Section 4. Medical Coverage

Pages 41: Adjunctive Dental Care

Original text: Adjunctive dental benefits are available under the separate TRICARE dental programs.

Correction: Dental benefits are available under the separate TRICARE dental programs.

Page 45: Chart Title Correction: TRICARE Vision Care Coverage for Beneficiaries

Figure 4.1

Correction to Chart:

<table>
<thead>
<tr>
<th>Retirees and their Families</th>
<th>TRICARE Prime and TYA Prime</th>
<th>One routine eye exam every 24 months for ages three through five.</th>
<th>Network optometrist or ophthalmologist.</th>
</tr>
</thead>
<tbody>
<tr>
<td>TRICARE Standard, TRICARE Retired Reserve and TYA Standard</td>
<td>Routine eye exams are not covered for TRICARE Standard beneficiaries age six and older. One routine eye exam every 24-month period for beneficiaries ages three through five.</td>
<td>Network or non-network optometrist or ophthalmologist when applicable</td>
<td></td>
</tr>
</tbody>
</table>

Page 46: Infectious Disease Screening/Prophylaxis

Original text: TRICARE covers screening for infectious diseases, including hepatitis B, rubella antibodies and HIV, and screening and/or prophylaxis for tetanus, rabies, hepatitis A and B, meningococcal meningitis and tuberculosis. Routine HPV screening is not covered.

Correction: TRICARE covers screening for infectious diseases, including hepatitis B, rubella antibodies and HIV, and screening and/or prophylaxis for tetanus, rabies, hepatitis A and B, meningococcal meningitis, and tuberculosis. Human papillomavirus (HPV) testing is covered as a cervical cancer screening only when performed in conjunction with a PAP smear, also called a Pap test, and only for women aged 30 and older.

Limited Benefits

The following is a list of medical/surgical services that are covered with significant limitations. This list is not all-inclusive.

Note: Providers requesting coverage can refer to the Letter of Attestation page for additional authorization information.

- Abortions are only covered when the life of the mother would be endangered if the pregnancy were carried to term. The attending physician must certify in writing that the abortion was performed because a life-threatening condition existed. Medical documentation must be provided.

- Bariatric (weight loss) surgery such as gastric bypass, gastric stapling, gastroplasty, vertical banded gastroplasty and laparoscopic adjustable gastric banding may be covered benefits when the following conditions are met:
  - Beneficiary must be age 18 and older or have documentation of completed bone growth,

Pages 52–56: Exclusions and Limited Benefits

Correction of entire section to separate limited benefits from exclusions. The following replaces pages 52 – 56.

Note: In the original text, benefits were not identifiable as limited or excluded, making the information incorrect.
• Medical record documentation indicating previous attempts for non-surgical treatment of obesity were unsuccessful and

• Body mass index (BMI) is greater than or equal to 40 kg/m² or

• BMI is 35-39.9 kg/m² and the beneficiary has been diagnosed with one of the following comorbidities: cardiovascular disease, type 2 diabetes mellitus, obstructive sleep apnea, pickwickian syndrome, hypertension, coronary artery disease, obesity-related cardiomyopathy or pulmonary hypertension.

A pre-operative psychological evaluation and psychological testing, six hours or less, are covered benefits as part of the initial assessment to determine if the individual meets the requirements for surgery. This psychological evaluation as part of the psychological testing does not count towards the initial eight (8) outpatient behavioral health visits.

Note: Revision procedures due to noncompliance with post-operative nutrition and exercise recommendations or the beneficiary has undergone a once in a lifetime limit on weight loss surgery are excluded.

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

• Botulinum toxin type A, also known as Botox A injections are a limited benefit. Botulinum toxin type A injections may be covered for the following:
  • Prophylaxis of migraine headaches in patients 18 years of age and older, who have migraines 15 days or more per month with headache lasting four hours a day or longer.
  • Strabismus for patients 12 years of age and older.
  • Blepharospasm for patients 12 years of age and older.
  • Facial myokymia (craniofacial dystonia) for patients 12 years of age and older.
  • Oromandibular (jaw-closing) dystonia.
  • Laryngeal dystonia (spasmodic dysphonia).

• Cervical dystonia (repetitive contraction of the neck muscles) for patients 16 years and older.

