative diagnosed with colorectal cancer or an adenomatous polyp at age 60 or older, or colorectal cancer diagnosed in two second degree relatives. <p>High Risk:</p> <ol style="list-style-type: none"> 1. Once every one to two years for individuals with a genetic or clinical diagnosis of Hereditary Non-Polyposis Colorectal Cancer (HNPCC) or individuals at increased risk for HNPCC. Optical colonoscopy should be performed beginning at age 20 to 25 or 10 years younger than the earliest age of diagnosis, whichever is earlier. 2. For individuals diagnosed with Inflammatory Bowel Disease (IBD), Chronic Ulcerative Colitis (CUC), or Crohn's disease, cancer risk begins to be significant eight years after the onset of pancolitis or 10 to 12 years after the onset of left-sided colitis. For individuals meeting these risk parameters, optical colonoscopy should be performed every one to two years with biopsies for dysplasia. <p>The effective date for coverage of optical colonoscopy for individuals at increased or high risk is October 6, 1997.</p>	<p>CPT¹ Level III codes 0066T or 0067T.</p>
	<p>Computed Tomographic Colonography (CTC) for Individuals in whom an Optical Colonoscopy is Medically Contraindicated or Incomplete: CTC is covered as a colorectal cancer screening ONLY 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. CTC is NOT covered as a colorectal cancer screening for any other indication or reason.</p> <p>The effective date for coverage of CTC for this indication is March 15, 2006. CTC is NOT covered as a colorectal cancer screening for any other indication or reason.</p>	

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Skin Cancer:	Physical Examination: 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.
Oral Cavity and Pharyngeal Cancer:	Physical Examination: 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.
Thyroid Cancer:	Physical Examination: Palpation for thyroid nodules should be performed in adults with a history of upper body irradiation.	See appropriate level evaluation and management codes.
Infectious Diseases:	Tuberculosis (TB) Screening: Screen annually, regardless of age, all individuals at high risk for tuberculosis (as defined by Centers for Disease Control and Prevention (CDC) using Mantoux tests.	CPT ¹ codes 86580 and 86585.
	Rubella Antibodies: Test females, once, between the ages of 12 and 18, unless documented history of adequate rubella vaccination with at least one dose of rubella vaccine on or after the first birthday is documented.	CPT ¹ code 86762.
	Hepatitis B Screening: Screen pregnant women for HBsAG during prenatal period.	CPT ¹ code 87340.
Cardiovascular Diseases:	Cholesterol: A lipid panel at least once every five years, beginning at age 18.	CPT ¹ code 80061.
	Blood Pressure Screening: 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.
	Abdominal Aortic Aneurysm (AAA): One time AAA screening by ultrasonography for men, age 65 - 75, who have ever smoked.	CPT ¹ code 76999.
Other:	Body Measurement: 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.

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SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT PROCEDURE CODE
Other (Continued):	<p>Vision Care: Pediatric vision screening at birth and approximately six 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.</p> <p>Note: 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).</p>	CPT ¹ codes 92002, 92004, 92012, 92014, 92015, 99172, and 99173.
	<p>Hearing Screening: All neonates should undergo audiology screening before leaving the hospital. However, if not tested at birth all infants should undergo audiology screening before one month of age. Those who do not pass the audiologic screening should be tested before three months of age using Evoked Otoacoustic Emission (EOE) and/or Auditory Brainstem Response (ABR) testing.</p> <p>A hearing evaluation should be a part of routine examinations for all children, and those with possible hearing impairment should be referred for appropriate testing.</p>	CPT ¹ codes 92551, 92587, and 92588.
	<p>Pediatric Blood Lead: Assessment of risk for lead exposure by structured questionnaire based on 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.</p>	CPT ¹ code 83655.
	<p>Patient & Parent Education Counseling: 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.</p>	These are expected components of good clinical practice that are integrated into the appropriate office visit at no additional charge.

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SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT PROCEDURE CODE
Other (Continued):	<p>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 for use in the United States.</p> <p>The effective date of coverage for immunizations recommended by the CDC is the date that the ACIP recommendations for a particular vaccine or immunization are published in CDC MMWR or October 6, 1997, whichever is later.</p> <p>Immunizations recommended specifically for travel outside the United States are NOT covered, EXCEPT for those 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.</p>	

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- END -

Chapter 7

Section 7.1

Speech Services

Issue Date: April 19, 1983

Authority: [32 CFR 199.6\(c\)](#) and 10 USC 1079(e)

1.0 CPT¹ PROCEDURE CODES

92506 - 92508, 92630 - 92633

2.0 DESCRIPTION

Speech-language pathology services that provide evaluation, treatment, habilitation, and rehabilitation of communication disorders resulting from congenital anomalies, disease, injury, hearing loss, pervasive developmental disorders or a therapeutic process, or other condition, such as pragmatic language impairment, that prevents or diminishes an individual's ability to communicate.

3.0 POLICY

3.1 Speech-language pathology services prescribed and supervised by a physician, **certified Physician Assistant (PA) working under the supervision of a physician, or certified Nurse Practitioner (NP)** may be cost-shared.

3.2 Speech-language pathology services to improve, restore, or maintain function, or to minimize or prevent deterioration of function of a patient when prescribed by a physician, **certified PA working under the supervision of a physician, or certified NP** is covered in accordance with the rehabilitative therapy provisions found in [Section 18.1](#).

4.0 EXCLUSIONS

4.1 Services provided to address speech, language, or communication disorders resulting from occupational or educational deficits.

4.2 For beneficiaries under the age of three, services and items provided in accordance with the beneficiary's Individualized Family Service Plan (IFSP) as required by Part C of the Individuals with Disabilities Education Act (IDEA), and which are otherwise allowable under the TRICARE Basic Program or the Extended Care Health Option (ECHO) but determined not to be medically or psychologically necessary, are excluded.

4.3 For beneficiaries ages three to 21 who are receiving special education services from a public educational agency, cost-sharing of outpatient speech services that are required by the IDEA and

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which are indicated in the beneficiary's Individualized Education Program (IEP), may not be cost-shared except when the intensity or timeliness of speech services as proposed by the educational agency are not appropriate medical care.

4.4 Myofunctional or tongue thrust therapy.

4.5 Maintenance therapy that does not require a skilled level after a therapy program has been designed (see [Section 18.1](#)).

4.6 Videofluoroscopy evaluation in speech pathology is unproven.

4.7 Speech therapists (speech pathologists) are not authorized to bill using Evaluation and Management (E&M) codes listed in the Physicians' CPT.

