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CHANGE 2
6010.60-M
MAY 17, 2017

PUBLICATIONS SYSTEM CHANGE TRANSMITTAL FOR
TRICARE POLICY MANUAL (TPM), APRIL 2015

The Defense Health Agency has authorized the following addition(s)/revision(s).

CHANGE TITLE: INCORPORATING T-3 PUBLISHED CHANGES INTO T2017 MANUALS

CONREQ: 18514

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): This change brings the T2017 Manuals current with the T-3 Manuals, by incorporating T-3 changes published from December 20, 2016 through March 28, 2017 and adds revisions and administrative updates.

EFFECTIVE DATE: Thirty (30) days prior to healthcare delivery.

IMPLEMENTATION DATE: Thirty (30) days prior to healthcare delivery.

This change is made in conjunction with Apr 2015 TOM, Change No. 2, Apr 2015 TRM, Change No. 2, and Apr 2015 TSM, Change No. 2.

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WHEN PRESCRIBED ACTION HAS BEEN TAKEN, FILE THIS TRANSMITTAL WITH BASIC DOCUMENT.
CHANGE 2
6010.60-M
MAY 17, 2017

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neuroendocrine tumors. The effective date is May 1, 2008. See Chapter 5, Section 3.2 for policy regarding brachytherapy/radiation therapy.

2.13 Effective April 15, 2016, Collagen Cross-linking for the treatment of corneal ectasia due to the rare disease Keratoconus is safe and effective and may be considered for cost-sharing.

2.14 Radiofrequency Ablation (RFA), when performed using an U.S. Food and Drug Administration (FDA) approved electrosurgical cutting and coagulation device, may be considered for cost-sharing for the treatment of liver metastases from gastric cancer. The effective date is June 1, 2010.

2.15 Effective September 1, 2012, the NovoTTF-100A system (HCPCS A4555 and E0766) may be cost-shared for treatment of adult patients (22 years of age or older) with recurrent glioblastoma after surgical and radiation options have been exhausted.

2.16 Effective February 4, 2011, Radiesse® Voice laryngoplasty injections may be cost-shared for the treatment of type 1 laryngeal cleft (also described as supraglottic interarytenoid defects that extend no further than the true vocal folds).

2.17 Effective November 27, 1995, Orthotopic Liver Transplantation (OLT) may be cost-shared for the treatment of Crigler-Najjar Syndrome Type I. OLT may be performed both prior to the onset of neurological symptoms or after the onset of neurological symptoms.

2.18 Effective June 5, 2013, off-label use of intravenous immune globulin for the treatment of Hashimoto’s Encephalopathy, may be considered in exceptional circumstances where there is progressive neurologic decline despite appropriate steroid therapy or where steroid therapy is contraindicated.

2.19 Effective April 30, 2009, Intrapulmonary Percussive Ventilation (IPV) may be considered for cost-sharing when the diagnosis is Cystic Fibrosis (CF). See Chapter 8, Section 16.1 for policy regarding IPVs.

2.20 Effective January 4, 2013, allogeneic hematopoietic cell transplant (CPT procedure code 38240) for the treatment of primary plasma cell leukemia.

2.21 Off-label use of Photodynamic Therapy (CPT procedure code 67221) with Visudyne (HCPCS J3396) may be considered for cost-sharing for the treatment of retinal astrocytic hamartoma in Tuberous Sclerosis. The effective date is February 1, 2008.

2.22 Effective June 25, 2014, intracranial angioplasty with stenting (CPT procedure code 61635) of the venous sinuses may be considered for cost-sharing for the treatment of pseudotumor cerebri (also known as idiopathic intracranial hypertension and benign intracranial hypertension).

2.23 Effective February 1, 2012, OLT (CPT procedure code 47135) for the treatment of Acute Intermittent Porphyria.


2.25 Effective March 31, 2005, off-label use of rituximab injections may be considered for cost-sharing for the treatment of Stiff Person Syndrome.
3.0 EXCLUSIONS

3.1 The off-label use of rituximab for the treatment of pediatric linear Immunoglobulin A (IgA) dermatosis is unproven.

3.2 Proton Beam Therapy (PBT)/radiosurgery/radiotherapy for the treatment of thymoma is unproven.

3.3 Proton Beam Radiation Therapy (PBRT) for the treatment of juvenile nasal angiofibroma is unproven.

3.4 TRICARE Overseas Program (TOP) beneficiaries are not subject to the requirements of this policy.

- END -
Musculoskeletal System

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Authority: 32 CFR 199.4(c)(2) and (c)(3)
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1.0 CPT PROCEDURE CODES

20005 - 20551, 20555 - 22328, 22510 - 22515, 22532 - 22856, 22858, 22861, 22864 - 27138, 27146 - 27178, 27181 - 29861, 29870 - 29913, 29999

2.0 HCPCS CODES

S2118, 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 microdiskectomy with allogeneic or autogeneic iliac crest grafting and anterior plating is covered for the treatment of cervical spondylosis.

4.5 Total Ankle Replacement (TAR) (CPT 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.

4.6 Core decompression of the femoral head (hip) for early (precollapse stage I or II) avascular necrosis may be considered for cost-sharing (Healthcare Common Procedure Coding System (HCPCS) code S2325).

4.7 Single-level, cervical Total Disc Replacement (cTDR) (CPT procedure code 22856) and two-level cTDR (CPT procedure code 22858) using an FDA approved cervical artificial intervertebral disc for the treatment of cervical DDD, intractable radiculopathy, and/or myelopathy is covered if the disc is used in accordance with its FDA labeled indications.

4.8 High Energy Extracorporeal Shock Wave Therapy (HESWT) for the treatment of plantar fasciitis is covered when all of the following conditions are met:

- Patients have chronic plantar fasciitis of at least six months duration;
- Patients have undergone and failed six months of appropriate conservative therapy; and
- HESWT is defined as Energy Flux Density (EFD) greater than 0.12 millijoules per square millimeter (mJ/mm²).

4.9 Meniscal allograft transplant of the knee is covered.

4.10 Hip resurfacing (CPT procedure codes 27125 and 27130, and HCPCS S2118) with an FDA approved device is proven for the treatment of Degenerative Joint Disease (DJD) of the hip in patients who are less than 65 years old and who meet all of the following criteria:

- Have chronic, persistent pain and/or disability;
- Are otherwise healthy and active;
- Have normal proximal femoral bone geometry and bone quality; and
- Would otherwise receive a conventional Total Hip Replacement (THR), but are likely to outlive a conventional THR implant system's expected life.

4.11 Minimally Invasive Surgery (CPT procedure code 27279) for treatment of sacroiliac joint pain is proven.

5.0 EXCLUSIONS

5.1 Meniscal transplant (CPT 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 (CPT procedure codes 20552 and 20553) for migraine headaches.

5.5 Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytection for nerve root or spinal cord decompression and microdissection), three or more levels (CPT procedure code 0375T) is unproven.

5.6 Removal of total disc arthroplasty (artificial disc), anterior approach, cervical, each additional interspace (CPT 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 (CPT procedure codes 22857, 22862, 0163T, 0164T, and 0165T).

5.8 Low Energy (LE) or radial ESWT for the treatment of plantar fasciitis is unproven. Any form of ESWT for the treatment of lateral epicondylitis is unproven.

5.9 XSTOP Interspinous Process Decompression System (CPT 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 (CPT 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 (CPT procedure code 29862) for the treatment of FAI is unproven.

5.12 Hip arthroscopy with femoroplasty (CPT procedure code 29914) treatment of FAI; cam lesion is unproven.

5.13 Hip arthroscopy with acetabuloplasty (CPT procedure code 29915) treatment of FAI; pincer lesion is unproven.

5.14 Hip arthroscopy with labral repair (CPT procedure code 29916) for treatment of FAI syndrome is unproven.

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

5.16 Thermal Intradiscal Procedures (TIPs) (CPT procedure codes 22526, 22527, 62287, and Healthcare Common Procedure Coding System (HCPCS) code S2348) are unproven. TIPs are also known as: Intradiscal Electrothermal Annuloplasty (IEA), Intradiscal Electrothermal Therapy (IDET), Intradiscal Thermal Annuloplasty (DTA), Percutaneous Intradiscal Radiofrequency Thermocoagulation (PIRFT), Coblation Percutaneous Disc Decompression, Nucleoplasty (also known as Percutaneous Radiofrequency (RF) Thermomodulation or Percutaneous Plasma Diskectomy), Radiofrequency Annuloplasty (RA), Intradiscal Biacuplasty (IDB), Percutaneous (or Plasma) Disc Decompression (PDD), Targeted Disc Decompression (TDD), Cervical Intradiscal RF Lesioning.

5.17 Spinal manipulation under anesthesia (CPT procedure codes 00640 and 22505) for the treatment of back pain is unproven.
5.18 Minimally Invasive Lumbar Decompression (mild*) for the treatment of Degenerative Disc Disease (DDD) and/or spinal stenosis is unproven.