• Axillary hyperhidrosis (severe underarm sweating) that cannot be managed by topical agents for patients 18 years of age and older.

• Spasticity resulting from cerebral palsy.

• Upper limb spasticity for patients 18 years of age and older.

• Sialorrhea (excessive salivation or drooling) associated with Parkinson’s disease, for patients refractory to or unable to tolerate systemic anticholinergics.

• Chronic anal fissure if unresponsive to conservative therapeutic measures.

Botulinum toxin type B, also known as Myobloc, may be covered for the treatment of sialorrhea associated with Parkinson’s disease.

Botulinum toxin injections are not covered for headaches except as noted above and not covered for myofascial pain, fibromyalgia, low back pain, palmar hyperhidrosis or urinary urge incontinence. Botox® injections are not covered when used for cosmetic procedures.

• Bras (mastectomy) are limited to two per calendar year. The initial two mastectomy bras count as two for that calendar year. The beneficiary is not eligible for her first two replacement mastectomy bras until one year later.

• Cardiac rehabilitation may be covered for hospital-based acute rehabilitation, including inpatient hospitalization and up to 36 outpatient sessions per cardiac event. One of the following events must have occurred in the preceding 12 months:
  • Myocardial infarction.
  • Coronary artery bypass graft.
  • Coronary angioplasty.
  • Percutaneous transluminal coronary angioplasty.
  • Chronic stable angina (limited to 36 sessions in a calendar year).
  • Heart valve surgery.
  • Heart transplants, to include heart-lung.
Chiropractic care coverage is limited to ADSMs and is only available at specific MTFs under the Chiropractic Care Program.

Contact lenses and Eyeglasses are covered for non-active duty service member beneficiaries for the following reasons (Note: Eyeglasses are covered for active duty service members at MTFs):

- Contact lenses for infantile glaucoma.
- Corneal or scleral lenses for treatment of keratoconus.
- Scleral lenses to retain moisture when normal tearing is not present or is inadequate.
- Corneal or scleral lenses to reduce corneal irregularities other than astigmatism.
- Contact lenses or eyeglasses for absence or loss of human lens. Replacement contact lenses or eyeglasses are covered when there is a prescription change related to the absence or loss of human lens.
- Adjustments, cleaning and repairs for eyeglasses.
- Replacement of glasses due to loss, wear or physical growth.
- Deluxe or extra features for glasses such as mirror coating, polarization or progressive lenses.
- Replenishment of disposable contact lenses, after one initial package is cost-shared, when the prescription remains unchanged.

Cosmetic, plastic or reconstructive surgery is only covered when used to restore function, correct a serious birth defect, restore body form after a serious injury, improve appearance of a severe disfigurement after cancer surgery or for breast reconstruction after cancer surgery.

Cranial orthotic devices or molding helmets are covered only for postoperative use for infants (3–18 months) who have undergone surgical correction of craniosynostosis and have moderate-to-severe residual cranial deformities. TRICARE does not cover devices and helmets for treatment of nonsynostotic positional plagiocephaly or for the treatment of craniosynostosis before surgery.

Dental care services and dental X-rays are excluded except authorized adjunctive dental care (i.e., dental care that is medically necessary in the treatment of an otherwise covered medical—not dental—condition). See “Adjunctive Dental Care” in this section.

Diagnostic genetic testing is covered if medically proven and appropriate diagnostic genetic testing results influence a patient’s medical management. Services should be billed using the appropriate Evaluation and Management codes.

Education and Training are only covered under the TRICARE ECHO program and through diabetic self-management training services. Diabetes self-management training (DSMT) services must be performed by programs approved by the American Diabetes Association® and allows up to twenty 30-minute visits in the initial year and up to four 30-minute visits for each subsequent year.

The standards of this program must meet those established by the National Standards for Diabetes Self-Management Education Program and is approved by Medicare/Medicaid. The provider’s “Certificate of Recognition” from the American Diabetes Association must accompany the claim for reimbursement.

Note: “Self-help” services are excluded from coverage.

Genetic testing is only covered when medically proven and appropriate, and when the results of the test will influence the medical management of the patient.

