



OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
HEALTH AFFAIRS

16401 EAST CENTRETECH PARKWAY
AURORA, COLORADO 80011-9066

TRICARE
MANAGEMENT ACTIVITY

MB&RB

**CHANGE 61
6010.57-M
MARCH 16, 2012**

**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: COMBINED CODING AND CLARIFICATION UPDATES - 2011

CONREQ: 15443

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): See pages 3 and 4.

EFFECTIVE AND IMPLEMENTATION DATE: As indicated, otherwise upon direction of the Contracting Officer.

This change is made in conjunction with Feb 2008 TRM, Change No. 62.

**Ann N. Fazzini
Chief, Medical Benefits and
Reimbursement Branch**

**ATTACHMENT(S): 43 PAGE(S)
DISTRIBUTION: 6010.57-M**

CHANGE 61
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REMOVE PAGE(S)

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CHAPTER 5

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SUMMARY OF CHANGES

CHAPTER 1

1. Section 1.2. Added services or supplies provided by a sponsor or beneficiary, or member of the sponsor's immediate family to the Exclusions list (cannot self-prescribe).
2. Section 13.1.
 - a. Removes HCPCS Codes S3818, S3819, S3820, S3822, and S3823 as these are not reimbursable under TRICARE.
 - b. Adds HCPCS Code S8999 for reimbursement of a resuscitation bag for use by the patient on artificial respiration during power failure or other catastrophic event.

CHAPTER 5

3. Section 1.1. Revised Radiology (Diagnostic Imaging) CPT procedure codes. Changed CPT procedure code range from 73000 - 76083, 76086 - 76394, 76400, 76496 - 76499 to 73000 - 76499. Added 77071 - 77084. Removed outdated codes 76070 - 76078, and added 77078 - 77084 to bone density studies.

CHAPTER 7

4. Section 2.1. Added HPV DNA procedure codes 87620 - 87622 to the CPT procedure code range.
5. Section 2.2.
 - a. Corrects clerical errors in text under Colorectal Cancer.
 - b. Adds CPT codes 92585 and 92586 and revised language under Hearing Screenings.
6. Section 2.5. Modifies language to be consistent with language in Chapter 7, Section 2.2, under Hearing Screenings.

CHAPTER 8

7. Section 7.1. Clarification to remove the phrase "which require enteral tube feedings." This change will reduce confusion about the nutrition policy to clarify that oral nutrition therapy is allowed when medically necessary and policy is met.

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SUMMARY OF CHANGES (Continued)

CHAPTER 9

8. Section 17.1. Corrects titles to make consistent with the TRICARE Operations Manual.
9. Addendum A. Corrects the footnotes in the table, changing Santa Cruz to Santa Clara nad changing Massachusetts to Alaska.

CHAPTER 11

10. Section 3.8. Clarifies credentialing requirements for clinical psychologists to mirror those in 32 CFR 199.6(c)(3)(iii)(A).

APPENDIX A

11. Adds new acronyms.

Exclusions

Issue Date: June 1, 1999

Authority: [32 CFR 199.4\(g\)](#)

1.0 POLICY

1.1 In addition to any definitions, requirements, conditions, or limitations enumerated and described in other sections of this manual, the following specifically are excluded:

1.1.1 Services and supplies that are not medically or psychologically necessary for the diagnosis or treatment of a covered illness (including mental disorder) or injury or for the diagnosis and treatment of pregnancy or well-baby care.

1.1.2 X-ray, laboratory, and pathological services and machine diagnostic tests not related to a specific illness or injury or a definitive set of symptoms except for cancer screening allowed under the Preventive Services policy. (See [Chapter 7, Sections 2.1 and 2.2](#); and TRICARE Operations Manual (TOM) [Chapter 24, Section 6](#).)

1.1.3 Services and supplies related to inpatient stays in hospitals or other authorized institutions above the appropriate level required to provide necessary medical care.

1.1.4 Services and supplies related to an inpatient admission primarily to perform diagnostic tests, examinations, and procedures that could have been and are performed routinely on an outpatient basis.