5.19 ACI surgery for the repair of patellar cartilage lesions is unproven.

5.20 Athletic pubalgia surgery is unproven.

6.0 EFFECTIVE DATES

6.1 February 6, 2006, for percutaneous vertebroplasty and balloon kyphoplasty.

6.2 May 1, 2008, for TAR.

6.3 May 1, 2008, for core decompression of the femoral head.

6.4 December 24, 2012, for single-level, cTDR using an FDA approved cervical artificial intervertebral disc.

6.5 December 2, 2013, for HE ESWT for plantar fasciitis.

6.6 May 21, 2014, for hip resurfacing for treatment of DJD of the hip.

6.7 May 1, 2015, for meniscal allograft transplant of the knee.

6.8 July 27, 2015, for two-level cTDR using an FDA approved cervical artificial intervertebral disc.

6.9 August 23, 2016, Minimally Invasive Surgery (CPT procedure code 27279) for the treatment of sacroiliac joint pain is proven.
Chapter 4  Section 9.1

Cardiovascular System

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1.0 CPT PROCEDURE CODES

33010 - 33130, 33140, 33141, 33200 - 37186, 37195 - 37785, 92950 - 93272, 93303 - 93581, 93600 - 93745, 93770, 93797 - 93799, 0075T, 0076T

2.0 DESCRIPTION

The cardiovascular system involves the heart and blood vessels, by which blood is pumped and circulated through the body.

3.0 POLICY

3.1 Medically necessary services and supplies required in the diagnosis and treatment of illness or injury involving the cardiovascular system are covered.

3.2 Ventricular Assist Devices (VADs).

3.2.1 VADs (external and implantable) are covered if the device is U.S. Food and Drug Administration (FDA) approved and used in accordance with FDA approved indications.

3.2.2 VADs as destination therapy (Current Procedural Terminology (CPT) procedure code 33979) are covered if they have received approval from the FDA for that purpose and are used according to the FDA approved labeling instructions. Benefits are authorized when the procedure is performed at a TRICARE-certified heart transplantation center, a TRICARE-certified pediatric consortium heart transplantation center, or a Medicare facility which is approved for VAD implantation as destination therapy, for patients who meet all of the following conditions:

3.2.2.1 The patient has chronic end-stage heart failure (New York Heart Association Class IV end-stage left ventricular failure for at least 90 days with a life expectancy of less than two years).

3.2.2.2 The patient is not a candidate for heart transplantation.
3.2.2.3 The patient’s Class IV heart failure symptoms have failed to respond to optimal medical management, including a dietary salt restriction, diuretics, digitalis, beta-blockers, and ACE inhibitors (if tolerated) for at least 60 of the last 90 days.

3.2.2.4 The patient has Left Ventricular Ejection Fraction (LVEF) less than 25%.

3.2.2.5 The patient has demonstrated functional limitation with a peak oxygen consumption of less than 12 ml/kg/min; or the patient has a continued need for intravenous inotropic therapy owing to symptomatic hypotension, decreasing renal function, or worsening pulmonary congestion.

3.2.2.6 The patient has the appropriate body size (by device per FDA labeling) to support the VAD implantation.

3.3 Gamma and beta intracoronary radiotherapy (brachytherapy) is covered for the treatment of in-stent restenosis in native coronary arteries.

3.4 Transmyocardial Revascularization (TMR) (CPT procedures codes 33140 and 33141).

3.4.1 Coverage is available for patients with stable class III or IV angina which has been found refractory to standard medical therapy, including drug therapy at the maximum tolerated or maximum safe dosages. In addition, the angina symptoms must be caused by areas of the heart not amenable to surgical therapies such as percutaneous transluminal coronary angioplasty, stenting, coronary atherectomy or coronary bypass.

3.4.2 Coverage is limited to those uses of the laser used in performing the procedure which have been approved by the FDA for the purpose for which they are being used.

3.5 TMR as an adjunct to Coronary Artery Bypass Graft (CABG) is covered for patients with documented areas of the myocardium that are not amenable to surgical revascularization due to unsuitable anatomy.

3.6 FDA approved IDE clinical trials. See Chapter 8, Section 5.1, paragraphs 2.5 and 2.6 for policy.

3.7 Endovenous Radiofrequency Ablation (RFA)/obliteration (CPT procedure codes 36475 and 36476) and endovenous laser ablation/therapy (CPT procedure codes 36478 and 36479) for the treatment of saphenous venous reflux of named saphenous veins (which include greater, small, anterior accessory and posterior accessory) with symptomatic varicose veins and/or incompetent perforator veins is covered when:

3.7.1 One of the following indications is present:

3.7.1.1 Persistent symptoms interfering with activities of daily living in spite of conservative/non-surgical management. Symptoms include aching, cramping, burning, itching and/or swelling during activity or after prolonged standing.

3.7.1.2 Significant recurrent attacks of superficial phlebitis.

3.7.1.3 Hemorrhage from a ruptured varix.
3.7.1.4 Ulceration from venous stasis where incompetent varices are a contributing factor.

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

3.7.3 The patient’s anatomy is amenable to endovenous ablation.

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

3.8.1 There is no evidence of end-organ damage;

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

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

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

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

3.9.2 In rare clinical situations, as first line therapy.

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

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

3.10 Primary percutaneous transluminal mechanical thrombectomy (CPT procedure codes 37184 and 37185) and secondary percutaneous transluminal mechanical thrombectomy (CPT procedure code 37186) are proven and are covered for the treatment of acute limb ischemia due to peripheral arterial occlusion.

3.11 Percutaneous Transluminal Angioplasty (PTA) of the carotid artery with stenting (CPT procedure codes 37215, 0075T, and 0076T) in beneficiaries at high risk for Carotid Endarterectomy (CEA) is proven and covered when all of the following criteria are met:

3.11.1 Beneficiaries who have symptomatic Carotid Artery Stenosis (CAS) greater than 70%. 
3.11.2 Beneficiaries are at high risk for CEA due to one or more of the following significant comorbidities and/or anatomic risk factors:

- Congestive heart failure (New York Heart Association Class I, II/IV).
- Left ventricular ejection fraction of less than 30%.
- Myocardial Infarction (MI) within past 30 days.
- Unstable Angina.
- Known severe Coronary Artery Disease (CAD).
- Severe Chronic Obstructive Pulmonary Disease (COPD).
- Contralateral carotid artery occlusion.
- Contralateral laryngeal nerve palsy.
- Previous radiation therapy to the neck.
- Previous radical neck dissection.
- Previous ipsilateral endarterectomy with restenosis.
- Surgically inaccessible lesion.
- Inability to move the neck to a suitable position for surgery.
- Tracheostomy.
- Coagulopathy or other coagulation issues leading to contraindication for endarterectomy.

3.11.3 Beneficiaries who have had a disabling stroke are excluded from coverage.

3.11.4 Coverage is limited to procedures performed using FDA approved carotid artery stents and embolic protection devices.

3.11.5 The use of a distal embolic protection device is required. If deployment of the distal embolic protection device is not technically possible, then the procedure should be aborted due to the risks of CAS without distal embolic protection.

3.11.6 The degree of CAS shall be measured by duplex Doppler ultrasound or carotid artery angiography and recorded in the beneficiary’s medical records. If the stenosis is measured by ultrasound prior to the procedure, then the degree of stenosis must be confirmed by angiography at the start of the procedure. If the stenosis is determined to be less than 70% by angiography, then CAS should not proceed.
Chapter 4  Section 21.1

Eye And Ocular Adnexa

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1.0 CPT PROCEDURE CODES

0191T, 0192T, 0204T, 0253T, 0308T, 0376T, 65091 - 65755, 65772 - 66175, 66180 - 68899, 77600-77615

2.0 HCPCS PROCEDURE CODES

C1783, L8612

3.0 DESCRIPTION

The eye is the organ of vision and the ocular adnexa are the appendages or adjunct parts; i.e., eyelids, lacrimal apparatus.

4.0 POLICY

4.1 Services and supplies required in the diagnosis and treatment of illness or injury involving the eye or ocular adnexa are covered.

4.2 Phototherapeutic Keratectomy (PTK) is covered for corneal dystrophies.

4.3 Strabismus. Surgical procedures and eye examinations to correct, treat, or diagnose strabismus are covered.

4.4 Corneal transplants. A corneal transplant (keratoplasty) is a covered surgical procedure. Relaxing keratotomy to relieve astigmatism following a corneal transplant is covered.

4.5 Transpupillary thermotherapy (laser hyperthermia, Current Procedural Terminology (CPT) procedure codes 77600 - 77615), with chemotherapy, is covered for the treatment of retinoblastoma. See also Chapter 5, Section 5.1.