Hearing aids and certain repairs are covered for ADFMs who meet specific hearing loss requirements. TRICARE coverage excludes any fully implantable hearing aid that has no visible parts. However, semi-implantable hearing aids such as bone anchored hearing aids (BAHAs) may be covered for beneficiaries who meet coverage criteria.

Intelligence testing is covered only when medically necessary for the diagnosis or treatment planning of covered psychiatric disorders.

Laser/LASIK/refractive corneal surgery is covered only to relieve astigmatism following a corneal transplant.
• **Legend vitamins** specifically used to treat medical conditions may be cost-shared. In addition, prescription prenatal vitamins for prenatal care may be cost-shared.

• **Nutritional therapy** may be a covered when medically necessary and is the primary source of nutrition. Covered nutritional therapies include: enteral, parenteral and oral nutritional therapy. Additionally, intraperitoneal nutrition therapy is only covered for malnutrition as a result of end-stage renal disease. Nutritional therapy may be covered in an inpatient or outpatient setting. Enteral nutritional therapy for children less than one year of age available over the counter and not medically necessary is not a covered benefit.

• **Private hospital rooms** are not covered unless ordered for medical reasons or because a semiprivate room is not available. Hospitals that are subject to the TRICARE diagnosis-related group (DRG) payment system may provide the patient with a private room, but will receive only the standard DRG amount. The hospital may bill the patient for the extra charges if the patient requests a private room.

• **Pulmonary rehabilitation services** provided as part of a treatment program on an inpatient or outpatient basis may be covered. The pulmonary services must be proven treatment for the patient's condition. Examples of proven indications are: cardiopulmonary or pulmonary rehabilitation for pre- and post-lung transplant patients, severe Chronic Obstructive Pulmonary Disease (COPD) on an inpatient basis; and moderate and severe COPD on an outpatient basis.

• **Shoes, shoe inserts, shoe modifications, arch supports and alternative treatments** are covered only in very limited circumstances. Orthopedic shoes may be covered if they are a permanent part of a brace. For individuals with diabetes, extra-depth shoes with inserts or custom-molded shoes with inserts may be covered. Ultrasound treatment of heel spurs and/or plantar fasciitis (MendMeShop Ultrasound Therapy System®) does not meet the TRICARE coverage criteria and is not covered.

• **Wheelchairs (manual)** may be cost-shared when medically necessary. They are not covered if TRICARE has already cost-shared a power wheelchair. Medically necessary wheelchair accessories may be cost-shared. Examples include positioning wedges, contour cushions and cushions/surfaces for skin protection (e.g., ROHO® cushion).

**Exclusions**

In general, TRICARE excludes services and supplies that are not medically or psychologically necessary for the diagnosis or treatment of a covered illness (including behavioral health disorder), injury, or for the diagnosis and treatment of pregnancy or well-child care. All services and supplies (including inpatient institutional costs) related to a non-covered condition or treatment, or provided by an unauthorized provider, are excluded.

The following specific services are excluded under all circumstances. This list is not all-inclusive. Visit www.tricare.mil for additional information.

• Acupuncture.
• Alterations to living spaces.
• Artificial insemination, including in vitro fertilization, gamete intra-fallopian transfer and all other such reproductive technologies.
• Autopsy services or postmortem examinations.
• Birth control/contraceptives (non-prescription).
• Bone marrow transplants for treatment of ovarian cancer.
• Camps (e.g., for weight loss).
• Care or supplies furnished or prescribed by an immediate family member.
• Charges that providers may apply to missed or rescheduled appointments.
• Counseling services that are not medically necessary for the treatment of a diagnosed medical condition (e.g., educational, vocational and socioeconomic counseling; stress management; lifestyle modification).
• Custodial care.
• Diagnostic admission.
• Domiciliary care.
• Dyslexia treatment.
• Electrolysis.

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*ROHO® is a registered trademark of ROHO, Inc. All rights reserved.*
• Elevators or chairlifts.
• Exercise equipment, spas, whirlpools, hot tubs, swimming pools, health club memberships or other such charges or items.
• Experimental or unproven procedures.
• Food, food substitutes and nutritional supplements.
• Foot care (routine), except if required as a result of a diagnosed, systemic medical disease affecting the lower limbs, such as severe diabetes.
• General exercise programs, even if recommended by a physician and regardless of whether rendered by an authorized provider.