Note: If it is determined that the diagnostic x-ray, laboratory, and pathological services and machine tests performed during such admission were medically necessary and would have been covered if performed on an outpatient basis, benefits may be extended for such diagnostic procedures only, but cost-sharing will be computed as if performed on an outpatient basis.

1.1.5 Postpartum inpatient stay of a mother for purposes of staying with the newborn infant (usually primarily for the purpose of breast feeding the infant) when the infant (but not the mother) requires the extended stay; or continued inpatient stay of a newborn infant primarily for purposes of remaining with the mother when the mother (but not the newborn infant) requires extended postpartum inpatient stay.

1.1.6 Therapeutic absences from an inpatient facility, except when such absences are specifically included in a treatment plan approved by TRICARE.

1.1.7 Custodial care. The term "custodial care", as defined in [32 CFR 199.2](#), means treatment or services, regardless of who recommends such treatment or services or where such treatment or

services are provided, that (a) can be rendered safely and reasonably by a person who is not medically skilled; or (b) is or are designed mainly to help the patient with the Activities of Daily Living (ADL). These are also known as “essentials of daily living” as defined in [32 CFR 199.2](#).

1.1.8 Domiciliary care. The term “domiciliary care”, as defined in [32 CFR 199.2](#), means care provided to a patient in an institution or homelike environment because

- Providing support for the activities of daily living in the home is not available or is unsuitable; or
- Members of the patient’s family are unwilling to provide the care.

1.1.9 Inpatient stays primarily for rest or rest cures.

1.1.10 Costs of services and supplies to the extent amounts billed are over the allowed cost or charge.

1.1.11 Services or supplies for which the beneficiary or sponsor has no legal obligation to pay; or for which no charge would be made if the beneficiary or sponsor was not eligible under TRICARE; or whenever TRICARE is a secondary payer for claims subject to the **Diagnosis** Related Group (DRG) based payment system, amounts, when combined with the primary payment, which would be in excess of charges (or the amount the provider is obligated to accept as payment in full, if it is less than the charges).

1.1.12 Services or supplies furnished without charge.

1.1.13 Services and supplies paid for, or eligible for payment, directly or indirectly by a local, state, or Federal Government, except as provided under TRICARE, or by government hospitals serving the general public, or medical care provided by a Uniformed Service medical care facility, or benefits provided under title XIX of the Social Security Act (Medicaid).

Note: This exclusion applies to services and items provided in accordance with beneficiary’s Individualized Family Service Plan (**IFSP**) as required by Part C of the Individuals with Disabilities Education Act (**IDEA**), and which are otherwise eligible under the TRICARE Basic Program or the Extended Care Health Option (ECHO) but determined not to be “medically or psychologically necessary” as that term is defined within [32 CFR 199.2](#).

1.1.14 Services and supplies provided as a part of or under a scientific or medical study, grant, or research program.

1.1.15 Unproven drugs, devices, and medical treatments or procedures (see [Section 2.1](#)).

1.1.16 Services or supplies provided or prescribed by a **sponsor or beneficiary**, member of the beneficiary’s **or sponsor’s** immediate family, or person living in the beneficiary’s or sponsor’s household.

1.1.17 Services and supplies that are (or are eligible to be) payable under another medical insurance or program, either private or governmental, such as coverage through employment or Medicare.

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, 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 8](#).)

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](#).

3.2.6 S8999 for resuscitation bag for use by the patient on artificial respiration during power failure or other catastrophic event. The bag must be Food and Drug Administration (FDA) approved, used in accordance with FDA indications, and must be prescribed by a physician.

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 -

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 - 76499, 77071 - 77084, 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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4.4.2 Detection of CAD:

- Symptomatic--evaluation of intracardiac structures (use of Magnetic Resonance (MR) coronary angiography).
- Evaluation of suspected coronary anomalies.

4.4.3 Risk assessment with prior test results (use of vasolidator perfusion CMR or dobutamine stress function CMR).

- Coronary angiography (catheterization or CT).
- Stenosis of unclear significance.