4.6 Intrastromal Corneal Ring Segments (Intacs®) is covered for U.S. Food and Drug Administration (FDA) approved indications for beneficiaries with keratoconus who meet all of the following criteria:
4.6.1 Are unable to achieve adequate vision using lenses or spectacles; and

4.6.2 For whom corneal transplant is the only remaining option. Coverage allowed effective July 17, 2005.

4.7 Optional ExPRESS Mini glaucoma Shunt (CPT procedure code 0192T) to reduce Intraocular Pressure (IOP) in the treatment of glaucoma, that cannot be controlled effectively with medications.

4.8 Off-label use of Photodynamic Therapy (CPT procedure code 67221) with Visudyne (HCPCS J3396) may be considered for cost-sharing for the treatment of retinal astrocytic hamartoma in Tuberous Sclerosis. The effective date is February 1, 2008.

4.9 Transpupillary thermotherapy (CPT procedure code 67299) with Plaque Radiotherapy (Brachytherapy) is covered for the treatment of choroidal melanoma. See also Chapter 5, Section 3.2.

4.10 Photodynamic Therapy for the treatment of Central Serous Chorioretinopathy in accordance with the TRICARE provisions for the treatment of rare diseases.

4.11 Implantable Miniature Telescope (IMT) is covered for FDA approved indications for beneficiaries with end-stage-related macular degeneration.

4.12 Canaloplasty for the treatment of primary open angle glaucoma (CPT procedure codes 66174 and 66175) is covered.

4.13 Insertion of anterior segment aqueous drainage device (iStent®), without extra ocular reservoir, internal approach, during cataract surgery to reduce IOP in the treatment of glaucoma, initial insertion (CPT procedure codes 0191T, 0253T, C1783, and L8612), and each additional insertion (CPT procedure code 0376T).

4.14 Collagen Cross-linking for the treatment of corneal ectasia due to the rare disease Keratoconus is safe and effective and may be considered for cost-sharing.

5.0 EXCLUSIONS

5.1 Refractive corneal surgery except as noted in paragraph 4.4 (CPT procedure codes 65760, 65765, 65767, 65770, 65771).

5.2 Eyeglasses, and contact lenses except as noted in Chapter 7, Section 6.2.

5.3 Orthokeratology.

5.4 Orthoptics, also known as visual training, vision therapy, eye exercises, eye therapy, is excluded by 32 CFR 199.4(g)(46) (CPT procedure code 92065).

5.5 Epikeratophakia for treatment of aphakia and myopia is unproven.

5.6 Transpupillary thermotherapy (CPT procedure code 67299) as primary treatment of choroidal melanoma is unproven.
5.7 Autologous serum eye drops for the treatment of dry eye syndrome, keratitis, or ocular hypertension is unproven.

6.0 EFFECTIVE DATES

6.1 April 1, 2011, coverage for Optonal ExPRESS Mini Glaucoma Shunt.

6.2 July 17, 2005 coverage for Intrastromal Corneal Ring Segments (Intacs®).

6.3 December 1, 2014, coverage for Photodynamic Therapy for Central Serous Chorioretinopathy.

6.4 February 14, 2015, coverage for Canaloplasty for the treatment of glaucoma.

6.5 June 17, 2015, coverage date for IMT.

6.6 October 7, 2015, coverage date for iStent®.

6.7 April 15, 2016, for Collagen Cross-linking for corneal ectasia due to the rare disease Keratoconus.

- END -
4.13 Radiological supervision and interpretation, percutaneous vertebroplasty or vertebral augmentation including cavity creation, per vertebral body; under fluoroscopic guidance (CPT procedure code 72291) or under CT guidance (CPT procedure code 72292) is covered.

4.14 Multislice or multidetector row CT angiography (CT, heart) (CPT codes 75571 - 75574) is covered for the following indications:

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

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

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

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

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

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

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

4.14.4.3.1 Exercise stress echocardiography.

4.14.4.3.2 Exercise stress echo with dobutamine.

4.14.4.3.3 Exercise myocardial perfusion (SPECT).

4.14.4.3.4 Pharmacologic myocardial perfusion (SPECT).

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

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

4.14.7 Presurgical evaluation prior to biventricular pacemaker placement.

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

4.14.9 Presurgical cardiovascular evaluation for patients with equivocal stress study prior to kidney or liver transplantation.
4.14.10 Presurgical evaluation prior to electrophysiologic procedure to isolate pulmonary veins for radiofrequency ablation of arrhythmia focus.

4.14.11 CT angiography for acute ischemic stroke (CPT codes 70496 and 70498) are proven when medically necessary and appropriate.

4.14.12 CT angiography for intracerebral aneurysm and subarachnoid hemorrhage (CPT codes 70496 and 70498) are proven when medically necessary and appropriate.

4.15 Transient elastography (TE) (ultrasound-based transient elastography or FibroScan®) (CPT procedure codes 0346T and 91200) for the detection and monitoring of hepatic cirrhosis in patients with chronic hepatitis C is covered.

5.0 EXCLUSIONS

5.1 Bone density studies for the routine screening of osteoporosis.

5.2 Ultrafast CT (electron beam CT (HCPCS code S8092)) to predict asymptomatic heart disease is preventive. Ultrafast CT (electron beam CT) is excluded for symptomatic patients and for screening asymptomatic patients for CAD.

5.3 MRIs (CPT procedure codes 77058 and 77059) to screen for breast cancer in asymptomatic women considered to be at low or average risk of developing breast cancer; for diagnosis of suspicious lesions to avoid biopsy, to evaluate response to neoadjuvant chemotherapy, to differentiate cysts from solid lesions.

5.4 MRIs (CPT procedure codes 76058 and 77059) to assess implant integrity or confirm implant rupture, if implants were not originally covered or coverable.

5.5 3D rendering (CPT procedure codes 76376 and 76377) for monitoring coronary artery stenosis activity in patients with angiographically confirmed CAD is unproven.

5.6 3D rendering (CPT procedure codes 76376 and 76377) for evaluating graft patency in individuals who have undergone revascularization procedures is unproven.

5.7 3D rendering (CPT 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, heart, without contrast material, with quantitative evaluation of coronary calcium (CPT 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.

5.9 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) (CPT 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.
5.10 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) (CPT 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.

5.11 CT 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) (CPT 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.

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

5.13 Radiological supervision and interpretation of percutaneous vertebroplasty (CPT procedure codes 72291 and 72292).

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

5.15 Computer-Aided Detection with breast MRI (CPT 0159T) is unproven.

5.16 Magnetic Resonance Spectroscopy (MRS), also known as NMR spectroscopy, of the brain is unproven.

5.17 Digital Breast Tomosynthesis (DBT) (CPT procedure codes 77061 and 77062) is unproven.

6.0 EFFECTIVE DATES

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

6.2 March 31, 2006, for breast MRI.

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

6.4 January 1, 2007, for CPT 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.
6.8 December 9, 2014, for TE.

- END -
• Acoustic neuromas.

• As post-operative therapy for sacral chordoma under the rare disease policy as described in Chapter 1, Section 3.1.

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

4.5.1 As primary therapy for patients with melanoma of the uveal tract, with no evidence of metastasis or extrascleral extension, and with tumors up to 24 mm in largest diameter and 14 mm in height.

4.5.2 As postoperative therapy in patients who have undergone biopsy or partial resection of the chordoma or low grade (I or II) chondrosarcoma of the basisphenoid region (skull-base chordoma or chondrosarcoma) or cervical spine.

4.6 Extracranial stereotactic radiosurgery/radiotherapy including image-guided robotic linear accelerator-based stereotactic body radiotherapy (SBRT) (CPT procedure codes 77435, 77373 and HCPCS codes G0339, G0340) and all related medically necessary services and supplies (CPT procedure code 55876) are covered for the following indication.

• Primary and metastatic lung carcinoma.
• Prostate cancer.

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

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

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

4.9 High energy neutron radiation treatment (Current Procedural Terminology (CPT) procedure codes 77422 and 77423) is covered for adenoid cystic carcinoma for the following indications:

• Unresectable, inoperable or recurrent tumors.
• Locally advanced disease.
• In situations where surgical extirpation would cause considerable morbidity.

4.10 The off-label use of Selective Internal Radiation Therapy (SIRT), also known as radioembolization, with yttrium-90 microspheres (resin or glass) for the treatment of unresectable liver tumors from metastatic breast cancer is safe, effective, and in accordance with nationally accepted standards of practice in the medical community.

5.0 EXCLUSIONS

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

5.2 Intra-Operative Radiation Therapy (IORT) is unproven.

5.3 High energy neutron radiation treatment delivery, single treatment area using a single port or parallel-opposed ports with no blocks or simple blocking (CPT procedure code 77422) is unproven (except for treatment of adenoid cystic carcinoma, see paragraph 4.9).

5.4 High energy neutron radiation treatment delivery, single treatment area using a single port or parallel-opposed ports with no blocks or simple blocking one or more isocenter(s) with coplanar or non-coplanar geometry with blocking and/or wedge, and/or compensator(s) (CPT procedure code 77423) is unproven (except for treatment of adenoid cystic carcinoma, see paragraph 4.9).

