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TRICARE
MANAGEMENT ACTIVITY

MB&RB

CHANGE 83
6010.55-M
SEPTEMBER 29, 2008

PUBLICATIONS SYSTEM CHANGE TRANSMITTAL FOR TRICARE REIMBURSEMENT MANUAL (TRM)

The TRICARE Management Activity has authorized the following addition(s)/ revision(s) to the 6010.55-M, issued August 2002.

CHANGE TITLE: MAY 2007 CONSOLIDATED CHANGE

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): This change consists primarily of administrative changes and clarifications. Also included are the following: removal of requirement to send annual renewal letters to Active Duty Service Members (ADSMs) without dependents; revises DD2642 claim form; adds language regarding NASA Astronauts; extends Noble Eagle/Enduring Freedom Reserve Family Demonstration to 2009; excludes the use of the sponsor's Social Security Number (SSN) on the Monthly Health Insurance Portability and Accountability Act (HIPAA) Complaint Report; and clarifies preauthorized requirements for TRICARE Dual Eligible Fiscal Intermediary Contract (TDEFIC) claims.

EFFECTIVE AND IMPLEMENTATION DATE: October 1, 2008.

This change is made in conjunction with Aug 2002 TOM, Change No. 72, Aug 2002 TPM, Change No. 90, and Aug 2002 TSM, Change No. 67.

Reta Michak
Chief, Office of Medical Benefits and Reimbursement Branch

ATTACHMENT(S): 2 PAGE(S)
DISTRIBUTION: 6010.55-M

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

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CHAPTER 2	
Section 1, pages 3 and 4	Section 1, pages 3 and 4

duty in support of operations that result from the terrorist attacks on the World Trade Center and the Pentagon on September 11, 2001.

(2) The cost-share is partially waived in certain cases for these beneficiaries. On claims from non-participating professional providers for services rendered to Standard beneficiaries, the allowable amount is the lesser of the billed charge or the balance billing limit (115%) of the CMAC). In these cases, the cost-share is 20% of the lesser of the CMAC or the billed charge, and the cost-share for any amounts over the CMAC that are allowed is waived. Any amounts that are allowed over the CMAC will be paid entirely by TRICARE.

(3) The exception to the deductible and cost-share requirements under Operation Noble Eagle/Operation Enduring Freedom for TRICARE Standard and Extra is effective for services rendered from September 14, 2001, through October 31, 2009.

d. For Certain Reservists. The Director, TRICARE Management Activity, may waive the individual or family deductible for dependents of a reserve component member who is called or ordered to active duty for a period of more than 30 days but less than one year in support of a contingency operation. For this purpose, a reserve component member is either a member of the reserves or National Guard member who is called or ordered to full-time federal National Guard duty. A contingency operation is defined in 10 U.S.C. 101(a)(13). Also, for this purpose a dependent is a lawful husband or wife of the member or an eligible child.

B. TRICARE Prime.

1. Copayments and enrollment fees under TRICARE Prime are subject to review and annual updating. See Chapter 2, Addendum A for additional information on the benefits and costs. In accordance with Section 752 of the National Defense Authorization Act, P.L. 106-398, for services provided on or after April 1, 2001, a $0 copayment shall be charged to TRICARE Prime ADFMs of active duty service members (ADSMs) who are enrolled in TRICARE Prime. Pharmacy copayments and Point of Service charges are not waived by the FY 2001 Authorization Act.

2. In instances where the CMAC or allowable charge is less than the copayment shown on Addendum A, network providers may only collect the lower of the allowable charge or the applicable copayment.

3. The TRICARE Prime copayment requirement for emergency room services is on a PER VISIT basis; this means that only one copayment is applicable to the entire emergency room episode, regardless of the number of providers involved in the patient's care and regardless of their status as network providers.

4. No copayments or authorizations are required for TRICARE Prime clinical preventive services which are described in the TPM, Chapter 7, Section 2.2.

5. Effective for care provided on or after March 26, 1998, Prime enrollees shall have no copayments for ancillary services in the categories listed below (normal referral and authorization provisions apply):

a. Diagnostic radiology and ultrasound services included in the CPT[1] procedure code range from 70000 through 76999, or any other code for associated contrast media;

b. Diagnostic nuclear medicine services included in the CPT[1] procedure code range from 78000 through 78999;

c. Pathology and laboratory services included in the CPT[1] procedure code range from 80000 through 89399; and

d. Cardiovascular studies included in the CPT[1] procedure code range from 93000 through 93350.

e. Venipuncture included in the CPT[1] procedure code range from 36400 - 36416.

f. Fetal monitoring for CPT[1] procedure codes 59020, 59025, and 59050.

NOTE: Contractors are not required to search their files for claims for ancillary services which were not processed according to these guidelines. The contractor shall, however, if requested by an appropriate individual, adjust specific claims under these guidelines if the date of service is on or after March 26, 1998.

6. Point of Service (POS) option. See Chapter 2, Section 3.

C. Basic Program: TRICARE Standard.

1. Deductible Amount: Outpatient Care.

a. For care rendered all eligible beneficiaries prior to April 1, 1991, or when the active duty sponsor's pay grade is E-4 or below, regardless of the date of care:

(1) Deductible, Individual: Each beneficiary is liable for the first fifty dollars ($50.00) of the TRICARE-determined allowable amount on claims for care provided in the same fiscal year.

(2) Deductible, Family: The total deductible amount for all members of a family with the same sponsor during one fiscal year shall not exceed one hundred dollars ($100.00).

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