

INTRODUCTION

GENERAL

This TRICARE and Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) Policy Manual contains operational policy necessary to efficiently implement the Code of Federal Regulations at 32 CFR 199. This manual augments the 32 CFR 199 and must be used in conjunction for complete policy information.

This Manual is subordinate to the 32 CFR 199 and superior to all other TRICARE Management Activity (TMA) administration manuals (6020.24-M; 6010.49-M, and 6010.50-M), and to all TRICARE related verbal and written policy interpretation issued by a TRICARE contractor or Uniformed Service.

Any benefit or program administration issue for which benefit or program operation policy guidance is required should be described, in writing, to: Director, Medical Benefits and Reimbursement Systems, TMA, Aurora, CO 80011-9043.

When processing for an uncovered benefit for a diagnosis or condition that meets the definition of a rare disease, the contractor shall refer the case to the TRICARE Medical Director for a determination of coverage. Refer to TRICARE/CHAMPUS Policy Manual, [Chapter 8, Section 18.2](#) for information regarding rare diseases.

ADMINISTRATIVE AND EFFECTIVE DATES

Issuance date. The date located on the 1st page of each separate policy issuance. This is the date that the issuance was initially issued by TMA.

Revision date. The revision date is at the bottom of each page that has been revised along with the change number. This is the date that TMA changed the issuance in any way. Each time an issuance is changed, the revised page and/or issuance is given a change number. The revision date and the change number together identify a unique version of the issuance on a specific subject.

Effective date. A date within the body of the text of an issuance which establishes the specific date that a policy is to be applied to benefit adjudication or in program administration. An effective date may be earlier than the issuance or revision date. This date is explicit (e.g., Effective Date: January 1, 1998). The policy effective date takes precedence over the issuance date and the revision date. In the absence of an effective date the policy or instruction is considered to have always been applicable because the newly published policy or instruction confirms the application of existing published program requirements.

Implementation date. The implementation date of a policy or instruction is not noted in the issuance as this date is determined by the terms of the contract modification between TMA and the contractor. Unless otherwise directed by TMA, contractors are not to identify

finalized claims for readjudication under revised or new policy. However, the contractor shall readjudicate any denied claim affected by the policy that is brought to the contractor's attention by any source. Pending claims and denied claims in reconsideration shall be adjudicated using the current applicable policy.

BENEFIT POLICY (CHAPTERS 1 - 8)

Benefit policy applies to the scope of services and items which may be considered for cost-sharing by the TRICARE/CHAMPUS within the intent of the CFR Chapter [199.4](#) and Chapter [199.5](#).

The current edition of the American Medical Association's Physicians' Current Procedural Terminology (CPT) is incorporated by reference into this Manual to describe the scope of services potentially allowable as a benefit, subject to explicit requirements, limitations, and exclusions, in this Manual or in the 32 CFR 199.

A CPT listed procedure may be cost-shared only when the contractor determines the procedure is "appropriate medical care" and is "medically or psychologically necessary" and is not "unproven" as defined in the [32 CFR 199.2](#), or the Policy Manual does not explicitly exclude or limit cost-sharing of the CPT procedure.

Statements within the Policy Manual indicating that prior to payment a determination of "appropriate medical care" or "medical or psychological necessity" are not meant to imply an automatic requirement for referral of the claim by the claims processor for second or third level medical review. Policies which require referral to second or third level medical review prior to payment are indicated by "must be referred to second level for determination of medical necessity" or "require medical/peer review prior to payment" or are indicated through listing of a reference in the Operations Manual which may require development for medical review. Unless specifically indicated with this Policy Manual, the Operations Manual, or directed by TMA, the contractor is responsible for determining how and at what level the review and determination for medical necessity of a service/supply/treatment is accomplished.

PROGRAM POLICY (CHAPTER 9 - 13)

Program policy applies to beneficiary eligibility, provider eligibility, claims adjudication, claim payment, and quality assurance. Program policy implementation instructions are found in 6010.24-M, 6010.49-M, and 6010.50-M.

These chapters provide the methodology for pricing allowable services and items and for payment to specific categories and types of authorized providers. These methods allow the contractor to price and render payment for specific examples of services or items which are not explicitly addressed in the Manual but which belong to a general category or type which is addressed in the Manual.

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