5.5 Proton Beam Therapy (PBT)/radiosurgery/radiotherapy for the treatment of thymoma is unproven.

5.6 PBT radiosurgery/radiotherapy for the treatment of inoperable non-small cell lung cancer is unproven.

6.0 EFFECTIVE DATES

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

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

6.3 October 6, 1988, for gamma beam (gamma knife) radiosurgery/radiotherapy for treatment of AVM, benign brain tumors, acoustic neuromas, pituitary adenomas, craniopharyngiomas, other tumors of the posterior fossa and pineal region tumors.

6.4 January 1, 1990, for proton beam radiosurgery/radiotherapy for soft tissue sarcoma (liposarcoma).

6.5 June 18, 1990, for proton beam radiosurgery/radiotherapy for chordomas or chondrosarcomas.

6.6 January 1, 1994, for gamma beam (gamma knife) and linear accelerator radiosurgery/radiotherapy for metastatic brain tumors.

6.7 January 1, 1996, for proton beam radiosurgery/radiotherapy for uveal melanoma.
6.8 January 1, 1996, for helium ion beam radiosurgery/radiotherapy for uveal melanoma and chordomas or chondrosarcomas.

6.9 April 1, 1996, for linear accelerator radiosurgery/radiotherapy for AVMs and acoustic neuromas.

6.10 April 26, 1996, for proton beam radiosurgery/radiotherapy for prostate cancer.

6.11 October 1, 1997, for gamma knife radiosurgery/radiotherapy for high grade gliomas (glioblastoma multiforme, anaplastic astrocytomas).


6.13 The date of FDA approval for frameless stereotaxy.

6.14 October 24, 2014, for image-guided robotic linear accelerator-based Stereotactic Body Radiation Therapy (SBRT) and all related medically necessary services and supplies for the treatment of prostate cancer.

6.15 July 4, 2014, for the off-label use of SIRT, also known as radioembolization, with yttrium-90 microspheres (resin or glass) for the treatment of unresectable liver tumors from metastatic breast cancer.

- END -
4.0 EXCLUSIONS

4.1 All services and supplies directly and or indirectly related to surgical treatment for gender dysphoria (i.e., sex gender change), to include oophorectomy and orchiectomy, except when performed to correct ambiguous genitalia, which is documented to have been present at birth (CPT procedure codes 55970 and 55980).

4.2 Cosmetic, reconstructive or plastic surgery procedures are excluded from coverage (see Chapter 4, Section 2.1).

4.3 Endocrine treatment of prepubertal children prior to Tanner Stage 2 is excluded.

5.0 EFFECTIVE DATE

October 3, 2016, for non-surgical treatment of gender dysphoria.

- END -
<table>
<thead>
<tr>
<th>SERVICES</th>
<th>FREQUENCY OR AGE INTERVAL</th>
<th>RELEVANT PROCEDURE CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiovascular Diseases:</td>
<td>Cholesterol Screening: Screen children once between the ages of 9 and 11 and again between the ages of 17 and 21. Screen men age 35 and older. Screen men and women age 20 and older who are at increased risk for coronary heart disease.</td>
<td>CPT codes 80061, 82465, 83718 - 83721, and 84478.</td>
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<tr>
<td></td>
<td>Blood Pressure Screening: At least every two years after age six.</td>
<td>See appropriate level evaluation and management codes.</td>
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<td></td>
<td>Abdominal Aortic Aneurysm (AAA): One time AAA screening by ultrasonography for men, age 65 - 75, who have ever smoked.</td>
<td>CPT code 76700 and 76775. HCPCS code G0389.</td>
</tr>
<tr>
<td>Osteoporosis:</td>
<td>Osteoporosis Screening: Screen women for osteoporosis whose fracture risk is equal to or greater than that of a 65-year-old white woman who has no additional risk factors.</td>
<td>CPT codes 76977 and 77078 - 77081. HCPCS code G0130.</td>
</tr>
<tr>
<td>Intensive Behavioral Counseling for Sexually Transmitted Infections (STIs):</td>
<td>Intensive Behavioral Counseling for STIs: Intensive behavioral counseling (counseling that lasts more than 30 minutes) for all sexually active individuals who are at increased risk for STIs is covered when rendered by a TRICARE authorized provider.</td>
<td>CPT codes 99401 - 99404. HCPCS code G0445.</td>
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<td>Prenatal Screening Tests:</td>
<td>See Chapter 4, Section 18.1.</td>
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<tr>
<td>Other:</td>
<td>School Physicals: Physical examinations required in connection with school enrollment are covered.</td>
<td>CPT codes 99383 and 99393.</td>
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<td></td>
<td>Physical Examinations Required for Travel Outside the United States – Orders Required: A physical examination provided when required in the case of a family member who is traveling outside the United States as a result of the member's assignment and such travel is being performed under orders issued by a Uniformed Service is covered. Claims must include a copy of the travel orders or other official documentation verifying the official travel requirement.</td>
<td>See appropriate level evaluation and management codes.</td>
</tr>
<tr>
<td></td>
<td>Body Measurement: For children and adolescents: Height and weight typically is measured and Body Mass Index (BMI)-for-age calculated and plotted at each primary care visit using the CDC &quot;Data Table of BMI-for-age Charts&quot;. Children/adolescents with a BMI value greater than the 85th percentile typically receive appropriate nutritional and physical activity counseling as part of the primary care visit. Head circumference typically is measured through age 24 months. For adults: Height and weight typically is measured and BMI calculated at each primary care visit. Individuals identified with a BMI of 25 or above typically receive appropriate nutritional and physical activity counseling as part of primary care visit.</td>
<td>See appropriate level evaluation and management codes.</td>
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<tr>
<td></td>
<td>Vision Care: Routine eye exam once every two years for retirees and eligible family members who are enrolled in Prime. Active Duty Family Members (ADFM)s who are enrolled in Prime may receive a routine eye exam annually (see Section 6.1).</td>
<td>CPT codes 92002, 92004, 92012, 92014, 92015, 99172, and 99173.</td>
</tr>
<tr>
<td>Note:</td>
<td>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).</td>
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</table>
Note: Routine eye exams for diabetic beneficiaries are covered as a medically necessary service and shall be adjudicated as such, rather than as a preventive benefit.

Note: When a beneficiary's eligibility status changes from Active Duty Service Member (ADSM) or Prime Active Duty Family Member (ADFM) to Prime retiree or retiree family member, the two-year time requirement between routine eye examinations will start on the date of the eligibility status change. That is, a Prime retiree or retiree family member will be eligible for a routine eye examination in the first year of the status change regardless of whether or not an examination was performed in the previous year under ADFM eligibility status. The eligibility status of the beneficiary will dictate the coverage parameters of the eye examination.

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Hearing Screening: 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.</td>
<td>See appropriate level evaluation and management codes.</td>
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<td>Patient &amp; Parent Education And Counseling:</td>
<td></td>
<td>These are expected components of good clinical practice that are integrated into the appropriate office visit at no additional charge.</td>
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<td>• Accident &amp; Injury Prevention;</td>
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<td>• Cancer surveillance;</td>
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<tr>
<td>• Depression, stress, bereavement, &amp; suicide risk assessment;</td>
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<td>• Dietary assessment &amp; nutrition;</td>
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<td>• Intimate partner violence and abuse;</td>
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<td>• Physical activity &amp; exercise;</td>
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<tr>
<td>• Promoting dental health;</td>
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<tr>
<td>• Risk reduction for skin cancer;</td>
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<tr>
<td>• Safe sexual practices; and</td>
<td></td>
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<tr>
<td>• Tobacco, alcohol and substance abuse.</td>
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</table>
Chapter 8  Section 2.1

Durable Equipment (DE): Basic Program

Issue Date: December 29, 1982
Authority: 32 CFR 199.2, 32 CFR 199.4(d)(3)(ii), and 32 CFR 199.6(c)(3)(i), (c)(3)(ii), and (c)(3)(iii)
Revision: C-2, May 17, 2017

1.0 HCPCS PROCEDURE CODES

Level II Codes E0100 - E1900, K0001 - K0547

2.0 POLICY

2.1 DE, which is a medically necessary and appropriate item, ordered by a TRICARE authorized individual professional provider for the specific use of the beneficiary, and which complies with the following DE definition and coverage criteria may be cost-shared. A TRICARE authorized individual professional provider who may order or prescribe DE is a physician, a dentist, or any TRICARE authorized allied health care professional as described in 32 CFR 199.6(c)(3)(ii) and (c)(3)(iii), when acting within the scope of their license or certification, including the following:

- Doctors of Podiatric Medicine (DPMs).
- Doctors of Optometry (ODs).
- Certified Physician Assistants (CPAs).
- Certified Clinical Nurse Specialists (CCNSs) when recognized by TRICARE as:
  - Certified Nurse Practitioners (CNPs),
  - Certified Nurse Midwives (CNMs), or
  - Certified Psychiatric Nurse Specialists (CPNSs).
- Certified Registered Nurse Anesthetists (CRNAs).
- Certified Psychiatric Nurse Specialists (CPNSs).
- Licensed Physical Therapists.
- Licensed and Registered Occupational Therapists.