4.4.4 Structure and Function. Evaluation of ventricular and valvular function. Procedures may include Left Ventricular (LV)/Right Ventricular (RV) mass and volumes, MRA, quantification of valvular disease, and delayed contrast enhancement.

4.4.4.1 Assessment of complex congenital heart disease including anomalies of coronary circulation, great vessels, and cardiac chambers and valves.

4.4.4.2 Evaluation of LV function following Myocardial Infarction (MI) OR in heart failure patients. Patients with technically limited images from echocardiogram.

4.4.4.3 Quantification of LV function. Discordant information that is clinically significant from prior tests.

4.4.4.4 Evaluation of specific cardiomyopathies (infiltrative [amyloid, sarcoid], Hypertrophic Cardiomyopathy (HCM), or due to cardiotoxic therapies.

4.4.4.5 Characterization of native and prosthetic cardiac valves--including planimetry of stenotic disease and quantification of regurgitant disease. Patients with technically limited images from echocardiogram or Transesophageal Echocardiography (TEE).

4.4.4.6 Evaluation for Arrhythmogenic Right Ventricular Cardiomyopathy (ARVC). Patients presenting with syncope or ventricular arrhythmia.

4.4.4.7 Evaluation of myocarditis or MI with normal coronary arteries. Positive cardiac enzymes without obstructive atherosclerosis on angiography.

4.4.5 Structure and Function. Evaluation of intracardiac and extracardiac structures.

4.4.5.1 Evaluation of cardiac mass (suspected tumor or thrombus). Use of contrast for perfusion and enhancement.

4.4.5.2 Evaluation of pericardial conditions (pericardial mass, constrictive pericarditis).

4.4.5.3 Evaluation for aortic dissection.

4.4.5.4 Evaluation of pulmonary veins prior to radiofrequency ablation for atrial fibrillation. Left atrial and pulmonary venous anatomy including dimensions of veins for mapping purposes.

4.4.6 Detection of Myocardial Scar and Viability. Evaluation of myocardial scar (use of late gadolinium enhancement).

4.4.6.1 To determine the location and extent of myocardial necrosis including “no reflow” regions. Post acute MI.

4.4.6.2 To determine viability prior to revascularization. Establish likelihood of recovery of function with revascularization (Percutaneous Coronary Intervention [PCI] or Coronary Artery Bypass Graft [CABG]) or medical therapy.

4.4.6.3 To determine viability prior to revascularization. Viability assessment by Single Photon Emission Tomography (SPECT) or dobutamine echo has provided “equivocal or indeterminate” results.

4.5 MRA is covered when medically necessary, appropriate and the standard of care. (CPT³ procedure codes 70544 - 70549, 71555, 72159, 72198, 73225, 73725, and 74185.)

4.6 CT scans are covered when medically necessary, appropriate and the standard of care and all criteria stipulated in [32 CFR 199.4\(e\)](#) are met. (CPT³ procedure codes 70450 - 70498, 71250 - 71275, 72125 - 72133, 72191 - 72194, 73200 - 73206, 73700 - 73706, 74150 - 74175, 75635, and 76355 - 76380.)

4.7 TRICARE considers three-dimensional (3D) rendering (CPT³ procedure codes 76376 and 76377) medically necessary under certain circumstances (see [Section 2.1](#)).

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

4.9 Chest x-rays (CPT³ procedure codes 71010 - 71035) are covered.

4.10 Diagnostic mammography (CPT³ procedure codes 76090 - 76092/HCPCS codes G0204 - G0207) to further define breast abnormalities or other problems is covered.