- END -

Physical Medicine/Therapy

Issue Date: April 19, 1983

Authority: [32 CFR 199.4\(b\)\(2\)\(xi\)](#), [\(b\)\(3\)\(vii\)](#), and [\(c\)\(3\)\(x\)](#)

1.0 CPT¹ PROCEDURE CODES

93668, 96000 - 96004, 97001 - 97002, 97012 - 97530, 97532, 97533, 97542 - 97750, 97799

2.0 DESCRIPTION

2.1 The treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles, and devices to relieve pain, restore maximum function, and prevent disability following disease, injury or loss of a body part.

2.2 Physical therapy services consist of the physical evaluation of a patient by muscle testing and other means and the prescribed therapeutic treatment and services of a definite functional nature.

2.3 Physical therapy to improve, restore, or maintain function, or to minimize or prevent deterioration of function of a patient when prescribed by a physician is covered in accordance with the rehabilitative therapy provisions found in [Section 18.1](#).

3.0 POLICY

3.1 Benefits are payable for inpatient or outpatient physical therapy services that are determined to be medically necessary for the treatment of a covered condition, and that are directly and specifically related to an active written regimen.

3.2 Physical therapy services must be prescribed by a physician, **certified Physician Assistant (PA working under the supervision of a physician), or certified Nurse Practitioner (NP)** and professionally administered to aid in the recovery from disease or injury to help the patient in attaining greater self-sufficiency, mobility, and productivity through exercises and other modalities intended to improve muscle strength, joint motion, coordination, and endurance.

3.3 If physical therapy is performed by other than a physician, a physician (or other authorized individual professional provider acting within the scope of his/her license) should refer the patient for treatment and supervise the physical therapy.

3.4 Reimbursement for covered physical therapy services is based on the appropriate CPT¹ procedure codes for the services billed on the claim.

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3.5 Physical therapists are not authorized to bill using Evaluation and Management (E&M) codes listed in the Physician's Current Procedural Terminology (CPT).

4.0 EXCLUSIONS

4.1 The following services are not covered:

4.1.1 Diathermy, ultrasound, and heat treatments for pulmonary conditions.

4.1.2 General exercise programs, even if recommended by a physician (or other authorized individual professional provider acting within the scope of their license).

4.1.3 Electrical nerve stimulation used in the treatment of upper motor neuron disorders such as multiple sclerosis.

4.1.4 Separate charges for instruction of the patient and family in therapy procedures.

4.1.5 Repetitive exercise to improve gait, maintain strength and endurance, and assistive walking such as that provided in support of feeble or unstable patients.

4.1.6 Range of motion and passive exercises which are not related to restoration of a specific loss of function, but are useful in maintaining range of motion in paralyzed extremities.

4.1.7 Maintenance therapy that does not require a skilled level after a therapy program has been designed (see [Section 18.1](#)).

4.1.8 Services of chiropractors and naturopaths whether or not such services would be eligible for benefits if rendered by an authorized provider.

4.1.9 Acupuncture with or without electrical stimulation.

4.1.10 Athletic training evaluation (CPT² procedure codes 97005 and 97006).

4.1.11 CPT² procedure code 97532 or 97533 is not a covered benefit when used as a restorative approach. That is, cognitive function improves as a result of neuronal growth, which is enhanced through the repetitive exercise of neuronal circuits and that recovery of functions is determined by biological events.

4.1.12 CPT² procedure codes 97532 and 97533 for sensory integration training.

Note: This policy does not exclude multidisciplinary services, such as physical therapy, occupational therapy, or speech therapy after traumatic brain injury, stroke and children with an autistic disorder.

4.1.13 **Nonsurgical spinal decompression therapy (including Internal or Intervertebral Disc Decompression (IDD), Decompression Reduction Stabilization (DRS), or Vertebral Axial Decompression (VAX-D) therapy) provided by mechanical or motorized traction for the treatment**

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Occupational Therapy

Issue Date: July 3, 1997

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

1.0 CPT¹ PROCEDURE CODES

97003 - 97004, 97150, 97532, 97533, 97535, 97799

2.0 DESCRIPTION

Occupational therapy is the prescribed use of specific purposeful activity or interventions designed to promote health, prevent injury or disability, and which develop, improve, sustain, or restore functions which have been lost or reduced as a result of injury, illness, cognitive impairment, psychosocial dysfunction, mental illness, or developmental, learning or physical disability(ies), to the highest possible level for independent functioning.

3.0 POLICY

3.1 Occupational therapy prescribed and supervised by a physician, **certified Physician Assistant (PA) working under the supervision of a physician, or certified Nurse Practitioner (NP)** is covered.

3.2 Occupational therapy to improve, restore, or maintain function, or to minimize or prevent deterioration of function of a patient when prescribed by a physician is covered in accordance with the rehabilitative therapy provisions found in [Section 18.1](#).

4.0 EXCLUSIONS

4.1 The following occupational therapy services are not covered:

- Vocational assessment and training.
- General exercise programs.
- Separate charges for instruction of the patient and family in therapy procedures.
- Repetitive exercise to improve gait, maintain strength and endurance, and assisted walking such as that provided in support of feeble or unstable patients.

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4.2 Maintenance therapy that does not require a skilled level after a therapy program has been designed (see [Section 18.1](#)).

- Range of motion and passive exercises which are not related to restoration of a specific loss of function.
- CPT² procedure code 97532 or 97533 is not a covered benefit when used as a restorative approach. That is, cognitive function improves as a result of neuronal growth, which is enhanced through the repetitive exercise of neuronal circuits and that recovery of functions is determined by biological events.
- CPT² procedure codes 97532 and 97533 for sensory integration training is excluded.

Note: This policy does not exclude multidisciplinary services, such as physical therapy, occupational therapy, or speech therapy after traumatic brain injury, stroke and children with an autistic disorder.

4.3 Occupational therapists are not authorized to bill using Evaluation and Management (E&M) codes listed in the Physicians' Current Procedural Terminology (CPT).

4.4 For beneficiaries under the age of three, services and items provided in accordance with the beneficiary's Individualized Family Service Plan (IFSP) as required by Part C of the Individuals with Disabilities Education Act (IDEA), and which are otherwise allowable under the TRICARE Basic program or the Extended Care Health Option (ECHO) but determined not to be medically or psychologically necessary, are excluded.

4.5 For beneficiaries aged three to 21, who are receiving special education services from a public education agency, cost-sharing of outpatient occupational therapy services that are required by the IDEA and which are indicated in the beneficiary's Individualized Education Program (IEP), may not be cost-shared except when the intensity or timeliness of occupational therapy services as proposed by the educational agency are not sufficient to meet the medical needs of the beneficiary.

5.0 EFFECTIVE DATE

October 28, 1997.

- END -

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Botulinum Toxin Injections

Issue Date: October 12, 1998

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

1.0 CPT¹ PROCEDURE CODES

46505, 64612 - 64614, 64640, 64653, 67345

2.0 HCPCS PROCEDURE CODES

J0585, J0587

3.0 DESCRIPTION

These procedures involve the injection of small amounts of botulinum toxin into selected muscles for the nonsurgical treatment of the conditions relating to spasticity, various dystonias, nerve disorders, and muscular tonicity deviations.

