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**CHANGE 132
6010.58-M
OCTOBER 13, 2016**

**PUBLICATIONS SYSTEM CHANGE TRANSMITTAL FOR
TRICARE REIMBURSEMENT MANUAL (TRM), FEBRUARY 2008**

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

CHANGE TITLE: PREVENTIVE SERVICES ENHANCEMENTS

CONREQ: 18050

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): This change eliminates cost-shares for certain preventive services as listed in the TPM.

EFFECTIVE DATE: As Stated in the Issuance.

IMPLEMENTATION DATE: November 14, 2016.

This change is made in conjunction with Feb 2008 TOM, Change No. 195, and Feb 2008 TPM, Change No. 172.

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CHANGE 132
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REMOVE PAGE(S)

CHAPTER 2

Section 1, pages 15 through 18

Addendum A, pages 11 and 12

INSERT PAGE(S)

Section 1, pages 15 through 18

Addendum A, pages 11 and 12

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 2, Section 1

Cost-Shares And Deductibles

1.3.3.9.5 For RTCs, the cost-share for other than ADFMs shall be 25% of the TRICARE rate after it has been adjusted by the discount.

1.3.3.9.6 For institutions and for institutional services being reimbursed on the basis of the TRICARE-determined reasonable costs, the cost-share for beneficiaries other than ADFMs shall be 25% of the allowable billed charges after it has been adjusted by the discount.

Note: For all inpatient care for ADFMs, the cost-share shall continue to be either the daily charge or \$25 per stay, whichever is higher. There is no change to the requirement for the ADFM's cost-share to be applied to the institutional charges for inpatient services. If the contractor learns that the participating provider has billed a beneficiary for a greater cost-share amount, based on the provider's usual billed charges, the contractor shall notify the provider that such an action is a violation of the provider's signed agreement. (Also see [paragraph 1.3.3.4.](#)) For Prime ADFMs, the cost-share is \$0 for care provided on or after April 1, 2001.

1.3.3.10 Preventive Services

1.3.3.10.1 Based upon the NDAA for FY 2009 (Public Law 110-417, Section 711), effective for dates of service on or after October 14, 2008, no copayments or authorizations are required for the following preventive services as described in the TRICARE Policy Manual (TPM), [Chapter 7, Sections 2.1 and 2.5](#):

1.3.3.10.1.1 Colorectal cancer screening.

1.3.3.10.1.2 Breast cancer screening.

1.3.3.10.1.3 Cervical cancer screening.

1.3.3.10.1.4 Prostate cancer screening.

1.3.3.10.1.5 Immunizations.

1.3.3.10.1.6 Well-child visits for children under six years of age.

1.3.3.10.1.7 Visits for all other beneficiaries over age six when the purpose of the visit is for one or more of the covered benefits listed in [paragraphs 1.3.3.10.1.1 through 1.3.3.10.1.5](#). If one or more of the procedure codes described in the TPM, [Chapter 7, Section 2.1](#) for those preventive services listed in [paragraphs 1.3.3.10.1.1 through 1.3.3.10.1.5](#) is billed on a claim, then the cost-share is waived for the visit.

1.3.3.10.2 In addition to the services listed in [paragraph 1.3.3.10.1](#), effective January 1, 2017, cost-shares are eliminated for the services listed in the TPM, [Chapter 7, Section 2.1, paragraphs 3.1.1.1.2 and 3.1.5](#).

1.3.3.10.3 A beneficiary is not required to pay any portion of the cost of these preventive services even if the beneficiary has not satisfied the deductible for that year.

1.3.3.10.4 This waiver does not apply to any TRICARE beneficiary who is a Medicare-eligible beneficiary.

1.3.3.10.5 Appropriate cost-sharing and deductibles will apply for all other preventive services described in the TPM, Chapter 7, Section 2.1, paragraph 3.2 and Section 2.5.

1.4 TRICARE Extra

1.4.1 For Extra deductibles and cost-shares, see [Addendum A](#).

1.4.2 If non-enrolled TRICARE beneficiary receives care from a network provider out of the region of residence, and if the beneficiary has not met the fiscal year catastrophic cap, the beneficiary shall pay the Extra cost-share to the provider. The contractor for the beneficiary's residence shall process the claim under TRICARE Extra claims processing procedures if the TRICARE Encounter Provider Record (TEPRV) shows the provider to be contracted.

1.4.3 Preventive Services

1.4.3.1 Based upon the NDAA for FY 2009 (Public Law 110-417, Section 711), effective for dates of service on or after October 14, 2008, no copayments or authorizations are required for the following preventive services as described in the TPM, [Chapter 7, Sections 2.1 and 2.5](#):

1.4.3.1.1 Colorectal cancer screening.

1.4.3.1.2 Breast cancer screening.

1.4.3.1.3 Cervical cancer screening.

1.4.3.1.4 Prostate cancer screening.

1.4.3.1.5 Immunizations.

1.4.3.1.6 Well-child visits for children under six years of age.

1.4.3.1.7 Visits for all other beneficiaries over age six when the purpose of the visit is for one or more of the covered benefits listed in [paragraphs 1.4.3.1.1 through 1.4.3.1.5](#). If one or more of the procedure codes described in the TPM, [Chapter 7, Section 2.1](#) for those preventive services listed in [paragraphs 1.4.3.1.1 through 1.4.3.1.5](#) is billed on a claim, then the cost-share is waived for the visit.

