CHAPTER 1
SECTION 1.1

EXCLUSIONS

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I. POLICY

A. In addition to any definitions, requirements, conditions, or limitations enumerated and described in other sections of this manual, the following specifically are excluded:

1. Services and supplies that are not medically or psychologically necessary for the diagnosis or treatment of a covered illness (including mental disorder) or injury or for the diagnosis and treatment of pregnancy or well-baby care.

2. 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 papanicolaou (PAP) tests and other tests allowed under the Preventive Services policy. (See Chapter 7, Section 2.1; Chapter 7, Section 2.2; and Chapter 12, Section 8.1.)

3. Services and supplies related to inpatient stays in hospitals or other authorized institutions above the appropriate level required to provide necessary medical care.

4. Services and supplies related to an inpatient admission primarily to perform diagnostic tests, examinations, and procedures that could have been and are performed routinely on an outpatient basis.

NOTE: If it is determined that the diagnostic x-ray, laboratory, and pathological services and machine tests performed during such admission were medically necessary and would have been covered if performed on an outpatient basis, benefits may be extended for such diagnostic procedures only, but cost-sharing will be computed as if performed on an outpatient basis.

5. Postpartum inpatient stay of a mother for purposes of staying with the newborn infant (usually primarily for the purpose of breast feeding 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.

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

7. Custodial care. The term "custodial care", as defined in 32 CFR 199.2, means treatment or services, regardless of who recommends such treatment or services or where such treatment or services are provided, that (a) can be rendered safely and reasonably by a person who is not medically skilled; or (b) is or are designed mainly to help the patient with the activities of daily living, also known as "essentials of daily living" as defined in 32 CFR 199.2.

8. Domiciliary care. The term "domiciliary care", as defined in 32 CFR 199.2, means care provided to a patient in an institution or homelike environment because--(a) providing support for the activities of daily living in the home is not available or is unsuitable; or (b) members of the patient's family are unwilling to provide the care.

9. Inpatient stays primarily for rest or rest cures.

10. Costs of services and supples to the extent amounts billed are over the allowed cost or charge.

11. Services or supplies for which the beneficiary or sponsor has no legal obligation to pay; or for which no charge would be made if the beneficiary or sponsor was not eligible under TRICARE; or whenever TRICARE is a secondary payer for claims subject to the DRG-based payment system, amounts, when combined with the primary payment, which would be in excess of charges (or the amount the provider is obligated to accept as payment in full, if it is less than the charges).

12. Services or supplies furnished without charge.

13. Services and supplies paid for, or eligible for payment, directly or indirectly by a local, state, or Federal Government, except as provided under TRICARE, or by government hospitals serving the general public, or medical care provided by a Uniformed Service medical care facility, or benefits provided under title XIX of the Social Security Act (Medicaid).

14. Services and supplies provided as a part of or under a scientific or medical study, grant, or research program.

15. Unproven drugs, devices, and medical treatments or procedures (see Chapter 1, Section 2.1).

16. Services or supplies provided or prescribed by a member of the beneficiary's immediate family, or person living in the beneficiary's or sponsor's household.

17. Services and supplies that are (or are eligible to be) payable under another medical insurance or program, either private or governmental, such as coverage through employment or Medicare.

18. Services and supplies provided under circumstances or in geographic locations requiring a Nonavailability Statement, when such a statement was not obtained.

19. Services or supplies which require preauthorization if preauthorization was not obtained. Services and supplies which were not provided according to the terms of the preauthorization. An exception to the requirement for preauthorization may be granted if the services otherwise would be payable except for the failure to obtain preauthorization.

20. Psychoanalysis or psychotherapy provided to a beneficiary or any member of the immediate family that is credited towards earning a degree or furtherance of the education or training of a beneficiary or sponsor, regardless of diagnosis or symptoms that may be present.

21. Inpatient stays primarily to control or detain a runaway child, whether or not admission is to an authorized institution.

22. Services or supplies, including inpatient stays, directed or agreed to by a court or other governmental agency. However, those services and supplies (including inpatient stays) that otherwise are medically or psychologically necessary for the diagnosis or treatment of a covered condition and that otherwise meet all TRICARE requirements for coverage are not excluded (see Chapter 1, Section 1.2).

23. Services and supplies required as a result of occupational disease or injury for which any benefits are payable under a worker's compensation or similar law, whether or not such benefits have been applied for or paid; except if benefits provided under such laws are exhausted.

24. Services and supplies in connection with cosmetic, reconstructive, or plastic surgery except as specifically provided in 32 CFR 199.4(e)(8) (see Chapter 4, Section 2.1).

25. Surgery performed primarily for psychological reasons (such as psychogenic) (see Chapter 4, Section 2.1).

26. Electrolysis (see Chapter 4, Section 2.1).

27. Dental care or oral surgery, except as specifically provided in 32 CFR 199.4(e)(10) (see Chapter 4, Section 7.1 and Chapter 8, Section 13.1).