4.0 POLICY

4.1 Botulinum toxin A ([AbobotulinumtoxinA/OnabotulinumtoxinA](#)) and Botulinum toxin B ([RimabotulinumtoxinB](#)) injections may be considered for cost-sharing for treating conditions such as cervical dystonia (repetitive contraction of the neck muscles) in decreasing the severity of abnormal head position and neck pain for patients 16 years and older.

4.2 Botulinum toxin A ([OnabotulinumtoxinA](#)) injections may be considered for cost-sharing for treating conditions such as blepharospasm (spasm of the eyelids/uncontrolled blinking) and strabismus (squinting/eyes do not point in the same direction) associated with dystonia, including benign essential blepharospasm or VII nerve disorders for patients 12 years of age and older.

4.3 Botulinum toxin A ([OnabotulinumtoxinA](#)) injections may be considered for cost-sharing for treating conditions such as severe primary axillary hyperhidrosis (severe underarm sweating) that is inadequately managed by topical agents for patients 18 years of age and older.

4.4 Botox® ([OnabotulinumtoxinA](#)-chemodenervation-CPT¹ procedure code 46505) may be considered for off-label cost-sharing for the treatment of chronic anal fissure unresponsive to conservative therapeutic measures, effective May 1, 2007.

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4.5 Botulinum toxin A (AbobotulinumtoxinA/OnabotulinumtoxinA) injections may be considered for off-label cost-sharing for the treatment of spasticity resulting from Cerebral Palsy (CP), effective November 1, 2008.

4.6 Botox® (OnabotulinumtoxinA) and Myobloc® (RimabotulinumtoxinB) injections may be considered for Off-label cost-sharing for the treatment of sialorrhea associated with Parkinson disease patients who are refractory to, or unable to tolerate, systemic anticholinergics, effective October 1, 2009.

4.7 Botulinum toxin A (OnabotulinumtoxinA) injections for prophylaxis of headaches in adult patients with chronic migraine, which is defined as 15 days or more per month with headache lasting four hours a day or longer.

4.8 Botulinum toxin A (OnabotulinumtoxinA) injections to treat spasticity in flexor muscles of the elbow, wrist, and fingers (upper limb spasticity) in adults.

5.0 EXCLUSIONS

5.1 Botulinum toxin A injections are unproven for the following indications:

- Palmar hyperhidrosis.
- Urinary urge incontinence.
- Lower back pain/lumbago.
- Episodic migraine, chronic daily headache, cluster headache, cervicogenic headache, and tension-type headache.

5.2 Botox® (OnabotulinumtoxinA-chemodeneration-CPT² procedure code 64612) for the treatment of muscle spasms secondary to cervical degenerative disc disease and spinal column stenosis is unproven.

5.3 Botox® (OnabotulinumtoxinA) used for cosmetic indications (e.g., frown lines and brow furrows) is excluded from coverage.

6.0 EFFECTIVE DATES

6.1 May 1, 2007, for coverage of chronic anal fissure unresponsive to conservative therapeutic measures (CPT² procedure code 46505).

6.2 October 1, 2009, for coverage of sialorrhea associated with Parkinson disease patients who are refractory to, or unable to tolerate, systemic anticholinergics (CPT² procedure code 64653).

6.3 October 15, 2010, coverage for prophylaxis of headaches in adult patients with chronic migraine, which is defined as 15 days or more per month with headache lasting four hours a day or longer.

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

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Chapter 7, Section 27.1

Botulinum Toxin Injections

6.4 March 9, 2010, coverage for spasticity in flexor muscles of the elbow, wrist, and fingers (upper limb spasticity) in adults.

- 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 6A. RUG-IV Case-Mix Adjusted Federal Rates for Urban SNFs by Labor and Non-Labor Component", determine the highest cost RUG-IV category;

6.8.2.1.3 Multiply the labor component obtained in (2) by the "Table A. FY 2011 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;

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 6A, use "Table 7A. RUG-IV Case-Mix Adjusted Federal Rates for Rural SNFs by Labor and Non-Labor Component" and "Table B. FY 2011 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 2011 rates published in the **Federal Register** on July 22, 2010 (75 FR 42886).

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 maximum monthly or fiscal year Government cost-shares 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 services and 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. Except for those excluded activities, this exclusion does not otherwise restrict or prohibit the primary caregiver(s) from engaging in other activities they choose, including those outside the beneficiary's primary residence.**

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.

Physician Referral And Supervision

Issue Date: December 18, 1985

Authority: [32 CFR 199.6\(c\)\(3\)\(iii\)\(K\)](#), [\(c\)\(3\)\(iv\)](#); and 10 USC 1079(a)

1.0 ISSUE

1.1 In order to be considered for benefits on a fee-for-service basis, the services of the following individual professional providers of care may be provided only if the beneficiary/patient is referred by a physician for the treatment of a medically-diagnosed condition.

1.2 A physician must also provide continuing and ongoing oversight and supervision of the program or episode of treatment provided by **the following** individual providers:

- Licensed Registered Nurses (RNs).
- Licensed Practical Nurse (LPN) or Licensed Vocational Nurse (LVN).
- Audiologist.
- Pastoral Counselors.
- Mental Health Counselors.

2.0 POLICY

2.1 A physician must establish a diagnosis which, in order to be considered for benefits, must describe a covered condition. This means the physician must actually see the patient, do an evaluation and arrive at an initial diagnostic impression prior to referring the patient. Any change in the referral diagnosis must be coordinated with the referring physician.

2.2 The overall management of the patient rests with the physician and, in order to assure appropriate case management, coordination must be made with the referring physician on an ongoing basis. Physician supervision means the physician provides overall medical management of the case. The referring physician does not have to be physically located on the premises of the provider to whom the referral is made. Communication back to the referring physician is an indication of medical management.

2.3 Military physicians may refer patients to civilian providers. Because of the mobility of military physicians due to transfers, retirements and discharges, if the original referring physician has relocated, another military physician may assume responsibility for the case upon review of the military treatment facility clinical record, a narrative of the patient's present status and the proposed treatment plan.

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Chapter 11, Section 3.1

Physician Referral And Supervision

3.0 EXCLUSION

Any services provided prior to examination and subsequent referral by a physician.