2.2 Definition. As defined in the 32 CFR 199.2, DE is a medically necessary item that:

2.2.1 Can withstand repeated use;

2.2.2 Is primarily and customarily to serve a medical purpose; and

2.2.3 Is generally not useful to an individual in the absence of an illness or injury.
3.0 COVERAGE CRITERIA

3.1 Covered items that may be provided to a beneficiary as DE includes the following:

- Hospital beds.
- Iron lungs.
- Durable Medical Equipment (DME).
- Wheelchairs.
- Cardiorespiratory monitor under conditions specified in Section 2.2.

3.2 A covered DE shall be provided on a rental or purchase basis.

3.2.1 Coverage of DE shall be based on the price most advantageous to the government, taking into consideration the anticipated duration of the medically necessary need for the equipment and current price information for the type of item.

3.2.2 The cost analysis must include a comparison of the total price of the item as a monthly rental charge, a lease-purchase price, and a lump-sum purchase price and a provision for the time value of money at the rate determined by the U.S. Department of Treasury.

3.3 A prescribed item of DE that provides the medically appropriate level of performance and quality for the beneficiary’s medical condition present must be supported by adequate documentation, as defined in 32 CFR 199.2. Luxury, deluxe, immaterial, or non-essential features, which increase the cost of the item relative to a similar item without those features, based on industry standards for a particular item at the time the equipment is prescribed or replaced for a beneficiary, are not authorized. Only the “base” or “basic” model of equipment (or more cost-effective alternative equipment) shall be covered, except as authorized in paragraphs 3.6, 3.7, or 4.1.

3.4 The item of DE must be prescribed for a use consistent with required U.S. Food and Drug Administration (FDA) approved labeling for the item. When prescribed use of an item appears to be extraordinary, a signed statement from the manufacturer that a specific medical device is FDA approved for such a use is adequate evidence that the requirement of FDA approval is met.

3.5 The item of DE must not be otherwise excluded by the regulation and policy (for example, those found in 32 CFR 199.4(g), to include communication devices other than those allowed in Chapter 7, Section 23.1, eyeglasses, exercise/relaxation/comfort devices, comfort or convenience items, etc.).

3.6 Durable Medical Equipment (DME) is DE (as defined in paragraph 2.2) that meets the following additional coverage criteria:

3.6.1 It is medically appropriate to:

3.6.1.1 Improve, restore, or maintain the function of a malformed, diseased, or injured body part, or can otherwise minimize or prevent the deterioration of the beneficiary’s function or condition; or

3.6.1.2 Maximize the beneficiary’s function consistent with the beneficiary’s physiological or medical needs.
DME Customization. Customization of DME (equipment designed permanently to preclude the use of such equipment by another individual) owned by a beneficiary, and any accessory or item of supply for any such equipment, may be covered as determined by the Director (or designee) to be essential for:

- Achieving therapeutic benefit for the patient;
- Making the equipment serviceable; or
- Otherwise assuring the proper functioning of the equipment.

Wheelchairs, which otherwise meet the DE definition in paragraph 2.2, are covered to provide medically appropriate basic mobility.

Electric wheelchairs. An electric wheelchair, or TRICARE approved alternative to an electric wheelchair (e.g., scooter), may be provided in lieu of a manual wheelchair to provide basic mobility. Benefits will not be extended for the use of both an electric-powered, cart-type vehicle and an electric wheelchair during the same period of time.

Lifts. A vehicle lift, which otherwise meets the requirements of paragraph 3.3 and all other applicable provisions of this policy, may be covered when necessary to transport an otherwise authorized wheelchair (or an approved alternative). Coverage is limited to the basic model lift and must be a temporary (non-permanent/transferable) lift that transports the wheelchair itself (or an approved alternative).

Labor charges may be allowed to cover only the installation of the allowable vehicle wheelchair lift.

TRICARE does not cover transportation of beneficiaries, including to and from medical appointments, except for ambulances when medical care is provided to the individual in transit. A lift may be authorized solely to transport the wheelchair so that a traveling beneficiary may have “basic” mobility once at his or her destination.

Vehicle conversions are excluded. That is conversions such as but not limited to, raising the roof, widening the door, or permanent attachments installed (e.g., items that are non-transferable to another vehicle). Purchases and (or) conversions of personal vehicles for a wheelchair bound beneficiary fall outside the scope of the TRICARE medical benefits and, therefore, are excluded.

TRICARE’s allowable charge is based on the basic (or standard) model lift and authorized installation fees. Lifts beyond the basic (or standard) model required for transport of an authorized wheelchair are excluded from TRICARE coverage and cannot be considered in determining the TRICARE allowable costs. Beneficiaries who choose a lift other than the basic (or standard) model (i.e., luxury/deluxe) are responsible for the costs above and beyond the allowable amount of the basic lift. In such a case, the beneficiary is responsible for submitting sufficient information regarding the otherwise authorized basic model lift and costs of installation along with the itemized costs of the luxury/deluxe model and installation costs.

Note: Refer to paragraph 4.0 for TRICARE description of “any item of DE beyond the basic/standard model.”
3.7.3 Modifications of wheelchairs. Medically appropriate modifications (i.e., slight or small changes or alterations) to the wheelchair (or an approved alternative) to accommodate a particular physiological or medical need may be covered if necessary to provide basic mobility and to allow proper use of the wheelchair. When an otherwise covered wheelchair requires substantial modification, or is uniquely built to meet the special needs of a beneficiary, for basic mobility and proper use of the wheelchair, coverage may be provided only under a lump-sum purchase or rental-purchase agreement resulting in the beneficiary owning the modified wheelchair.

3.8 Repairs. Benefits are allowed for repair of beneficiary-owned DE when necessary to make the equipment functional because of reasonable wear and usage and the manufacturer’s warranty has expired, but only on the condition that the repair cost is less than the replacement cost. Coverage includes the use of a temporary replacement item provided during a reasonable period of repair.

3.9 Replacements. Benefits are allowed for replacement of beneficiary-owned DE with documentation that the DE is lost or stolen and not otherwise covered by another insurance (such as a homeowner’s policy). Replacement of beneficiary-owned DE is also allowed when the item is not functional due to normal wear, accidental damage, a change in the beneficiary’s condition, or the device has been declared adulterated by the FDA. (Exceptions exist for prosthetic devices; see Section 4.1 for more information.)

Note: Replacement is subject to review of documentation supporting why the current DE item is no longer usable/repairable and that the replacement cost is less than the repair cost.

Note: Replacement equipment is allowed only upon a new order or prescription by a TRICARE authorized individual professional provider with an explanation of the medical need.

3.9.1 When a rented item of DE is lost or stolen, the supplier is required to use modifier RA to notify the TRICARE contractor that the item has been lost or stolen, and a replacement item is being provided. Payment for the original rented item of DE that was lost or stolen is the contractual responsibility of the supplier.

3.9.2 TRICARE will not continue to pay rental fees on equipment that has been lost or stolen. Once the medically necessary DE has been replaced by the supplier and provided to the beneficiary, rental fees for the replacement item shall resume based on the continuous use provision, if applicable.

3.10 An item of DE which otherwise meets the DE benefits requirement that is essential to provide a fail-safe in-home life-support system, or that replace in-like-kind an item of equipment that is not serviceable because of normal wear, accidental damage, a change in the beneficiary’s condition, has been declared adulterated by the FDA, or is being, or has been recalled by the manufacturer, is not considered duplicate and, therefore is covered.

Note: For the purpose of this policy, “duplicate” means an item of equipment that meets the definition of DE and serves the same purpose that is served by an item of DE previously cost-shared by TRICARE. For example, various models of a stationary oxygen concentrator with no significant differences are considered duplicates, whereas stationary and portable concentrators are not considered duplicates of each other because the latter is intended to provide a beneficiary with mobility outside the home. Also for example, an electric wheelchair, which otherwise meets the definition of DE would not be duplicative of a manual wheelchair previously cost-shared by TRICARE in that the electric wheelchair provides independent mobility not provided by the manual wheelchair.
4.0 POLICY CONSIDERATION

4.1 Upgraded DE (Deluxe, Luxury, or Immaterial Features)

4.1.1 Medically Necessary Upgrades. An upgraded item of DE, which otherwise meets the DE benefit requirement and is medically necessary, is covered if the prescription specifically states the medical reason why an upgrade is necessary. For example, the beneficiary does not have the physical strength or balance required to lift a standard walker and, therefore, one with wheels is required. Equipment lacking documentation of medical necessity for the deluxe, luxury, or immaterial feature device may have the TRICARE allowed amount for the base model applied to the upgraded equipment, with the beneficiary responsible for the difference between the allowed amount for the base model and the provider's billed charges. For a wheelchair, the upgrade must be required for the beneficiary to maintain basic mobility. See the TRICARE Reimbursement Manual (TRM), Chapter 1, Section 11 of this manual for pricing and payment policy.