28. Services and supplies related to obesity or weight reduction whether surgical or nonsurgical; wiring of the jaw or any procedure of similar purposes; regardless of the circumstances under which performed; except that benefits may be provided for the gastric bypass, gastric stapling, or gastroplasty procedures in connection with morbid obesity as provided in 32 CFR 199.4(e)(15) (see Chapter 4, Section 13.2 and Chapter 8, Section 7.2).

29. Services and supplies related to transsexualism or such other conditions as gender dysphoria (including, but not limited, to intersex surgery, psychotherapy, and prescription drugs), except as specifically provided in 32 CFR 199.4(e)(7) (see Chapter 4, Sections 15.1, 16.1, 17.1, and Chapter 7, Section 1.1).

30. Sex therapy, sexual advice, sexual counseling, sex behavior modification, psychotherapy for mental disorders involving sexual deviations (i.e., transvestic fetishism),

or other similar services, and any supplies provided in connection with therapy for sexual dysfunctions or inadequacies (see Chapter 4, Section 15.1 and Chapter 7, Section 1.1).

31. Removal of corns or calluses or trimming of toenails and other routine podiatry services, except those required as a result of a diagnosed systemic medical disease affecting the lower limbs, such as severe diabetes (see Chapter 8, Section 11.1).

32. Treatment of dyslexia.

33. Surgery to reverse surgical sterilization procedures (see Chapter 4, Sections 15.1 and 17.1 and Chapter 7, Section 2.3).

34. Noncoital reproductive procedures including artificial insemination, in-vitro fertilization, gamete intrafallopian transfer and all other such reproductive technologies. Services and supplies related to artificial insemination (including semen donors and semen banks), in-vitro fertilization, gamete intrafallopian transfer and all other noncoital reproductive technologies (see Chapter 4, Sections 17.1, 18.1 and Chapter 7, Section 2.3).

35. Nonprescription contraceptives (see Chapter 4, Section 17.1 and Chapter 7, Section 2.3).

36. Diagnostic tests to establish paternity of a child; or tests to determine sex of an unborn child (see Chapter 4, Section 18.2 and Chapter 5, Section 2.1).

37. Preventive care, such as routine annual, or employment-requested physical examinations; routine screening procedures; immunizations; except as provided in the Preventive Services policy (see Chapter 7, Sections 2.1, 2.2, 2.5, 2.6 and Chapter 12, Section 2.2).

38. Services of chiropractors and naturopaths whether or not such services would be eligible for benefits if rendered by an authorized provider (see Chapter 7, Section 18.5).

39. Counseling services that are not medically necessary in the treatment of a diagnosed medical condition. For example, educational counseling, vocational counseling, and counseling for socioeconomic purposes, stress management, life-style modification, etc. Services provided by a certified marriage and family therapist, pastoral or mental health counselor in the treatment of a mental disorder are covered only as specifically provided in 32 CFR 199.6. Services provided by alcoholism rehabilitation counselors are covered only when rendered in a TRICARE/CHAMPUS-authorized treatment setting and only when the cost of those services is included in the facility's TRICARE/CHAMPUS-determined allowable cost rate.

NOTE: See Chapter 8, Section 7.1 for policy on Nutritional Therapy. Diabetes Outpatient Self-Management Training is covered (see Chapter 8, Section 8.1).

40. Acupuncture, whether used as a therapeutic agent or as an anesthetic.

41. Hair transplants, wigs, or hairpieces, except as allowed in accordance with section 744 of the DoD Appropriations Act for 1981 (see Chapter 4, Section 2.1 and Chapter 8, Section 12.1).

42. Self-help, academic education or vocational training services and supplies, unless the provisions of 32 CFR 199.4(b)(1)(v) relating to general or special education, apply.

NOTE: See 32 CFR 199.5 and Chapter 9, Section 10.1, for training benefits under PFPWD.

43. Exercise equipment, spas, whirlpools, hot tubs, swimming pools, health club membership or other such charges or items (see Chapter 8, Section 2.1).

44. General exercise programs, even if recommended by a physician and regardless of whether or not rendered by an authorized provider. In addition, passive exercises and range of motion exercises also are excluded, except when prescribed by a physician and rendered by a physical therapist concurrent to, and as an integral part of a comprehensive program of physical therapy (see Chapter 7, Sections 18.2 and 18.3).

45. Services of an audiologist or speech therapist, except when prescribed by a physician and rendered as a part of treatment addressed to the physical defect itself and not to any educational or occupational defect (see Chapter 7, Sections 7.1 and 8.1).