- END -

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Chapter 11, Section 12.1

Corporate Services Provider Class

2.2.2.3 The following minimal requirements should be adhered to in the establishment of alternative reimbursement methodologies for in-system/network corporate services providers in order to ensure quality of care and fiscal accountability:

2.2.2.3.1 Alternative reimbursement methodologies may include and/or be a combination of fee schedules, discounts from usual and customary fees or CMAC, flat fee arrangements (negotiated all inclusive rates), capitation arrangements, discounts off of DRGs, per diems; or such other method as is mutually agreed upon, provided such alternative payments do not exceed what would have otherwise been allowed under Standard TRICARE payment methodologies in another setting (e.g., comparable services rendered in a hospital inpatient or outpatient setting).

2.2.2.3.2 Payments in full (e.g., negotiated flat fees, all-inclusive global fees, capitation arrangements, discounts off of DRGs and per diems) are prospective reimbursement systems which may include items related or incidental to the treatment of the patient but for which coverage is not normally extended under TRICARE. These incidental services are to be included in the negotiated prospective payment rate; i.e., they can neither be billed to the beneficiary or deducted from the negotiated global rate.

2.2.3 All billing for Corporate Services Providers should be submitted on a Centers for Medicare and Medicaid Services (CMS) 1500 (08/2005). TRICARE Management Activity (TMA) will assign pricing rate codes (e.g., assigning a pricing rate code "GP" for non-institutional per diem rates) to accommodate approved alternative reimbursement systems. The contractor should designate the coding that it wants to use as part of the alternative reimbursement request submitted to the Deputy Director, TMA or designee for review and approval.

2.2.4 The contractor will determine the appropriate procedural category of a qualified organization and may change the category based upon the provider's TRICARE claim characteristics. The category determination is conclusive and may not be appealed.

2.2.5 The corporate entity will not be allowed additional facility charges that are not already incorporated into the professional services fee structure (i.e., facility charges that are not already included in the overhead and malpractice cost indices used in establishing locally-adjusted CMAC rates).

2.2.6 While the expanded provider category will allow coverage of professional services for corporate entities qualifying for provider authorization status under the provisions of this policy, it will at the same time restrict coverage of professional services for those corporate entities which cannot meet the criteria for corporate services provider status under TRICARE.

2.3 Conditions for Coverage/Authorization

2.3.1 Be a corporation or a foundation, but not a professional corporation or professional association;

2.3.2 Be institution-affiliated or freestanding;

2.3.3 Provide services and related supplies of a type rendered by TRICARE individual professional providers employed directly or contractually by a corporation, or diagnostic technical services and related supplies of a type which requires direct patient contact and a technologist

who is licensed by the state in which the procedure is rendered or who is certified by a Qualified Accreditation Organization;

2.3.4 Provide the level of care that does not necessitate that the beneficiary be provided with on-site sleeping accommodations and food in conjunction with the delivery of the services except for sleep disorder diagnostic centers in which on-site sleeping accommodations are an integral part of the diagnostic evaluation process.

2.3.5 Render services for which direct or indirect payment is expected to be made by TRICARE only after obtaining written authorization (i.e., comply with applicable TRICARE authorization requirements before rendering designated services or items for which TRICARE cost-share/copayment may be expected);

2.3.6 Comply with all applicable organizational and individual licensing or certification requirements that exist in the state, county, municipality, or other political jurisdiction in which the corporate entity provides services;

2.3.7 Maintain Medicare approval for payment when the contractor determines that a category, or type, of provider is substantially comparable to a provider or supplier for which Medicare has regulatory conditions of participation or conditions of coverage, or when Medicare approved status is not required, be accredited by a qualified accreditation organization, as defined in [Section 12.2](#); and

2.3.8 Has entered into a negotiated provider contract with a network provider or a participation agreement with a non-network provider which at least complies with the minimum participation agreement requirements set forth in [Section 12.3](#). The participation agreement will accompany the application form (Application for TRICARE-Provider Status: CORPORATE SERVICES PROVIDER) sent out as part of the initial authorization process for non-network providers as described below.

2.4 Application Process

2.4.1 The information collected on the "Application for TRICARE-Provider Status: CORPORATE SERVICES PROVIDERS" (i.e., the information collection form for which the provider is seeking TRICARE authorization status) will be used by the contractor in determining whether the provider meets the criteria for authorization as a corporate services provider under the TRICARE program (refer to [Addendum D](#) for a copy of the corporate services provider application form).

2.4.2 The application will be sent out and information collected when a:

2.4.2.1 Provider requests permission to become a TRICARE provider;

2.4.2.2 Claim is filed for care received from a provider who is not listed on the contractor's provider file; or

2.4.2.3 Formerly TRICARE authorized provider requests reinstatement.

Acronyms And Abbreviations

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
AC	Active Component
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
ACSP	Autism Demonstration Corporate Services Provider
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
ADDP	Active Duty Dental Program
ADFM	Active Duty Family Member

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Appendix A

Acronyms And Abbreviations

ADH	Atypical Ductal Hyperplasia
ADL	Activities of Daily Living
ADP	Automated Data Processing
ADSM	Active Duty Service Member
AF	Atrial Fibrillation
AFB	Air Force Base
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	Ambulatory Infusion Suite Automated Information Systems
AIX	Advanced IBM Unix
AJ	Administrative Judge
ALA	Annual Letter of Assurance
ALB	All Lines Busy
ALH	Atypical Lobular Hyperplasia
ALL	Acute Lymphocytic Leukemia
ALOS	Average Length-of-Stay
ALS	Action Lead Sheet Advanced Life Support
ALT	Autolymphocyte Therapy
AM&S	Acquisition Management and Support (Directorate)
AMA	Against Medical Advice American Medical Association
AMCB	American Midwifery Certification Board
AMH	Accreditation Manual for Hospitals
AMHCA	American Mental Health Counselor Association
AML	Acute Myelogenous [Myeloid] Leukemia
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

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Acronyms And Abbreviations

ARVC	Arrhythmogenic Right Ventricular Cardiomyopathy
ASA	Adjusted Standardized Amount American Society of Anesthesiologists
ASAP	Automated Standard Application for Payment
ASC	Accredited Standards Committee Ambulatory Surgical Center
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
ATA	American Telemedicine Association
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
BC	Birth Center
BCaBA	Board Certified Assistant Behavior Analyst
BCABA	Board Certified Associate Behavior Analyst
BCAC	Beneficiary Counseling and Assistance Coordinator
BCBA	Board Certified Behavior Analyst
BCBS	Blue Cross [and] Blue Shield
BCBSA	Blue Cross [and] Blue Shield Association
BCC	Biostatistics Center
BH	Behavioral Health
BI	Background Investigation
BIPA	Benefits Improvement Protection Act
BL	Black Lung
BLS	Basic Life Support
BMI	Body Mass Index
BMT	Bone Marrow Transplantation