1.4.3.2 In addition to the services listed in [paragraph 1.4.3.1](#), effective January 1, 2017, cost-shares are eliminated for the services listed in the TPM, [Chapter 7, Section 2.1, paragraphs 3.1.1.1.2 and 3.1.5](#).

1.4.3.3 A beneficiary is not required to pay any portion of the cost of these preventive services even if the beneficiary has not satisfied the deductible for that year.

1.4.3.4 This waiver does not apply to any TRICARE beneficiary who is a Medicare-eligible beneficiary.

1.4.3.5 Appropriate cost-sharing and deductibles will apply for all other preventive services described in the TPM, [Chapter 7, Section 2.1, paragraph 3.2 and Section 2.5](#).

1.5 Cost-Shares: Ambulance Services

1.5.1 For the basis of payment of ambulance services, see [Chapter 1, Section 14](#).

1.5.2 Outpatient. The following are beneficiary copayment/cost-sharing requirements for medically necessary ambulance services when paid on an outpatient basis:

1.5.2.1 TRICARE Prime

1.5.2.1.1 For care provided prior to April 1, 2001, for ADFMs in pay grades E-1 through E-4, \$10. For care provided on or after April 1, 2001, for ADFMs in pay grades E-1 through E-4, \$0. See [Addendum A](#) for further information.

1.5.2.1.2 For care provided prior to April 1, 2001, for ADFMs in pay grades E-5 and above, \$15. For care provided on or after April 1, 2001, for ADFMs in pay grades E-5 and above, \$0. See [Addendum A](#) for further information.

1.5.2.1.3 For retirees and their family members, \$20.

1.5.2.2 TRICARE Extra

1.5.2.2.1 A cost-share of 15% of the fee negotiated by the contractor for ADFMs.

1.5.2.2.2 A cost-share of 20% of the fee negotiated by the contractor for retirees, their family members, and survivors.

1.5.2.3 TRICARE Standard

1.5.2.3.1 A cost-share of 20% of the allowable charge for ADFMs.

1.5.2.3.2 A cost-share of 25% of the allowable charge for retirees, their family members, and survivors.

1.5.2.4 Inpatient: Non-Network Providers

1.5.2.4.1 ADFMs. No cost-share is taken for ambulance services (transfers) rendered in conjunction with an inpatient stay.

1.5.2.4.2 Other Beneficiary. The cost-share applicable to inpatient care for beneficiaries other than ADFMs is 25% of the allowable amount.

1.5.2.5 Exceptions

1.5.2.5.1 Inpatient Cost-share Applicable To Each Separate Admission

A separate cost-share amount is applicable to each separate beneficiary for each inpatient admission EXCEPT:

1.5.2.5.1.1 Any admission which is not more than 60 days from the date of the last inpatient discharge shall be treated as one inpatient confinement with the last admission for cost-share amount determination.

1.5.2.5.1.2 Certain heart and lung hospitals are excepted from cost-share requirements. See [Chapter 1, Section 27](#), entitled "Legal Obligation To Pay".

1.5.2.5.2 Inpatient Cost-Share: Maternity Care

See [paragraph 1.3.3.3](#). All admissions related to a single maternity episode shall be considered one confinement regardless of the number of days between admissions. For ADFMs, the cost-share will be applied to the first institutional claim received.

1.5.2.5.3 Special Cost-Share Provisions

1.5.2.5.3.1 For services provided prior to International Classification of Diseases, 10th Revision (ICD-10) implementation. Effective October 1, 1987, the inpatient cost-share amount from DRG-exempt institutional provider claims in the following categories cannot exceed that which would have been imposed if the service were subject to the DRG-based payment system. This will not affect ADFMs. For all other beneficiaries, the cost-share shall be the lesser of:

- That calculated according to [paragraph 1.3.3.2.2](#); or
- That calculated according to [paragraph 1.3.3.4.2](#).

1.5.2.5.3.1.1 Child Bone Marrow Transplant (BMT)

All services related to discharges involving BMT for a beneficiary less than 18 years old with International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) principal or secondary diagnosis code V42.8 and ICD-9-CM procedure codes 41.0 through 41.04, 41.06, and 41.91.

1.5.2.5.3.1.2 Child Human Immunodeficiency Virus (HIV) Seropositivity

All services related to discharges involving HIV seropositive beneficiary less than 18 years old with ICD-9-CM principal or secondary diagnosis codes 042, 079.53, and 795.71.