46. Eye exercises or visual training (orthoptics) (see Chapter 4, Section 21.1 and Chapter 7, Section 6.1).

47. Eye and hearing examinations except as specifically provided in 32 CFR 199.4(c)(2)(xvi) or except when rendered in connection with medical or surgical treatment of a covered illness or injury. Vision and hearing screening in connection with well-baby care is not excluded (see Chapter 4, Section 21.1 and Chapter 7, Sections 2.1, 2.2, 2.5, 6.1 and 8.1).

NOTE: Under the PFPWD, vision and hearing examinations for the purpose of establishing a qualifying condition, confirming the severity of the disabling effects of a qualifying condition, or measuring the extent of function loss may be cost-shared (see Chapter 9, Section 8.1).

48. Prostheses, other than those determined to be necessary because of significant conditions resulting from trauma, congenital anomalies, or disease. All dental prostheses are excluded, except for those specifically required in connection with otherwise covered orthodontia directly related to the surgical correction of a cleft palate anomaly (see Chapter 8, Section 4.1).

49. Orthopedic shoes, arch supports, shoe inserts, and other supportive devices for the feet, including special-ordered, custom-made built-up shoes, or regular shoes later built up (see Chapter 8, Sections 3.1 and 11.1).

50. Eyeglasses, spectacles, contact lenses, or other optical devices, except as specifically provided under 32 CFR 199.4(e)(6) (see Chapter 7, Section 6.2).

51. Hearing aids or other auditory sensory enhancing devices (see Chapter 7, Section 8.2).

NOTE: Hearing aid services may be cost-shared only for eligible beneficiaries through the Program for Persons with Disabilities on the basis of a hearing disability or of multiple disabilities, one of which involves a hearing disability.

52. Services or advice rendered by telephone are excluded, except that a diagnostic or monitoring procedure which incorporates electronic transmission of data or remote detection and measurement of a condition, activity, or function (biotelemetry) is not excluded when:

a. The procedure without electronic transmission of data or biotelemetry is otherwise an explicit or derived benefit; and

b. The addition of electronic transmission of data or biotelemetry to the procedure is found to be medically necessary and appropriate medical care which usually improves the efficiency of the management of a clinical condition in defined circumstances; and

c. That each data transmission or biotelemetry device incorporated into a procedure that is otherwise an explicit or derived benefit of this section, has been classified by the FDA, either separately or as a part of a system, for use consistent with the defined circumstances in 32 CFR 199.4(g)(52)(ii).

NOTE: See Chapter 7, Section 22.1 for policy on Telemedicine/TeleHealth.

53. Air conditioners, humidifiers, dehumidifiers, and purifiers.

54. Elevators or chair lifts.

55. Alterations to living spaces or permanent features attached thereto, even when necessary to accommodate installation of covered durable medical equipment or to facilitate entrance or exit.

56. Items of clothing or shoes, even if required by virtue of an allergy.

57. Food, food substitutes, vitamins, or other nutritional supplements, including those related to prenatal care, except as specifically covered (see Chapter 8, Sections 7.1 and 7.2).

58. Enuretic conditioning programs.

59. Autopsy and postmortem (see Chapter 6, Section 1.1).

60. All camping even though organized for a specific therapeutic purpose, and even though offered as a part of an otherwise covered treatment plan or offered through an approved facility.

61. Housekeeping, homemaker, or attendant services, sitter or companion (for exceptions, see 32 CFR 199.4(e)(19) regarding hospice care) (see the TRICARE Reimbursement Manual, Chapter 11, Sections 1 and 4.).

62. All services and supplies (including inpatient institutional costs) related to a noncovered condition or treatment, or provided by an unauthorized provider.

63. Personal, comfort, or convenience items, such as beauty and barber services, radio, television, and telephone (for exceptions, see 32 CFR 199.4(e)(19) regarding hospice care).

NOTE: Admission kits are covered.

64. Services and supplies related to "stop smoking" regimens.

65. Megavitamin psychiatric therapy, orthomolecular psychiatric therapy.

66. All transportation except by ambulance, as specifically provided under 32 CFR 199.4(d) and (e)(5).

NOTE: Transportation of a PFPWD beneficiary to or from a facility or institution to receive otherwise allowable services or items may be cost-shared. Transportation of an accompanying medical attendant to ensure the safe transport of the PFPWD beneficiary may be cost-shared (see Chapter 9, Section 13.1).

67. All travel even though prescribed by a physician and even if its purpose is to obtain medical care, except as specified in 32 CFR 199.4(a)(6).

NOTE: For the exception for certain Prime travel expenses and non-medical attendants, see 32 CFR 199.17(p)(4)(vi) and the TRICARE Reimbursement Manual, Chapter 1, Section 30.

68. Services and supplies provided by other than a hospital, unless the institution has been approved specifically by TRICARE. Nursing homes, intermediate care facilities, halfway houses, homes for the aged, or institutions of similar purpose are excluded from consideration as approved facilities.

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