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Acronyms And Abbreviations

BNAF	Budget Neutrality Adjustment Factor
BOS	Bronchiolitis Obliterans Syndrome
BP	Behavioral Plan
BPC	Beneficiary Publication Committee
BPS	Beneficiary and Provider Services
BRAC	Base Realignment and Closure
BRCA	BReast CAncer (genetic testing)
BRCA1/2	BReast CAncer Gene 1/2
BS	Bachelor of Science
BSGI	Breast-Specific Gamma Imaging
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
C&P	Compensation and Pension
C/S	Client/Server
CA	Care Authorization
CA/NAS	Care Authorization/Non-Availability Statement
CABG	Coronary Artery Bypass Graft
CAC	Common Access Card
CAD	Coronary Artery Disease
CAF	Central Adjudication Facility
CAH	Critical Access Hospital
CAMBHC	Comprehensive Accreditation Manual for Behavioral Health Care
CAP	Competitive Acquisition Program
CAP/DME	Capital and Direct Medical Education
CAPD	Continuous Ambulatory Peritoneal Dialysis
CAPP	Controlled Access Protection Profile
CAS	Carotid Artery Stenosis
CAT	Computerized Axial Tomography
CB	Consolidated Billing
CBC	Cypher Block Chaining
CBE	Clinical Breast Examination
CBHCO	Community-Based Health Care Organizations
CBP	Competitive Bidding Program
CBSA	Core Based Statistical Area
CC	Common Criteria Convenience Clinic Criminal Control (Act)
CC&D	Catastrophic Cap and Deductible
CCDD	Catastrophic Cap and Deductible Data

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Acronyms And Abbreviations

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
CEA	Carotid Endarterectomy
CEIS	Corporate Executive Information System
CEO	Chief Executive Officer
CEOB	CHAMPUS Explanation of Benefits
CES	Cranial Electrotherapy Stimulation
CFO	Chief Financial Officer
CFR	Code of Federal Regulations
CFRD	Cystic Fibrosis-Related Diabetes
CFS	Chronic Fatigue Syndrome
CGMS	Continuous Glucose Monitoring System
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CHAMPVA	Civilian Health and Medical Program of the Department of Veteran Affairs
CHBC	Criminal History Background Check
CHBR	Criminal History Background Review
CHC	Civilian Health Care
CHCBP	Continued Health Care Benefits Program
CHCS	Composite Health Care System
CHEA	Council on Higher Education Accreditation
CHKT	Combined Heart-Kidney Transplant
CHOP	Children's Hospital of Philadelphia
CI	Counterintelligence
CIA	Central Intelligence Agency
CID	Central Institute for the Deaf
CIF	Central Issuing Facility
	Common Intermediate Format
CIO	Chief Information Officer

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CIPA	Classified Information Procedures Act
CJCSM	Chairman of the Joint Chiefs of Staff Manual
CL	Confidentiality Level (Classified, Public, Sensitive)
CLIA	Clinical Laboratory Improvement Amendment
CLIN	Contract Line Item Number
CLKT	Combined Liver-Kidney Transplant
CLL	Chronic Lymphocytic Leukemia
CMAC	CHAMPUS Maximum Allowable Charge
CMHC	Community Mental Health Center
CML	Chronic Myelogenous Leukemia
CMN	Certificate(s) of Medical Necessity
CMO	Chief Medical Officer
CMP	Civil Money Penalty
CMR	Cardiovascular Magnetic Resonance
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
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
CP	Cerebral Palsy
CPA	Certified Public Accountant
CPE	Contract Performance Evaluation
CPI	Consumer Price Index
CPI-U	Consumer Price Index - Urban (Wage Earner)
CPNS	Certified Psychiatric Nurse Specialists

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Acronyms And Abbreviations

CPR	CAC PIN Reset
CPT	Chest Physiotherapy Current Procedural Terminology
CPT-4	Current Procedural Terminology, 4th Edition
CQM	Clinical Quality Management
CQMP	Clinical Quality Management Program
CQMP AR	Clinical Quality Management Program Annual Report
CQS	Clinical Quality Studies
CRM	Contract Resource Management (Directorate)
CRNA	Certified Registered Nurse Anesthetist
CRS	Cytoreductive Surgery
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
CTA	Computerized Tomography Angiography
CTC	Computed Tomographic Colonography
CTCL	Cutaneous T-Cell Lymphoma
CTEP	Cancer Therapy Evaluation Program
CUC	Chronic Ulcerative Colitis
CVAC	CHAMPVA Center
CVS	Contractor Verification System
CY	Calendar Year
DAA	Designated Approving Authority
DAO	Defense Attache Offices
DBA	Doing Business As
DC	Direct Care
DCAA	Defense Contract Audit Agency
DCAO	Debt Collection Assistance Officer
DCID	Director of Central Intelligence Directive
DCII	Defense Clearance and Investigation Index
DCIS	Defense Criminal Investigating Service Ductal Carcinoma In Situ
DCN	Document Control Number
DCP	Data Collection Period
DCPE	Disability Compensation and Pension Examination

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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
DELM	Digital Epiluminescence Microscopy
DENC	Detailed Explanation of Non-Concurrence
DepSecDef	Deputy Secretary of Defense
DES	Data Encryption Standard Disability Evaluation System
DFAS	Defense Finance and Accounting Service
DG	Diagnostic Group
DGH	Denver General Hospital
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
DLI	Donor Lymphocyte Infusion
DM	Disease Management
DMDC	Defense Manpower Data Center
DME	Durable Medical Equipment
DMEPOS	Durable medical equipment, prosthetics, orthotics, and supplies
DMI	DMDC Medical Interface
DMIS	Defense Medical Information System
DMIS-ID	Defense Medical Information System Identification (Code)
DMLSS	Defense Medical Logistics Support System
DMZ	Demilitarized Zone

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

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

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Acronyms And Abbreviations

EHHC	ECHO Home Health Care Extended Care Health Option Home Health Care
EHP	Employee Health Program
EHRA	European Heart Rhythm Association
EIA	Educational Interventions for Autism Spectrum Disorders
EIDS	Executive Information and Decision Support
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
EOB	Explanation of Benefits
EOBs	Explanations of Benefits
EOC	Episode of Care
EOE	Evoked Otoacoustic Emission
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)
FAI	Femoroacetabular Impingement
FAP	Familial Adenomatous Polyposis
FAR	Federal Acquisition Regulations
FASB	Federal Accounting Standards Board