4.1.2 If the beneficiary prefers to upgrade an item of DE, which otherwise meets the DE benefit requirements, the beneficiary will be solely responsible for the cost that exceeds the cost of what the Government would pay for the standard equipment. The upgraded item must be within the range of services that are appropriate for the beneficiary's medical condition (e.g., beneficiaries can upgrade from a standard manual wheelchair to a power wheelchair, when there is no medical objection from the physician, but not from a walker to a wheelchair).

4.2 Beneficiary Liability

4.2.1 When the beneficiary prefers to upgrade an item of DE, which otherwise meets the DE benefit requirements, the provider may collect the charges that exceed the cost of what the Government would pay for the standard equipment, only if the beneficiary were given written notice that the item has been (or may be) denied and agrees in writing, to be financially liable for the difference between the charges for the upgraded item, and the charges for the standard item. Should the provider fail to provide written notice and receive written agreement from the beneficiary of financial liability, for network providers, the beneficiary is “held harmless” in accordance with the TRICARE Operations Manual (TOM), Chapter 5, Section 1, paragraph 2.5.1. For non-network providers, Chapter 1, Section 4.1 of this manual applies.

4.2.2 Beneficiaries are also liable for the repairs on the upgraded item/features.

Note: Deluxe, luxury, or immaterial features are items of DE that are more expensive than the item that is medically necessary. Deluxe items include comfort or convenience features that enhance standard DE equipment, but are not considered medically necessary. Comfort and convenience items are defined as those optional items, which the patient may elect at an additional charge, but are not medically necessary in the treatment of a patient's condition. These devices exceed what is medically necessary and increase the cost of the item to the Government relative to a similar item without those features.

5.0 EXCLUSIONS

5.1 DE for a beneficiary who is a patient in a type of facility that ordinarily provides the same type of DME item to its patients at no additional charge in the usual course of providing its services is excluded.
5.2 DE that is available to the beneficiary from a Uniformed Services Medical Treatment Facility (USMTF).

5.3 An item of DE that has been lost or stolen (except as provided in paragraph 3.9), or for an item under warranty, or when a DE is damaged while using the equipment in a manner inconsistent with its common use.

5.4 DE with luxury, deluxe, immaterial, or non-essential features, which increase the cost of the item relative to a similar item without those features, based on industry standards for a particular item at the time the equipment is prescribed or replaced for a beneficiary. (See paragraph 4.0 for Policy Consideration.)

5.5 Exercise, relaxation, comfort, sporting items, or sporting devices. Exercise equipment, to include wheelchairs and items primarily and customarily designed for use in sports or recreational activities, spas, whirlpools, hot tubs, swimming pools health club memberships or other such charges, or items.

5.6 Repairs of deluxe, luxury, or immaterial features of DE (except as provided in paragraph 3.8),

5.7 Repairs of DE damaged while using the equipment in a manner inconsistent with its common use.

5.8 Maintenance agreement.

5.9 Routine periodic servicing, such as testing, cleaning, regulating, and checking which the manufacturer does not require be performed by an authorized technician.

5.10 Duplicate items of otherwise allowable DE to be used solely as a back-up to currently owned or rented equipment, except as provided in paragraph 3.10.

5.11 DE must be considered durable -- can withstand repeated use. Therefore, DE does not include expendable items such as incontinent pads, diapers, ace bandages, etc. Such items are excluded from DE coverage. Refer to Section 6.1 for policy regarding supplies and dressings (consumables).

5.12 Non-medical equipment (e.g., humidifier, electric air cleaners, exercycle, safety grab bars, training equipment, etc.). See 32 CFR 199.4.

6.0 EFFECTIVE DATE

September 1, 2005.

- END -
• The pharmaceutical agent is furnished by a provider in accordance with all applicable state laws and licensing requirements.

2.2.5 Coverage may also be considered for off-label uses of drugs and biologics.

2.2.5.1 Off-label drugs and biologics must meet the definition of Off-Label Use of a Drug or Device as described in 32 CFR 199.2:

Off-Label Use of a Drug or Device. A use other than an intended use for which the prescription drug, biologic or device is legally marketed under the Federal Food, Drug, and Cosmetic Act or the Public Health Services Act. This includes any use that is not included in the approved labeling for an approved drug, licensed biologic, approved device or combination product; any use that is not included in the cleared statement of intended use for a device that has been determined by the Food and Drug Administration (FDA) to be substantially equivalent to a legally marketed predicate device and cleared for marketing; and any use of a device for which a manufacturer or distributor would be required to seek pre-market review by the FDA in order to legally include that use in the device's labeling.

2.2.5.2 Approval for reimbursement of off-label uses of drugs and biologics reimbursed by the medical program shall be provided by the contractor. The contractor shall provide approval for the reimbursement of off-label uses when the off-label use is medically necessary and demonstrations from medical literature, national organizations, or technology assessment bodies show that the off-label use of the drug or biologic is safe, effective and in accordance with nationally accepted standards of practice in the medical community. If the drug is FDA approved and the off-label use is medically necessary, supported by medical literature identified by the contractor, which indicates the drug is nationally accepted as standard practice, and is not otherwise excluded, the contractor may approve the cost-sharing for the off-label drug. Drugs provided by the TRICARE Overseas Program (TOP) shall continue to follow the policies established in Chapter 12, TRICARE Operations Manual (TOM), Chapter 24, and the TOP contract.

2.2.6 Pharmaceutical agents grandfathered by the Federal Food, Drug and Cosmetic Act of 1938 may be cost-shared as if FDA approved.

2.2.7 Insulin and related supplies may be cost-shared for known diabetic patients, even though a prescription may not be required for purchase.

2.2.8 Pharmaceutical agents with FDA “orphan drug” designation and marketing approval may be cost-shared when used in the treatment of a rare disease or condition. For the purpose of the Pharmacy Benefits Program, TRICARE adopts the FDA definition of the term “rare disease or condition.”

2.2.9 Legend vitamins may be cost-shared only when used as a specific treatment of a medical condition. In addition, prenatal vitamins that require a prescription in the United States (U.S.) may be cost-shared. Prenatal vitamins requiring a prescription are covered for prenatal care only.

2.2.10 Pharmaceutical agents intended to promote smoking cessation, including legend and Over-The-Counter (OTC) drugs, may be cost-shared when approved by Defense Health Agency (DHA) for inclusion in the DoD Smoking Cessation Program, outlined in Public Law 110-417, section 713, when
dispensed at the TRICARE Mail Order Pharmacy (TMOP) to beneficiaries deemed eligible under the aforementioned law.

2.2.11 The DoD establishes quantity limits and prior authorizations for certain pharmaceutical agents. Prior authorization request forms, criteria, and list of pharmaceutical agents with established quantity limits are available at: http://www.tricare.mil/CoveredServices/Pharmacy/Drugs/PriorAuth.aspx.

2.2.12 National Defense Authorization Act (NDAA) Fiscal Year (FY) 2015, Section 702 mandates beneficiaries to obtain select brand name maintenance medications from the TMOP or the Military Treatment Facility (MTF)/Enhanced Multi-Service Market (eMSM) pharmacy beginning October 1, 2015. Active Duty Service Members (ADSMs) are exempt. TOP TRICARE For Life (TFL) beneficiaries, with the exception of those beneficiaries residing in the U.S. territories, may not be eligible for this program. In order to be eligible they need to be residing in a country that allows use of TMOP, have prescriptions written by a U.S. licensed provider(s), and have an APO/FPO mailing address.

2.2.12.1 Maintenance medications are defined as medications prescribed for a chronic, long-term condition that is taken on a regular, recurring basis. Those maintenance medications which are clinically appropriate and cost-effective to dispense at TMOP will be included in the program as select maintenance medications. Exceptions may be granted per the following guidelines.

2.2.12.2 A refill is defined as either a subsequent filling of an original prescription under the same prescription number (or other authorization as the original prescription), or a new original prescription for the same medication, strength and form issued at or near the end date of an earlier prescription.

2.2.12.3 DHA will establish, maintain, and periodically revise and update a list of select maintenance medications accessible at http://www.health.mil/SelectDrugList and by telephone through the pharmacy contractor’s call center.

2.2.12.4 The NDAA authorizes a waiver of the mail order requirement based on patient needs and other appropriate circumstances. This waiver is obtained through an administrative override request to the TRICARE pharmacy contractor under procedures established by the Director, DHA. There is a blanket waiver for prescription medications that are for acute care needs. There is also a blanket waiver for prescriptions covered by OHI. There is a case-by-case waiver to permit prescription maintenance medication refills at a retail pharmacy when necessary due to personal need or hardship, emergency, or other special circumstances (i.e., nursing home residents).