Inpatient stays:
• For rest or rest cures.
• To control or detain a runaway child, whether or not admission is to an authorized institution.
• To perform diagnostic tests, examinations, and procedures that could have been and are performed routinely on an outpatient basis.
• In hospitals or other authorized institutions above the appropriate level required to provide necessary medical care.

• Learning disability service
• Medications:
  • Drugs prescribed for cosmetic purposes.
  • Fluoride preparations.
  • Homeopathic and herbal preparations.
  • Multivitamins.
  • Over-the-counter products (except insulin and diabetic supplies).
• Megavitamins and orthomolecular psychiatric therapy.
• Mind expansion and elective psychotherapy.
• Naturopaths.
• Non-surgical treatment of obesity or morbid obesity.
• Personal, comfort or convenience items, such as beauty and barber services, radio, television and telephone

• Postpartum inpatient stay for a mother to stay with a newborn infant (usually primarily for the purpose of breastfeeding the infant) when the infant (but not the mother) requires the extended stay, or continued inpatient stay of a newborn infant primarily for purposes of remaining with the mother when the mother (but not the newborn infant) requires extended postpartum inpatient stay
• Preventive care, such as routine, annual or employment-requested physical examinations; routine screening procedures; or immunizations, except as provided under the clinical preventive services benefit (see “Clinical Preventive Services” earlier in this section).
• Psychiatric treatment for sexual dysfunction.
• Services and supplies:
  • Provided under a scientific or medical study, grant or research program.
  • For which the beneficiary has no legal obligation to pay or for which no charge would be made if the beneficiary or sponsor were not TRICARE-eligible.
• Furnished without charge (i.e., cannot file claims for services provided free-of-charge).
• For the treatment of obesity, such as diets, weight-loss counseling, weight-loss medications, wiring of the jaw or similar procedures (for gastric bypass see “Limitations” earlier in this section).
• Inpatient stays directed or agreed to by a court or other governmental agency (unless medically necessary).
• Required as a result of occupational disease or injury for which any benefits are payable under a workers’ compensation or similar law, whether such benefits have been applied for or paid, except if benefits provided under these laws are exhausted.
• Eligible to be fully payable under another medical insurance or program, either private or governmental, such as coverage through employment or Medicare (in such instances, TRICARE is the secondary payer for any remaining charges).
• Sex changes or sexual inadequacy treatment, with the exception of treatment of ambiguous genitalia that has been documented to be present at birth.
• Sleep Apnea Therapy/Provent® Professional nasal expiratory resistance device in the treatment of obstructive sleep apnea.

• SleepSafe™ bed.

• Sterilization reversal surgery.

• Surgery performed primarily for psychological reasons (such as psychogenic surgery).

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

• Transportation except by ambulance.

• Weight-reduction products.

• X-ray, laboratory, and pathological services and machine diagnostic tests not related to a specific illness or injury or a definitive set of symptoms, except for cancer-screening mammography, cancer screening, Pap tests and other tests allowed under the clinical preventive services benefit.

Section 5: Behavioral Health Care Services

Page 58: Outpatient Services

Original text: The following outpatient psychotherapy coverage limits apply:

• Psychotherapy—Two sessions per week, in any combination of the following types:
  • Individual (adult or child): Sixty minutes per session (may extend to 120 minutes for crisis intervention)
  • Family or conjoint: Ninety minutes per session (may extend to 180 minutes for crisis intervention)
  • Psychoanalysis (limited benefit)

Correction: The following outpatient psychotherapy coverage limits apply:

• Psychotherapy—Two sessions per week, in any combination of the following types:
  • Individual (adult or child): Sixty minutes per session (may extend to 120 minutes for crisis intervention).
  • Family or conjoint: Ninety minutes per session (may extend to 180 minutes for crisis intervention).
  • Psychoanalysis (limited benefit).
  • Group: Ninety minutes per session.
  • Collateral visits (limited benefit).

Page 59: Psychological Testing and Assessment

Original text: Psychological and/or neuropsychological testing and assessment are covered only when provided in conjunction with psychotherapy. Testing is limited to six hours per FY. TRICARE covers three substance use disorder rehabilitation treatments in a lifetime and one per benefit period. A benefit period begins with the first date of the covered treatment and ends 365 days later. For treatment meeting applicable criteria, limits may be waived and payment authorized.