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FBI	Federal Bureau of Investigation
FCC	Federal Communications Commission
FCCA	Federal Claims Collection Act
FDA	Food and Drug Administration
FDB	First Data Bank
FDL	Fixed Dollar Loss
Fed	Federal Reserve Bank
FEHBP	Federal Employee Health Benefit Program
FEL	Familial Erythrophagocytic Lymphohistiocytosis
FEV ₁	Forced Expiratory Volume
FFM	Foreign Force Member
FHL	Familial Hemophagocytic Lymphohistiocytosis
FI	Fiscal Intermediary
FIPS	Federal Information Processing Standards (or System)
FIPS PUB	FIPS Publication
FISH	Fluorescence In Situ Hybridization
FISMA	Federal Information Security Management Act
FL	Form Locator
FMCRA	Federal Medical Care Recovery Act
FMRI	Functional Magnetic Resonance Imaging
FOBT	Fecal Occult Blood Testing
FOC	Full Operational Capability
FOIA	Freedom of Information Act
FPO	Fleet Post Office
FQHC	Federally Qualified Health Center
FR	Federal Register Frozen Records
FRC	Federal Records Center
FSO	Facility Security Officer
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
GHP	Group Health Plan
GHz	Gigahertz
GIFT	Gamete Intrafallopian Transfer
GIQD	Government Inquiry of DEERS

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GP	General Practitioner
GPCI	Geographic Practice Cost Index
H/E	Health and Environment
HAC	Health Administration Center Hospital Acquired Condition
HAVEN	Home Assessment Validation and Entry
HBA	Health Benefits Advisor
HBO	Hyperbaric Oxygen Therapy
HCC	Health Care Coverage
HCDP	Health Care Delivery Program
HCF	Health Care Finder
HCFA	Health Care Financing Administration
HCG	Human Chorionic Gonadotropin
HCIL	Health Care Information Line
HCM	Hypertrophic Cardiomyopathy
HCO	Healthcare Operations Division
HCP	Health Care Provider
HCPC	Healthcare Common Procedure Code (formerly HCFA Common Procedure Code)
HCPCS	Healthcare Common Procedure Coding System (formerly HCFA Common Procedure Coding System)
HCPR	Health Care Provider Record
HCSR	Health Care Service Record
HDC	High Dose Chemotherapy
HDC/SCR	High Dose Chemotherapy with Stem Cell Rescue
HDGC	Hereditary Diffuse Gastric Cancer
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
HIAA	Health Insurance Association of America
HIC	Health Insurance Carrier
HICN	Health Insurance Claim Number
HINN	Hospital-Issued Notice Of Noncoverage
HINT	Hearing in Noise Test
HIPAA	Health Insurance Portability and Accountability Act (of 1996)

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HIPEC	Hyperthermic Intraperitoneal Chemotherapy
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 Non-Polyposis Colorectal Cancer
HOPD	Hospital Outpatient Department
HPA&E	Health Program Analysis & Evaluation
HPSA	Health Professional Shortage Area
HPV	Human Papilloma Virus
HRA	Health Reimbursement Arrangement
HRG	Health Resource Group
HRS	Heart Rhythm Society
HRT	Heidelberg Retina Tomograph Hormone Replacement Therapy
HSCRC	Health Services Cost Review Commission
HTML	HyperText Markup Language
HTTP	HyperText Transfer (Transport) Protocol
HTTPS	Hypertext Transfer (Transport) Protocol Secure
HUAM	Home Uterine Activity Monitoring
HUD	Humanitarian Use Device
HUS	Hemolytic Uremic Syndrome
HVPT	Hyperventilation Provocation Test
IA	Information Assurance
IATO	Interim Approval to Operate
IAVA	Information Assurance Vulnerability Alert
IAVB	Information Assurance Vulnerability Bulletin
IAVM	Information Assurance Vulnerability Management
IAW	In accordance with
IBD	Inflammatory Bowel Disease
IC	Individual Consideration Integrated Circuit
ICASS	International Cooperative Administrative Support Services
ICD	Implantable Cardioverter Defibrillator
ICD-9-CM	International Classification of Diseases, 9th Revision, Clinical Modification
ICF	Intermediate Care Facility
ICMP	Individual Case Management Program
ICMP-PEC	Individual Case Management Program For Persons With Extraordinary Conditions
ICN	Internal Control Number

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ICSP	Individual Corporate Services Provider
ID	Identification Identifier
IDB	Intradiscal Biacuplasty
IDD	Internal or Intervertebral Disc Decompression
IDE	Investigational Device Exemption Investigational Device
IDEA	Individuals with Disabilities Education Act
IDES	Integrated Disability Evaluation System
IDET	Intradiscal Electrothermal Therapy
IDME	Indirect Medical Education
IdP	Identity Protection
IDTA	Intradiscal Thermal Annuloplasty
IE	Interface Engine Internet Explorer
IEA	Intradiscal Electrothermal Annuloplasty
IEP	Individualized Educational Program
IFSP	Individualized Family Service Plan
IG	Implementation Guidance
IgA	Immunoglobulin A
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 Instant Message/Messaging Intramuscular
IMRT	Intensity Modulated Radiation Therapy
IND	Investigational New Drugs
INR	International Normalized Ratio Intramuscular International Normalized Ratio
INS	Immigration and Naturalization Service
IOC	Initial Operational Capability
IOD	Interface Operational Description
IOLs	Intraocular Lenses
IOM	Internet Only Manual
IORT	Intra-Operative Radiation Therapy
IP	Inpatient
IPC	Information Processing Center (outdated term, see SMC)
IPHC	Intraperitoneal Hyperthermic Chemotherapy
IPN	Intraperitoneal Nutrition
IPP	In-Person Proofing

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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
JC	Joint Commission (formerly Joint Commission on Accreditation of Healthcare Organizations (JCAHO))
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
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
LCIS	Lobular Carcinoma In Situ
LDL	Low Density Lipoprotein
LDLT	Living Donor Liver Transplantation
LDR	Low Dose Rate
LLLT	Low Level Laser Therapy
LNT	Lexical Neighborhood Test

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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 Lesion
LSN	Location Storage Number
LTC	Long-Term Care
LUPA	Low Utilization Payment Adjustment
LV	Left Ventricle [Ventricular]
LVEF	Left Ventricular Ejection Fraction
LVN	Licensed Vocational Nurse
LVRS	Lung Volume Reduction Surgery
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
MBI	Molecular Breast Imaging
MCIO	Military Criminal Investigation Organization
MCS	Managed Care Support
MCSC	Managed Care Support Contractor
MCSS	Managed Care Support Services
MCTDP	Myelomeningocele Clinical Trial Demonstration Protocol
MD	Doctor of Medicine
MDI	Mental Developmental Index Multiple Daily Injection
MDR	MHS Data Repository
MDS	Minimum Data Set
MEB	Medical Evaluation Board
MEC	Marketing and Education Committee
MEI	Medicare Economic Index
MEPS	Military Entrance Processing Station
MEPRS	Medical Expense Performance Reporting System
MET	Microcurrent Electrical Therapy
MFCC	Marriage and Family Counseling Center
MGCRB	Medicare Geographic Classification Review Board
MGIB	Montgomery GI Bill
MH	Mental Health
MHO	Medical Holdover
MHS	Military Health System