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

4.12 Bone density studies (CPT³ procedure codes [77078 - 77084](#)) are covered for the following:

4.13 The diagnosis and monitoring of osteoporosis.

4.14 The diagnosis and monitoring of osteopenia.

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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, **87620 - 87622**, 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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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, orchiopey, 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 -

TRICARE Policy Manual 6010.57-M, February 1, 2008

Chapter 7, Section 2.2

Clinical Preventive Services - TRICARE Prime

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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Clinical Preventive Services - TRICARE Prime

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
<p>Colorectal Cancer (Continued):</p>	<p>Optical (Conventional) Colonoscopy for Individuals at <u>Average</u>, <u>Increased</u>, or <u>High Risk</u> for Colon Cancer (Continued):</p> <p>Increased Risk (Individuals with a family history):</p> <p>1. Once every five years for individuals with a first degree relative 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 beginning at age 40 or 10 years younger than the earliest affected relative, whichever is earlier.</p> <p>2. Once every 10 years, beginning at age 40, for individuals with a first degree relative diagnosed with sporadic colorectal cancer or an adenomatous polyp at age 60 or older, or colorectal cancer diagnosed in two second degree relatives.</p> <p>High Risk:</p> <p>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.</p> <p>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> <p>The effective date for coverage of optical colonoscopy for individuals at increased or high risk is October 6, 1997.</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>	<p>CPT¹ Level III codes 0066T or 0067T.</p>
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SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT PROCEDURE CODE
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>	CPT ¹ codes 92002, 92004, 92012, 92014, 92015, 99172, and 99173.
	<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>	
	<p>Hearing Screening: According to the American Academy of Pediatrics (AAP) and the Joint Committee on Infant Hearing (JCIH), all newborns should undergo hearing screening using evoked Otoacoustic Emissions (OAE) testing or automated Auditory Brainstem Response (ABR) testing before one month of age; preferably, before leaving the hospital. An infant who does not pass the hearing screening should undergo appropriate audiological and medical evaluations to confirm the presence of a hearing loss at no later than three months of age.</p>	CPT ¹ codes 92551 and 92585 - 92588.
	<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>	
	<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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Clinical Preventive Services - TRICARE Prime

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 -

Well-Child Care

Issue Date: April 19, 1983

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

1.0 CPT¹ PROCEDURE CODES

54150, 54160, **54161**, 81000 - 81015, 81099, 83655, 84030, 84035, 85014, 85018, 86580, 86585, 90465 - 90468, 90471 - 90474, 90476 - 90748, 92002, 92004, 92012, 92014, 92015, 92551, 92585 - 92588, 99172, 99173, 99381 - 99383, 99391 - 99393, 99460 - 99463, 99499.

2.0 DESCRIPTION

Well-child care includes routine newborn care, health supervision examinations, routine immunizations, periodic health screening, and developmental assessment in accordance with the American Academy of Pediatrics (AAP) guidelines.

3.0 POLICY

Well-child care is covered for beneficiaries from birth to age six when services are provided by the attending pediatrician, family physician, ophthalmologist or optometrist, certified Nurse Practitioner (NP), or certified Physician Assistant (PA). Well-child services are considered preventive and are subject to the same cost-sharing/copayment and authorization requirements prescribed under the TRICARE Prime and Standard Clinical Preventive Services benefits, except as described in the TRICARE Reimbursement Manual (TRM), [Chapter 2, Section 1, paragraphs 1.3.3.10 and 1.4.3](#) (see [Sections 2.1 and 2.2](#)).

4.0 POLICY CONSIDERATIONS

4.1 Visits for diagnosis or treatment of an illness or injury are not included in the well-child benefit. Benefits should be extended on the basis of the medical necessity for the services.

4.2 For children whose health screening and immunizations may not be current, payment may be made for well-child visits and immunizations up to midnight of the day prior to the day the child turns six years old, and thereafter under the TRICARE **Clinical Preventive Services benefit** (see [Sections 2.1 and 2.2](#)).

4.3 Immunizations are covered for **the** 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 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**

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Report (MMWR). Refer to the CDC's web site (<http://www.cdc.gov>) for access to the MMWRs and a current schedule of CDC recommended vaccines. 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.

Note: The procedure codes in this policy are not necessarily an all-inclusive list of vaccines currently recommended for use in the United States by the CDC's ACIP.