2.2.12.5 The pharmacy contractor shall notify beneficiaries of the new rules and the mechanisms which will allow them to receive adequate medication during their transition to TMOP.

2.2.12.6 The pharmacy contractor shall provide a toll free number to assist beneficiaries in transferring their prescriptions from retail pharmacies to TMOP.

2.2.12.7 Beneficiaries shall be advised that they may receive up to two, 30-day fills at a retail pharmacy while they transition their prescription. The beneficiary shall be contacted after each of these two fills and advised that the prescription must be transferred. Requests for a third fill at retail will be blocked and the beneficiary advised to call the pharmacy contractor for assistance.
3.4 Application To Purchase Care

3.4.1 General

In order to purchase CHCBP coverage, an eligible individual must submit a CHCBP enrollment application to the contractor. The name and address of the contractor will be extensively publicized and is available through the CHCBP contractor, contractors, overseas TRICARE Service Centers (TSCs), DoD transition offices, Military Treatment Facilities (MTFs)/Enhanced Multi-Service Markets (eMSMs), and other DoD and Uniformed Services entities which provide information regarding TRICARE. A member or former member of the Uniformed Services who is eligible to purchase CHCBP may purchase self-only or family coverage. If the member or former member purchases family coverage, family members cannot purchase self-only coverage.

3.4.2 Application

3.4.2.1 Applicants for enrollment in CHCBP are required to use DoD Document (DD) Form 2837, CHCBP Application. DD Form 2837 is available electronically on the TRICARE web site (http://www.tricare.mil/Resources/Forms/Enrollment/CHCBP.aspx) and through the contractor's web site. It is also available in hardcopy from the contractor or, in overseas locations, at a TSC. Supporting eligibility documentation may be requested by the contractor.

3.4.2.2 Payment of the premium for the first quarter (three months) coverage must be submitted along with the application. Payment must be by check or money order made out to “The Treasury of the United States” or by credit card. The exact amount of the premium is available from the contractor or wherever the applicant obtains information regarding the CHCBP.

3.5 Period of Coverage

3.5.1 Limits on Coverage Periods. Coverage under the CHCBP varies depending on the category of beneficiary as listed in Figure 10.4.1-1.

3.5.2 If coverage under the CHCBP is terminated because the former beneficiary regains eligibility for TRICARE coverage under 10 USC Chapter 55 or 10 USC § 1145(a), once that eligibility for TRICARE coverage ends, CHCBP coverage is again available per Figure 10.4.1-1.

Note: If the member elects family coverage, eligibility periods for the family are identical to those for the member.

3.6 CHCBP Administration

3.6.1 General

Only TRICARE Standard and Extra benefits and procedures apply to the CHCBP.

3.6.2 Exceptions

3.6.2.1 Eligibility

The CHCBP has unique eligibility requirements as contained in paragraph 3.1.
3.6.2.2 Use of MTFs/eMSMs

CHCBP purchasers are not eligible to receive care at MTFs/eMSMs except in a medical emergency. Should emergency MTF/eMSM care be required, payment may be made to the MTF/eMSM as an authorized provider.

3.6.2.3 Beneficiary Liability

3.6.2.3.1 For purposes of CHCBP deductible and cost-sharing requirements, and catastrophic cap limits, amounts applicable to the category of beneficiary (active duty or retired) to which the CHCBP beneficiary's sponsor last belonged shall continue to apply. Because separating active duty members were not eligible for TRICARE Standard, amounts applicable to family members of active duty members shall apply to this category of beneficiary.

3.6.2.3.2 Active duty cost-shares shall apply to emancipated children and family members placed in legal custody whose sponsor is an active duty member at the time of application. If the sponsor retires during the period of coverage of the emancipated child or family member placed in legal custody, retirees' cost-shares shall apply to the beneficiary as of the date of retirement of the sponsor.

3.6.2.3.3 Former spouses shall pay retiree cost-shares the same as under TRICARE.

3.6.2.3.4 Deductible and cost-sharing amounts for the CHCBP must be met independent of TRICARE deductible and cost-sharing amounts. Any deductible and cost-sharing amounts previously paid under TRICARE cannot be carried over to the CHCBP CC&D. Similarly, CHCBP cost-shares and deductibles do not carry over to a TRICARE plan should the beneficiary regain TRICARE eligibility except for the purchase of retroactive TYA coverage (see the TRICARE Operations Manual (TOM), Chapter 25). The CHCBP contractor and the pharmacy contractor shall have an automated process to monitor CHCBP CC&D totals for accurately calculating deductible and cost-share amounts. See the TOM, Chapter 23, Section 3, for details.

3.6.2.3.5 A dependent spouse who is Medicare-eligible and is also covered under TRICARE for Life (TFL), and who then divorces their sponsor, is eligible to purchase CHCBP if they otherwise meet CHCBP requirements (including requirements to remain unmarried and not otherwise be eligible for TRICARE as a 20/20/20 or 20/20/15 former spouse). In such circumstances CHCBP is a second payor to Medicare.

3.7 Premiums

3.7.1 Rates

Premium rates are established by the Assistant Secretary of Defense (Health Affairs) (ASD(HA)) for two rate groups--individual and family. The rates are based on Federal Employee Health Benefit Program (FEHBP) employee and agency contributions required for a comparable health benefits plan, plus an administrative fee. The administrative fee, not to exceed 10% of the basic premium amount, is determined based on actual expected administrative costs for administration of the CHCBP. Premium rates may be updated annually and will be published when updated.
3.7.1 Rate Groups

3.7.1.2 Members or former members must select their rate group at the time they apply—either individual or family. If the member or former member purchases family coverage, family members cannot purchase self-only coverage. Otherwise, all other CHCBP purchasers must select the individual option.

3.7.1.3 Changing Rate Groups

Only the member or former member identified in Figure 10.4.1-1 is eligible to change rate groups.

3.7.1.3.1 Family to Individual. After purchasing coverage, the member or former member may change from family to individual at any time by notifying the contractor in writing. At that point, only the member or former member can be covered under CHCBP.

3.7.1.3.2 Individual to Family. Changes from individual to family may be made by the member or former member when one of the following qualifying events has occurred:

- The birth of a child;
- Marriage of the member or former member;
- Legal adoption of a child;
- Placement by a court of a child as a legal ward in the member’s or former member’s home; or
- A child is no longer eligible to purchase TYA coverage.

3.7.1.3.3 If one of the above qualifying events has occurred, the member or former member may change his/her coverage from individual to family, effective the date of the qualifying event, if:

- The qualifying event occurred after the initial purchase of CHCBP coverage;
- The member or former member sends a written request to the contractor no later than 60 days from the date of the qualifying event (Date Of Birth (DOB), date of marriage, etc.);
- The written request includes documentation of the qualifying event (a copy of the birth certificate, etc.) and the necessary additional premium. Premiums are to be prorated based upon the days of each type of coverage.

3.7.2 Payments

3.7.2.1 Premiums must be paid quarterly to the contractor no later than 30 days after the start of the coverage quarter.
3.7.2.2 Failure to make a premium payment as required will result in denial of continued CHCBP coverage and denial of payment for any services provided on or after the first day of the coverage quarter for which the premium payment was not paid. Beneficiaries denied coverage due to lack of premium payments will be locked out of the CHCBP as of the paid-through coverage end date, and will not be permitted to re-enroll.

4.0 EFFECTIVE DATES

4.1 October 1, 1994.

4.2 The effective coverage date for former beneficiaries not previously eligible to purchase CHCBP coverage before the NDAA for FY 2008, is no earlier than October 16, 2011.

- END -
Chapter 12

TRICARE Overseas Program (TOP)

1.0 GENERAL

1.1 The TOP is the Department of Defense’s (DoD’s) program for the delivery of health care support services overseas (all locations outside of the 50 United States (U.S.) and the District of Columbia). The delivery of health care services overseas represents a unique situation that cannot be effectively addressed by applying all of the standards that apply in the 50 U.S. and the District of Columbia. TOP blends many of the features of the TRICARE program in the U.S. while allowing for significant cultural differences unique to health care practices and services in overseas locations.

1.2 TOP provides health care coverage for all overseas beneficiaries, including Service members, eligible Reserve Component (RC) personnel, Active Duty Family Members (ADFM) (including family members of eligible RC personnel), retired military and their respective family members, and transitional survivors. This coverage applies regardless of where the services are received. TOP also provides health care coverage for stateside beneficiaries residing in the 50 U.S. or the District of Columbia (excluding beneficiaries enrolled to the Uniformed Services Family Health Plan (USFHP) and the Continued Health Care Benefit Program (CHCBP)) who receive health care in an overseas location. TOP coverage includes all dental care for Service members permanently assigned to, and receiving dental care in, a remote overseas location. TOP coverage also includes urgent and emergency dental care for Service members who are Temporary Duty/Temporary Additional Duty (TDY/TAD), in an authorized leave status, deployed or deployed on liberty in remote overseas locations. Specific TOP program eligibility and health care coverage is based upon beneficiary status, location, and enrollment elections. All beneficiaries must be eligible for TRICARE as verified via the Defense Enrollment Eligibility Reporting System (DEERS).