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MHSO	Managing Health Services Organization
MHSS	Military Health Services System
MI	Myocardial Infarction
MI&L	Manpower, Installations, and Logistics
MIA	Missing In Action
MIDCAB	Minimally Invasive Direct Coronary Artery Bypass
MIRE	Monochromatic Infrared Energy
MLNT	Multisyllabic Lexical Neighborhood Test
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	Magnetic Resonance Medical Review Mentally Retarded
MRA	Magnetic Resonance Angiography
MRHFP	Medicare Rural Hospital Flexibility Program
MRI	Magnetic Resonance Imaging
MRPU	Medical Retention Processing Unit
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
MUE	Medically Unlikely Edits
MV	Multivisceral (transplant)
MVS	Multiple Virtual Storage
MWR	Morale, Welfare, and Recreation
N/A	Not Applicable
N/D	No Default
NAC	National Agency Check

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NACI	National Agency Check Plus Written Inquiries
NACLC	National Agency Check with Law Enforcement and Credit
NADFM	Non-Active Duty Family Member
NARA	National Archives and Records Administration
NAS	Naval Air Station
	Non-Availability Statement
NATO	North Atlantic Treaty Organization
NAVMED	Naval Medical (Form)
NBCC	National Board of Certified Counselors
NCCI	National Correct Coding Initiatives
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
NGPL	No Government Pay List
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

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NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
NPR	Notice of Program Reimbursement
NPS	Naval Postgraduate School
NPWT	Negative Pressure Wound Therapy
NQF	National Quality Forum
NRC	Nuclear Regulatory Commission
NRS	Non-Routine [Medical] Supply
NSDSMEP	National Standards for Diabetes Self-Management Education Programs
NTIS	National Technical Information Service
NUBC	National Uniform Billing Committee
NUCC	National Uniform Claims Committee
O/ATIC	Operations/Advanced Technology Integration Center
OA	Office of Administration
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
OCMO	Office of the Chief Medical Officer
OCONUS	Outside of the Continental United States
OCR	Office of Civil Rights
OCSP	Organizational Corporate Services Provider
OCT	Optical Coherence Tomograph
OD	Optical Disk
OF	Optional Form
OGC	Office of General Counsel
OGC-AC	Office of General Counsel-Appeals, Hearings & Claims Collection Division
OGP	Other Government Program
OHI	Other Health Insurance
OHS	Office of Homeland Security
OIG	Office of Inspector General
OMB	Office of Management and Budget
OP/NSP	Operation/Non-Surgical Procedure
OPD	Outpatient Department
OPM	Office of Personnel Management
OPPS	Outpatient Prospective Payment System
OR	Operating Room

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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
PACO ₂	Partial Pressure of Carbon Dioxide
PAO ₂	Partial Pressure of Oxygen
PAK	Pancreas After Kidney (transplant)
PAP	Papanicolaou
PAT	Performance Assessment Tracking
PatID	Patient Identifier
PAVM	Pulmonary Arteriovenous Malformation
PBM	Pharmacy Benefit Manager
PC	Peritoneal Carcinomatosis Personal Computer Professional Component
PCA	Patient Controlled Analgesia
PCDIS	Purchased Care Detail Information System
PCI	Percutaneous Coronary Intervention
PCM	Primary Care Manager
PCMBN	PCM By Name
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
PDD	Percutaneous (or Plasma) Disc Decompression
PDDBI	Pervasive Developmental Disorders Behavior Inventory
PDDNOS	Pervasive Developmental Disorder Not Otherwise Specified
PDF	Portable Document Format

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PDI	Potentially Disqualifying Information
PDQ	Physicians's Data Query
PDR	Person Data Repository
PDS	Person Demographics Service
PDTS	Pharmacy Data Transaction System
PDX	Principal Diagnosis
PE	Physical Examination
PEC	Pharmacoeconomic Center
PEP	Partial Episode Payment
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
PFPWD	Program for Persons with Disabilities
Phen-Fen	Pondimin and Redux
PHI	Protected Health Information
PHIMT	Protected Health Information Management Tool
PHP	Partial Hospitalization Program
PHS	Public Health Service
PI	Program Integrity (Office)
PIA	Privacy Impact Assessment (Online)
PIC	Personnel Investigation Center
PIE	Pulsed Irrigation Evacuation
PIN	Personnel Identification Number
PIP	Personal Injury Protection Personnel Identity Protection
PIRFT	Percutaneous Intradiscal Radiofrequency Thermocoagulation (PIRFT)
PIT	PCM Information Transfer
PIV	Personal Identity Verification
PK	Public Key
PKE	Public Key Enabling
PKI	Public Key Infrastructure
PKU	Phenylketonuria
PLS	Preschool Language Scales
PM-DRG	Pediatric Modified-Diagnosis Related Group
PMPM	Per Member Per Month
PMR	Percutaneous Myocardial Laser Revascularization
PNET	Primitive Neuroectodermal Tumors
PNT	Policy Notification Transaction
POA	Power of Attorney Present On Admission

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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
PPACA	Patient Protection and Affordable Care Act
PPD	Per Patient Day
PPN	Preferred Provider Network
PPO	Preferred Provider Organization
PPP	Purchasing Power Parity
PPS	Prospective Payment System Ports, Protocols and Services
PPSM	Ports, Protocols, and Service Management
PPV	Pneumococcal Polysaccharide Vaccine
PQI	Potential Quality Indicator Potential Quality Issue
PR	Periodic Reinvestigation
PRC	Program Review Committee
PRFA	Percutaneous Radiofrequency Ablation
PRG	Peer Review Group
PRO	Peer Review Organization
ProDUR	Prospective Drug Utilization Review
PROM	Programmable Read-Only Memory
PRP	Personnel Reliability Program
PRPP	Pharmacy Redesign Pilot Project
PSA	Prime Service Area Physician Scarcity Area
PSAB	Personnel Security Appeals Board
PSCT	Peripheral Stem Cell Transplantation
PSD	Personnel Security Division
PSG	Polysomnography
PSI	Personnel Security Investigation
PST	Pacific Standard Time
PT	Pacific Time Physical Therapist Physical Therapy Prothrombin Time
PTA	Pancreas Transplant Alone Percutaneous Transluminal Angioplasty
PTC	Processed To Completion

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PTCA	Percutaneous Transluminal Coronary Angioplasty
PTK	Phototherapeutic Keratectomy
PTNS	Posterior Tibial Nerve Stimulation
PTSD	Post-Traumatic Stress Disorder
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	Radiofrequency Annuloplasty Remittance Advice
RAM	Random Access Memory
RAP	Request for Anticipated Payment
RAPIDS	Real-Time Automated Personnel Identification System
RC	Reserve Component
RCC	Recurring Credit/Debit Charge
RCN	Recoupment Case Number Refund Control Number
RCS	Report Control Symbol
RD	Regional Director Registered Dietitian
RDBMS	Relational Database Management System
RDDDB	Reportable Disease Database
REM	Rapid Eye Movement
RF	Radiofrequency
RFA	Radiofrequency Ablation
RFI	Request For Information
RFP	Request For Proposal
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