1.5.2.5.3.1.3 Child Cystic Fibrosis

All services related to discharges involving beneficiary less than 18 years old with ICD-9-CM principal or secondary diagnosis code 277.0 (cystic fibrosis).

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Chapter 2, Addendum A

Benefits And Beneficiary Payments Under The TRICARE Program

4.0 INPATIENT SERVICES (CONTINUED)

BENEFICIARY COPAYMENT/COST-SHARE (SEE NOTE 3)				
TRICARE BENEFITS	TRICARE PRIME PROGRAM		TRICARE EXTRA PROGRAM	TRICARE STANDARD PROGRAM
TYPE OF SERVICE	ADFM's	RETIREES, THEIR FAMILY MEMBERS, & SURVIVORS		
<p>FOR MENTAL ILLNESS With authorization, Length-of-Stay (LOS) is determined by medical and psychological necessity for inpatient mental health care for adults and children and residential treatment for children and adolescents.</p>	\$0 copayment per visit.	\$40 per diem charge. No separate copayment/cost-share for separately billed professional charges.	<p>ADFM's: \$20 per diem charge (\$25 minimum charge per admission). Retirees, their Family Members, & Survivors: Cost-share--20% of total charges (based on the fee schedule negotiated by the contractor) for institutional services, plus 20% cost-share of separately billed professional charges (based on the fee schedule negotiated by the contractor).</p>	<p>ADFM's: \$20 per diem charge (\$25 minimum charge per admission). Retirees, their Family Members, & Survivors: Inpatient High Volume Hospital: Cost-share--25% hospital specific per diem. Inpatient Low Volume Hospital: Lower of fixed daily amount or 25% hospital billed charges. RTC: Cost-share--25% of the TRICARE allowed amount. Partial Hospitalization: Cost-share--25% of the TRICARE allowed amount. Plus, 25% cost-share of allowable charges for separately billed professional charges.</p>
<p>SUBSTANCE USE TREATMENT (Inpatient, partial) With authorization, seven days for detoxification and 21 days for rehabilitation per 365 days. Maximum of one rehabilitation program per year and three per lifetime. Detoxification and rehabilitation days count toward limit for mental health benefits.</p>				
<p>PARTIAL HOSPITALIZATION-MENTAL HEALTH With authorization, up to 60 days per fiscal year (minimum hours/day of therapeutic services).</p>				

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 2, Addendum A

Benefits And Beneficiary Payments Under The TRICARE Program

5.0 POINT OF SERVICE (POS)

BENEFICIARY COPAYMENT/COST-SHARE				
TRICARE STANDARD BENEFITS	TRICARE PRIME PROGRAM		TRICARE EXTRA PROGRAM	TRICARE STANDARD PROGRAM
TYPE OF SERVICE	ADFM's	RETIREES, THEIR FAMILY MEMBERS, & SURVIVORS		
A Prime enrollee may receive services under the Point of Service option by self-referring for non-emergency care. Refer to Section 3 , for policy on the POS option.	<p>Outpatient Deductible: \$300.00 individual \$600.00 family.</p> <p>Inpatient and Outpatient Cost-Share: 50% of the allowed charges (see Note 6).</p>	<p>Outpatient Deductible: \$300.00 individual \$600.00 family.</p> <p>Inpatient and Outpatient Cost-Share: 50% of the allowed charges (see Note 6).</p>	POS option does NOT apply to TRICARE Extra beneficiaries.	POS option does NOT apply to TRICARE Standard beneficiaries.

Refer to [Section 2](#) for information on catastrophic loss protection.

Note 1: As indicated in the TPM, [Chapter 7, Section 2.2](#), there are no copayments associated with covered preventive services for TRICARE Prime beneficiaries. Effective for dates of service on or after October 14, 2008, cost-shares are **eliminated** for certain preventive services for TRICARE Standard and Extra beneficiaries, as described in [Section 1, paragraphs 1.3.3.10 and 1.4.3](#). **Effective January 1, 2017, cost-shares are eliminated for the services listed in the TPM, Chapter 7, Section 2.1, paragraphs 3.1.1.1.2 and 3.1.5.**

Note 2: For dates of service on or after March 26, 1998, under TRICARE Prime, services defined as “ancillary services” in [Section 1](#) require no copayment.

Note 3: An eligible former spouse is responsible for payment of copayment/cost-sharing amounts identical to those required for beneficiaries other than family members of active duty members.

Note 4: Eye examinations are covered under the TRICARE Prime Program's “clinical preventive services”. See the TPM, [Chapter 7, Section 2.2](#).

Note 5: The TRICARE Regional Director (RD) and Director of each TRICARE Area Office (TAO) shall be granted the authority to extend the deemed period up to 120 days, on a case-by-case or regional basis.

Note 6: TRICARE Reimbursement will be limited to 50% of the billed/allowed charges.

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