Correction: Psychological and/or neuropsychological testing and assessment are covered only when provided in conjunction with psychotherapy. Testing is limited to six hours per FY. A benefit period begins with the first date of the covered treatment and ends 365 days later. For treatment meeting applicable criteria, limits may be waived and payment authorized.

Page 63: Behavioral Health Care and Other Health Insurance

Original text:

• TRICARE pays after a beneficiary’s other health insurance (OHI), including Medicare,
• employment-based coverage and other insurance policies and plans.
• If the OHI denies a claim because the beneficiary did not follow the OHI’s rules, TRICARE will also not pay.

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• If services are denied by the patient’s OHI on the basis care is not medically necessary, TRICARE benefits can only be considered after all avenues of appeal available with the OHI have been pursued.

• Prior authorization is required for those services previously listed that will be billed to TRICARE, even when the beneficiary has OHI.

Correction:

• TRICARE pays after a beneficiary’s other health insurance (OHI), including Medicare, employment-based coverage and other insurance policies and plans.

• If the OHI denies a claim because the beneficiary did not follow the OHI’s rules, TRICARE will also not pay.

• If services are denied by the patient’s OHI on the basis care is not medically necessary, TRICARE benefits can only be considered after all avenues of appeal available with the OHI have been pursued.

Section 6: Health Care Management and Administration

Page 67: Important Referral Requirement Exceptions

Original text:

• Behavioral health services provided by licensed or certified mental health counselors or pastoral counselors require a physician’s documented referral and supervision (a physician is defined as an M.D. or a D.O.).

• For outpatient services, the notification letter will include an authorization number for the approved service(s) or will provide guidance on how to appeal a denied authorization.

Correction:

• Behavioral health services provided by licensed or certified mental health counselors or pastoral counselors require a physician’s documented referral and supervision (a physician is defined as an M.D. or a D.O.).

Page 83: Health Net Conditions of Participation for Network Providers

Original text:

• Maintain professional liability coverage with limits of at least $200,000 per occurrence and $600,000 aggregate

Correction:

• Maintain professional liability coverage in accordance with your provider agreement, but generally the limits are at least $200,000 per occurrence and $600,000 aggregate

Section 7: Claims Processing and Billing Information

Page 101: TRICARE and Other Health Insurance

Original text: It is very important to ensure providers have accurate information regarding other Health Net, Inc. insurance and TRICARE coverage. Incorrect information submitted by a provider could cause unnecessary delays or denials.

Correction: It is very important to ensure providers have accurate information regarding other health insurance and TRICARE coverage. Incorrect information submitted by a provider could cause unnecessary delays or denials.

Section 8: TRICARE Reimbursement Methodologies

Page 115: Surgeon’s Services for Multiple Surgeries

Original text: Multiple surgical procedures have specific reimbursement requirements. When multiple subject to discounting are performed, the primary procedure (i.e., the procedure subject to discounting with the highest allowable rate) will be paid at 100 percent of the contracted rate.
Correction: Multiple surgical procedures have specific reimbursement requirements. When multiple surgical procedures subject to discounting are performed, the primary procedure (i.e., the procedure subject to discounting with the highest allowable rate) will be paid at 100 percent of the contracted rate.

Page 118: Filing Claims for PHPs Charges

Original text: TRICARE has adopted Medicare’s PHP reimbursement methodology for hospital-based PHPs. There are two separate APC payment rates under this reimbursement methodology:

1. Days with three services or units of service.
   - APC 0172: For days with three services with dates of service prior to January 1, 2011
   - APC 0173: For days with four or more services with a date of service on or after January 1, 2011

Correction: TRICARE has adopted Medicare's PHP reimbursement methodology for hospital-based PHPs. There are two separate APC payment rates under this reimbursement methodology:

1. Days with three services or units of service.
   - APC 0172—For dates of service prior to January 1, 2011.
   - APC 0173—For dates of service on or after January 1, 2011.

2. Days with four or more services or units of service.
   - APC 0175—For dates of service prior to January 1, 2011.
   - APC 0176—For dates of service on or after January 1, 2011.