4.4 Well-child care for newborns includes the routine care of the newborn in the hospital, newborn circumcision, and newborn metabolic screening as recommended by the AAP. In 2005, the AAP endorsed the newborn screening report from the American College of Medical Genetics that significantly expanded metabolic screening for newborn infants. These conditions include a core panel of 28 conditions and an additional secondary panel of 25 conditions. The most recently endorsed conditions for screening are reflected in the Department of Defense/Veteran Administration (DoD/VA) Clinical Practice Guideline. Only routine well-child care for newborns is covered as part of the mother's maternity episode, i.e., a separate cost-share is not required for the infant.

Note: Male circumcision performed during newborn period (0 - 30 days) is covered. Male circumcision performed outside the newborn period due to medical complications at birth or during the newborn period that prevented performing the circumcision within the newborn period, may be covered up to 30 days after discharge. Male circumcision performed after the newborn period without medical complications at birth, may be covered if medically necessary and otherwise authorized for benefits.

4.5 Each office visit for well-child care includes the following services:

4.5.1 History and physical examination and mental health assessment.

4.5.2 Developmental and behavioral appraisal.

4.5.2.1 Height and weight should be measured regularly throughout infancy and childhood.

4.5.2.2 Head circumference should be measured for children through 24 months of age.

4.5.2.3 Sensory screening: vision, hearing (by history).

4.5.2.3.1 Eye and vision screening by primary care provider during routine examination at birth, and approximately six months of age.

4.5.2.3.2 According to the AAP and the Joint Committee on Infant Hearing (JCIH), all newborns should undergo hearing screening using evoked Otoacoustic Emissions (OAE) testing or automated Auditory Brainstem Response (ABR) testing before one month of age; preferably, before leaving the hospital. An infant who does not pass the hearing screening should undergo appropriate audiological and medical evaluations to confirm the presence of a hearing loss at no later than three months of age.

Chapter 8

Section 7.1

Nutritional Therapy

Issue Date: April 19, 1983

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

1.0 HCPCS PROCEDURE CODES

B4034 - B9999

2.0 DESCRIPTION

Nutritional therapy provides medically necessary nutrient intake for individuals with:

- Inborn errors of metabolism;
- Medical conditions of malabsorption;
- Pathologies of the alimentary or gastrointestinal tract; and/or
- Neurological or physiological conditions which require enteral tube feedings.

3.0 POLICY

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

3.1.1 Enteral nutritional therapy.

3.1.2 Parenteral nutritional therapy.

3.1.3 Oral nutritional therapy.

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

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

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

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

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Nutritional Therapy

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

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

4.0 EXCLUSIONS

4.1 Food and food substitutes.

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

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

4.4 The above exclusions apply also to prenatal care.

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

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

- END -

Chapter 9

Section 17.1

Providers

Issue Date: August 4, 1988

Authority: [32 CFR 199.6\(e\)](#)

1.0 POLICY

1.1 Services and items cost-shared through the Extended Care Health Option (ECHO) must be rendered by TRICARE authorized providers.

1.2 ECHO inpatient care providers: A provider of residential institutional care authorized under the ECHO must:

1.2.1 Be a not-for-profit organization which primarily provides services to the disabled, OR

1.2.2 Be a facility operated by the state or under state contract, AND

1.2.3 Meet all applicable licensing or certification requirements that are extant in the state, county, municipality, or other political jurisdiction in which the provider is located.

1.3 ECHO outpatient care providers. A provider of ECHO outpatient, ambulatory, or in-home services shall be:

1.3.1 An authorized provider of services as defined in [32 CFR 199.6](#), or

1.3.2 An individual, corporation, foundation, or public entity that predominantly renders services of a type uniquely allowable as a ECHO benefit and not otherwise allowable as a benefit of [32 CFR 199.4](#), that meets all applicable licensing or other regulatory requirements that are extant in the state, county, municipality, or other political jurisdiction in which the ECHO service is rendered.

1.4 Individual professional providers authorized by [32 CFR 199.6](#) for the Basic Program are also authorized providers for the ECHO. Individual professional providers who can be authorized only under the ECHO must meet all applicable licensing and other regulatory requirements that are extant in that state, county, municipality, or other political jurisdiction in which the ECHO service is rendered, or, in the absence of such licensing or regulatory requirements, as determined by the Director, TRICARE Management Activity (TMA) or designee.