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ROM	Read-Only Memory Rough Order of Magnitude
ROT	Read-Only Table
ROTC	Reserved Officer Training Corps
ROVER	RHHI OASIS Verification
RPM	Record Processing Mode
RRA	Regional Review Authority
RTC	Residential Treatment Center
rTMS	Repetitive Transcranial Magnetic Stimulation
RUG	Resource Utilization Group
RV	Residual Volume Right Ventricle [Ventricular]
RVU	Relative Value Unit
SAAR	System Authorization Access Request
SAD	Seasonal Affective Disorder
SADMERC	Statistical Analysis Durable Medical Equipment Regional Carrier
SAFE	Sexual Assault Forensic Examination
SAO	Security Assistant Organizations
SAP	Special Access Program
SAPR	Sexual Assault Prevention and Response
SAS	Sensory Afferent Stimulation
SAT	Service Assist Team
SBCC	Service Branch Classification Code
SBI	Special Background Investigation
SCA	Service Contract Act
SCH	Sole Community Hospital
SCHIP	State Children's Health Insurance Program
SCI	Sensitive Compartmented Information Spinal Cord Injury
SCIC	Significant Change in Condition
SCOO	Special Contracts and Operations Office
SCR	Stem Cell Rescue
S/D	Security Division
SD (Form)	Secretary of Defense (Form)
SEP	Sensory Evoked Potentials
SES	Senior Executive Service
SelRes	Selected Reserve
SF	Standard Form
SGDs	Speech Generating Devices
SHCP	Supplemental Health Care Program

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SI	Sensitive Information Small Intestine (transplant) Special Indicator (code) Status Indicator
SIDS	Sudden Infant Death Syndrome
SIF	Source Input Format
SII	Special Investigative Inquiry
SI/L	Small Intestine-Live (transplant)
SIOP-ESI	Single Integrated Operational plan-Extremely Sensitive Information
SIP	System Identification Profile
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
SSDI	Social Security Disability Insurance
SSL	Secure Socket Layer
SSM	Site Security Manager
SSN	Social Security Number
SSO	Short-Stay Outlier
ST	Speech Therapy
STF	Specialized Treatment Facility
STS	Specialized Treatment Services
STSF	Specialized Treatment Service Facility
SUBID	Sub-Identifier
SUDRF	Substance Use Disorder Rehabilitation Facility
SVO	SIT Validation Office

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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
TAR	Total Ankle Replacement
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
TCSRC	Transitional Care for Service-Related Conditions
TDD	Targeted Disc Decompression
TDEFIC	TRICARE Dual Eligible Fiscal Intermediary Contract
TDP	TRICARE Dental Plan
TDY	Temporary Duty
TED	TRICARE Encounter Data
TEE	Transesophageal Echocardiograph [Echocardiography]
TEFRA	Tax Equity and Fiscal Responsibility Act
TEOB	TRICARE Explanation of Benefits
TEPRC	TRICARE Encounter Pricing (Record)
TEPRV	TRICARE Encounter Provider (Record)
TET	Tubal Embryo Transfer
TF	Transfer Factor
TFL	TRICARE For Life
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
TIP	Thermal Intradiscal Procedure
TIPS	Transjugular Intrahepatic Portosystemic Shunt
TIS	TRICARE Information Service
TLAC	TRICARE Latin America/Canada
TLC	Total Lung Capacity
TMA	TRICARE Management Activity

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TMA-A	TRICARE Management Activity - Aurora
TMAC	TRICARE Maximum Allowable Charge
TMCPA	Temporary Military Contingency Payment Adjustment
TMH	Telemental Health
TMI&S	Technology Management Integration & Standards
TMOP	TRICARE Mail Order Pharmacy
TMR	Transmyocardial Revascularization
TMS	Transcranial Magnetic Stimulation
TNEX	TRICARE Next Generation (MHS Systems)
TNP	Topical Negative Pressure
TOB	Type of Bill
TOE	Target of Evaluation
TOL	TRICARE Online
TOM	August 2002 TRICARE Operations Manual 6010.51-M February 2008 TRICARE Operations Manual 6010.56-M
TOP	TRICARE Overseas Program
TOPO	TRICARE Overseas Program Office
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
TRIAP	TRICARE Assistance Program
TRM	August 2002 TRICARE Reimbursement Manual 6010.55-M February 2008 TRICARE Reimbursement Manual 6010.58-M
TRO	TRICARE Regional Office
TRO-N	TRICARE Regional Office-North
TRO-S	TRICARE Regional Office-South
TRO-W	TRICARE Regional Office-West
TRPB	TRICARE Retail Pharmacy Benefits
TRR	TRICARE Retired Reserve
TRRx	TRICARE Retail Pharmacy
TRS	TRICARE Reserve Select

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Appendix A

Acronyms And Abbreviations

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
TTPA	Temporary Transitional Payment Adjustment
TTY	Teletypewriter
TUNA	Transurethral Needle Ablation
TYA	TRICARE Young Adult
UAE	Uterine Artery Embolization
UARS	Upper Airway Resistance Syndrome
UB	Uniform Bill
UBO	Uniform Business Office
UCBT	Umbilical Cord Blood Stem Cell Transplantation
UCC	Uniform Commercial Code Urgent Care Center
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
UPPP	Uvulopalatopharyngoplasty
URFS	Unremarried Former Spouse
URL	Universal Resource Locator
US	Ultrasound 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

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Appendix A

Acronyms And Abbreviations

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
VAC	Vacuum-Assisted Closure
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
VRDX	Reason Visit Diagnosis
VSAM	Virtual Storage Access Method
VSD	Ventricular Septal Defect
WAC	Wholesale Acquisition Cost
WAN	Wide Area Network
WATS	Wide Area Telephone Service
WC	Worker's Compensation
WEDI	Workgroup for Electronic Data Interchange
WIC	Women, Infants, and Children (Program)
WII	Wounded, Ill, and Injured
WLAN	Wireless Local Area Network
WORM	Write Once Read Many
WRAMC	Walter Reed Army Medical Center
WTC	World Trade Center
WTRR	Wire Transfer Reconciliation Report
WTU	Warrior Transition Unit
X-Linked SCID	X-Linked Severe Combined Immunodeficiency Syndrome

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Appendix A

Acronyms And Abbreviations

XML	eXtensible Markup Language
ZIFT	Zygote Intrafallopian Transfer

2D	Two Dimensional
3D	Three Dimensional

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