Note: USFHP enrollees must be authorized to receive care by their USFHP Primary Care Manager (PCM), regardless of where the care is rendered. Claims for overseas care rendered to USFHP enrollees shall be sent to the USFHP for processing and payment. Claims for overseas care rendered to CHCBP enrollees shall be sent to the CHCBP contractor for processing and payment.

1.3 TOP health care services are provided by Military Treatment Facilities (MTFs)/Enhanced Multi-Service Markets (eMSMs), MTF/eMSM Partnership Providers, and a complement of network- and non-network purchased care sector providers and institutions.

1.4 Three geographic regions have been identified for the oversight of health care delivery overseas: TRICARE Eurasia-Africa (including the European continent, the Middle East, and Africa), TRICARE Pacific (including Asia, Australia, and the islands of the Pacific and Indian Oceans), and
TRICARE Latin America and Canada (TLAC) (including Puerto Rico, the Caribbean basin, Latin America, South America, and Canada). Three TRICARE Area Offices (TAOs) have been established for these geographic regions to provide management and oversight of TOP health care delivery for eligible TRICARE beneficiaries. The TAO Directors, working in concert with the MTFs/eMSMs and their respective services, are responsible for organizing and managing health care delivery for beneficiaries in their respective regions. A single TRICARE Overseas health care support contractor (hereinafter referred to as the “TOP contractor”) supports the TAOs, MTFs/eMSMs, services, beneficiaries, and purchased care sector providers by providing or arranging for the delivery of health care services, claims processing services, and a variety of health care administrative services.

2.0 TRICARE PROGRAMS/SERVICES IN OVERSEAS LOCATIONS

2.1 The following TRICARE programs or services are available under the TOP contract: TOP Prime, TOP Prime Remote, TOP Standard, TOP TRICARE for Life (TFL), TRICARE Reserve Select (TRS), TRICARE Retired Reserve (TRR), TRICARE Plus, the Extended Care Health Option (ECHO), TRICARE Young Adult (TYA), and the Transitional Assistance Management Program (TAMP).

2.2 The following TRICARE programs or services may be available in certain overseas locations, but are not administered under the TOP contract: TRICARE Dental Program (TDP), TRICARE Retiree Dental Program (TRDP), TFL, TRICARE Pharmacy (TPharm) Program, TRICARE Active Duty Dental Program (ADDP), and the CHCBP.

2.3 TRICARE Extra is not available outside the 50 U.S. and the District of Columbia.

3.0 TOP BENEFIT POLICY

3.1 TOP benefit policy applies to the scope of services and items which may be considered for coverage by TRICARE within the intent of 32 CFR 199.4 and 32 CFR 199.5. Specifically, TRICARE may cost-share a procedure that is determined to be appropriate medical care, is medically or psychologically necessary, is not unproven as defined in 32 CFR 199.2, and the service or supply is not specifically limited in coverage or explicitly excluded by statute, regulation, or policy.

3.2 While “appropriate medical care” references the norm for medical practice in the U.S., TOP gives consideration to the significant cultural differences unique to foreign countries. The TOP contractor shall exercise reasonable judgment to accommodate cultural differences relevant to the practices and delivery of host nation health care services. Services and supplies which otherwise fall within the range of TRICARE benefits (including, but not limited to, clinical preventive services, prescription drugs, and Durable Equipment (DE)/Durable Medical Equipment (DME)) may be eligible for coverage under TOP when the diagnosis or description of illness supports the reasonableness of the procedure, service, or supply and is commonly accepted practice in an overseas location. Services and supplies, which are specifically excluded from TRICARE coverage cannot be covered under TOP simply because of cultural differences. A specific waiver is required if the service or supply would not normally be considered a TRICARE benefit. Refer to Section 1.2 for a list of authorized benefit variations for TOP.

3.3 Cultural differences may apply to things like location of care (provider comes to the patient’s home) or the manner in which care is provided (services commonly done by a provider class in the U.S. may be performed by a provider assistant or physician overseas, depending on the country). Cultural differences may also apply to the manner in which claims are submitted to TRICARE. For example, certain countries may require a separate delineation of charges for health care delivery and
administrative practices that are attendant to the delivery of health care. These charges may be payable under TRICARE if they are determined to be reasonable and customary for a particular overseas location. Also, due to cultural differences, purchased care sector providers may, and frequently do submit claims containing narrative summaries in lieu of diagnostic and/or procedural codes. These claims may be payable under TRICARE; however, the TOP contractor shall establish processes to ensure that narrative claims are converted to codes that accurately describe the services rendered and billed by the host nation provider. Fees for transplant donor searches in Germany may be reimbursed on a global flat fee basis since the German Government does not permit health care facilities to itemize such charges. Itemized fees for supplies that are related or incidental to inpatient treatment in Japanese hospitals (e.g., hospital gowns) may be reimbursed if similar supplies would be covered under reimbursement methodologies used within the U.S. In some countries, multi-specialty group practices may submit claims that do not identify the name of the provider who actually rendered the care, the individual's professional status, or the provider number. Such cultural differences in billing practices shall be accommodated for foreign multi-specialty group practices (subject to all provider licensure/certification requirements in the contract). The TOP contractor shall implement internal management controls to ensure that all payments are reasonable and customary for the location.

3.4 The TOP benefit package includes pharmacy services through the TOP contractor for drugs dispensed by purchased care sector pharmacies, institutions, and providers. TOP beneficiaries may also receive limited services through the TPharm contract, to include retail network pharmacy services (in U.S. territories) and mail order pharmacy (MOP) services. The TPharm MOP may be used by all TOP beneficiaries provided certain criteria are met, such as a U.S. credentialed provider to write the prescription and a U.S. zip coded address to ship to (Army Post Office (APO), Fleet Post Office (FPO), or Diplomatic Pouch Mail). Additionally, Service members or ADFMs assigned to U.S. Embassies/State Departments may also use TPharm MOP services. TOP beneficiaries who are covered by Other Health Insurance (OHI) with a prescription drug benefit may not use TPharm MOP services unless the OHI plan does not cover the medication needed, or the OHI coverage limit has been met. The TPharm MOP cannot ship drugs which must be refrigerated (e.g., insulin) to an address outside the 50 U.S. and the District of Columbia.

Note: The TPharm retail network pharmacy benefit is available in the 50 U.S., the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, American Samoa, and the Northern Mariana Islands.

4.0 APPLICABILITY OF TRICARE REQUIREMENTS

4.1 All TRICARE requirements set forth in the TRICARE Policy Manual (TPM), the TRICARE Reimbursement Manual (TRM), TRICARE Operations Manual (TOM), and the TRICARE Systems Manual (TSM) apply to the TOP, unless specifically waived or superseded by the TOP contract, this chapter, or the TOM, Chapter 24.

4.2 For purposes of TOP implementation, any applicable manual language that refers to “TRICARE Prime” and “TRICARE Prime Remote” shall apply to TOP Prime and TOP Prime Remote, language that refers to “Director, TRICARE Regional Offices” shall apply to TAO Directors, language that refers to “TRICARE Standard” shall apply to TOP Standard.

4.3 Waiver of rigid application of the requirements for processing review of claims has been granted by the Director, Defense Health Agency (DHA) to overcome variations between U.S. standards
of health care practice and standards of health care practice in foreign countries. Examples of these variations are:

- TOP purchased care sector providers, (both network and non-network) are not required to meet all TRICARE provider certification requirements to become a TOP host nation authorized provider; or

- Charges for taxi companies for driving physicians to accidents or private residences.

5.0 CONTRACTOR RESPONSIBILITIES

The TOP contractor shall support the best value in the coordination and delivery of health care services in overseas locations for Service member, ADFMs, and other TRICARE-eligible beneficiaries. This includes all health care services provided in an overseas location, regardless of the beneficiary's enrollment location or residence address. Contractor responsibilities under this contract include (but are not limited to) enrollment processing, purchased care sector provider certification, network development and maintenance, Beneficiary and Provider Services (BPS) (including education and marketing), MTF/eMSM optimization, medical management, fraud and abuse prevention and detection, medically-necessary patient evacuations and transfers, active duty dental care in remote overseas locations (except for U.S. territories), and claims processing. The contractor shall provide a designated Point of Contact (POC) to assist the TAO Directors or designee(s). Additionally, every stateside regional contractor shall offer traveling TOP beneficiaries use of existing toll free Health Care Finders (HCFs) numbers/services to locate a stateside TRICARE network provider. Specific contractor responsibilities are addressed in the TRICARE Manuals and in the TRICARE Overseas health care support contract. Refer to the TOM, Chapter 24 for additional TOP program instructions.

- END -