1.5 For the purpose of services rendered in conjunction with Applied Behavioral Analysis (ABA) under the ECHO Special Education benefit (see [Section 9.1](#)), TRICARE-authorized providers are those that:

1.5.1 Have a current State license to provide ABA services; or

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Providers

1.5.2 Are currently State-certified as an Applied Behavioral Analyst; or

1.5.3 Where such State license or certification is not available, are certified by the Behavioral Analyst Certification Board (BACB) as either a Board Certified Behavior Analyst (**BCBA**) or a Board Certified **Assistant** Behavior Analyst (**BCaBA**); and

1.5.4 Otherwise meet all applicable requirements of TRICARE-authorized providers.

1.6 ECHO vendor. A provider of an allowable ECHO item, supply, equipment, orthotic, or device shall be deemed to be an authorized vendor for the provision of the specific item, supply, equipment, orthotic, or device when the vendor supplies such information as the Managed Care Support Contractor (MCSC) or Director, TRICARE Area Office (TAO) determines necessary to adjudicate a specific claim.

1.7 Provider requirements for the Department of Defense (DoD) Enhanced access to autism Services Demonstration are indicated in the TRICARE Operations Manual (TOM), [Chapter 18, Section 8](#).

2.0 EFFECTIVE DATE

September 1, 2005.

- END -

ECHO Home Health Care (EHHC) Benefit

The following example illustrates the process of calculating the maximum fiscal year benefit for EHHC as described in [Section 15.1, paragraph 6.8](#).

This example is based on the Fiscal Year (FY) 2012 rates for the Medicare Program; Prospective Payment System (PPS) and Consolidated Billing for Skilled Nursing Facilities (SNFs) for FY 2012; Notice published by the Centers for Medicare and Medicaid Services (CMS) in the **Federal Register** on August 8, 2011 (76 FR 48486).

STEP	DESCRIPTION	URBAN ¹	RURAL ²
1	Tables 6 and 7 Highest RUG-IV Category	RUX	RUX
2	Tables 6 and 7 Labor Component of RUX	506.32	518.02
3	Tables A and B Wage Index	1.6878	1.3962
4	Adjusted Labor Component (Step 2 x Step 3)	854.57	723.26
5	Tables 6 and 7 Non-Labor Component	230.76	236.09
6	Total RUX Daily Rate (Step 4 + Step 5)	1,085.33	959.35
7	Total FY EHHC Benefit (Step 6 x 365) ³	396,145.45	350,162.75

¹ Beneficiary resides in **Santa Clara**, CA (Core Based Statistical Area (CBSA) Code 41940).

² Beneficiary resides in rural **Alaska** (State Code 22).

³ 366 in Leap Year.

- END -

Chapter 11

Section 3.8

Clinical Psychologist

Issue Date: December 5, 1984

Authority: [32 CFR 199.6\(c\)\(3\)\(iii\)\(A\)](#)

1.0 ISSUE

Clinical Psychologist.

2.0 POLICY

2.1 To be certified as an authorized clinical psychologist, an individual must be licensed or certified by the state for the independent practice of psychology; and

2.1.1 Possess a doctoral degree in psychology from a regionally accredited university; and

2.1.2 Have two years of supervised clinical experience in psychological health services of which at least one year is post-doctoral and one year (may be the post-doctoral year) is in an organized psychological health service training program; or

2.1.3 As an alternative to paragraphs 2.1.1 and 2.1.2 be listed in the **National Register of Health Service Providers in Psychology**.

2.2 A provider has fulfilled the degree requirement if the provider holds a doctorate from a regionally accredited institution and if the doctorate (or doctorate combined with additional coursework) fulfills the licensing/certifying/registering jurisdiction's educational requirements to become a licensed/certified/registered psychologist at the independent practice level.

2.3 A provider who does not qualify as an authorized clinical psychologist is to be offered the alternative of applying for provider status under another mental health provider category or of applying for listing in the **National Register of Health Service Providers in Psychology**.

- END -

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Appendix A

Acronyms And Abbreviations

ICF	Intermediate Care Facility
ICMP	Individual Case Management Program
ICMP-PEC	Individual Case Management Program For Persons With Extraordinary Conditions
ICN	Internal Control Number
ICSP	Individual Corporate Services Provider
ID	Identification Identifier
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
IOP	Intraocular Pressure
IORT	Intra-Operative Radiation Therapy

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Appendix A

Acronyms And Abbreviations

IP	Inpatient
IPC	Information Processing Center (outdated term, see SMC)
IPHC	Intraperitoneal Hyperthermic Chemotherapy
IPN	Intraperitoneal Nutrition
IPP	In-Person Proofing
IPPS	Inpatient Prospective Payment System
IPS	Individual Pricing Summary
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
JCIH	Joint Committee on Infant Hearing
JCOS	Joint Chiefs of Staff
JFTR	Joint Federal Travel Regulations
JNI	Japanese National Insurance
JTF-GNO	Joint Task Force for Global Network Operations
JUSDAC	Joint Uniformed Services Dental Advisory Committee
JUSMAC	Joint Uniformed Services Medical Advisory Committee
JUSPAC	Joint Uniformed Services Personnel Advisory Committee
KB	Knowledge Base
KO	Contracting Officer
LAA	Limited Access Authorization
LAC	Local Agency Check
LAK	Lymphokine-Activated Killer
LAN	Local Area Network
LASER	Light Amplification by Stimulated Emission of Radiation
LCF	Long-term Care Facility

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Appendix A

Acronyms And Abbreviations

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
LOC	Letter of Consent
LOD	Letter of Denial/Revocation Line of Duty
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

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Appendix A

Acronyms And Abbreviations

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
MHSO	Managing Health Services Organization
MHSS	Military Health Services System
MI	Myocardial Infarction
MI&L	Manpower, Installations, and Logistics
MIA	Missing In Action
MIAP	Multi-Host Internet Access Portal
MIDCAB	Minimally Invasive Direct Coronary Artery Bypass
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

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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
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
NG	National Guard
NGPL	No Government Pay List
NHLBI	National Heart, Lung and Blood Institute
NHSC	National Health Service Corps
NICHHD	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

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NMOP	National Mail Order Pharmacy
NMR	Nuclear Magnetic Resonance
NMT	Nurse Massage Therapist
NOAA	National Oceanic and Atmospheric Administration
NoPP	Notice of Private Practices
NOSCASTC	National Operating Standard Cost as a Share of Total Costs
NP	Nurse Practitioner
NPDB	National Practitioner Data Bank
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
NPR	Notice of Program Reimbursement
NPS	Naval Postgraduate School
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
OAE	Otoacoustic Emissions
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

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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
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

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PCP	Primary Care Physician Primary Care Provider
PCS	Permanent Change of Station
PCSIB	Purchased Care Systems Integration Branch
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
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

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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
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

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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
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
RADDP	Remote Active Duty Dental Program
RAM	Random Access Memory
RAP	Request for Anticipated Payment
RAPIDS	Real-Time Automated Personnel Identification System
RC	Reserve Component
RCC	Recurring Credit/Debit Charge Renal Cell Carcinoma
RCCPDS	Reserve Component Common Personnel Data System
RCN	Recoupment Case Number Refund Control Number
RCS	Report Control Symbol
RD	Regional Director Registered Dietitian
RDBMS	Relational Database Management System
Rddb	Reportable Disease Database

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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
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

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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
SFTP	Secure File Transfer Protocol
SGDs	Speech Generating Devices
SHCP	Supplemental Health Care Program
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

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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
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 Program/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

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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
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

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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
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

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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
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 Thorascopic 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

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WATS	Wide Area Telephone Service
WC	Worker's Compensation
WebDOES	Web DEERS Online Enrollment System (application)
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
XML	eXtensible Markup Language
ZIFT	Zygote Intrafallopian Transfer

2D	Two Dimensional
3D	Three Dimensional

- END -

