3-7-97

DEPARTMENT OF DEFENSE
OFFICE OF CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES
AURORA, COLORADO 80045-6900

PDD

CHANGE 12
OCHAMPUS 6010.47-M
FEBRUARY 14, 1997

PUBLICATIONS SYSTEM CHANGE TRANSMITTAL FOR TRICARE/CHAMPUS POLICY MANUAL

THE DIRECTOR, OCHAMPUS, HAS AUTHORIZED THE FOLLOWING ADDITION(S)/REVISION(S) TO THE TRICARE/CHAMPUS POLICY MANUAL

REVISION(S)

CHAPTER(S): 3; 12 SECTION(S): 1.6B, 1.6E, 5.3, 6.1, 8.5; 2.1T1, 2.2, 2.3T1, 7.1, 7.2, 8.1, 10.1, 14.1,

REMOVE PAGE(S): Chapter 3: Sec. 1.6B, pgs.1-6; Sec. 1.6E, pgs.1-5; Sec. 5.3, pgs.1-7; Sec. 6.1, pgs.1-8; Sec. 8.5,pgs.1-6; Chapter 12: Sec. 2.1T1, pgs.1-13; Sec. 2.2,pg.1; Sec. 2.3,pgs.1-2; Sec. 7.1,pgs.1-2 Sec. 7.2, pgs1-2, Sec. 8.1, pg. 1-2, Sec. 10.1,pg.1-2, Sec 14.1, pg. 1-5.

INSERT: ATTACHED ADDITIONAL/REPLACEMENT PAGE(S): Chapter 3: Sec. 1.6B, pgs.1-6; Sec. 1.6E, pgs.1-5; Sec. 5.3, pgs.1-7; Sec. 6.1, pgs.1-8; Sec. 8.5,pgs.1-6; Chapter 12: Sec. 2.1T1, pgs.1-13; Sec. 2.2, pgs.1-2, Sec. 2.3,pgs.1-2; Sec. 7.1,pgs.1-2 Sec. 7.2, pgs1-2, Sec. 8.1, pg. 1-2, Sec. 10.1,pg.1-2, Sec 14.1, pgs.1-5.

SUMMARY OF ADDITIONS/REVISIONS: This change allows enrollment fee portability and split enrollment for TRICARE Prime enrollees and clarifies catastrophic cap provisions.

EFFECTIVE DATE AND IMPLEMENTATION: As indicated on the attached pages.

THIS CHANGE IS MADE IN CONJUNCTION WITH OPERATIONS MANUAL CHANGE NO.79, COM-FI NO.82, AND ADP MANUAL CHANGE NO.N/A.

Sheila H. Sparkman
Director, Program Development and Evaluation

ATTACHMENT(S): 62 PAGE(S)
DISTRIBUTION: 6010.47-M

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

Subject: HEART-LUNG AND LUNG TRANSPLANTATION	Chapter: 3
	Section: 1.6B
Authority: DoD 6010.8-R, Chapter 4, E.5.	Issue Date: October 27, 1995

PROCEDURE CODES

33930 - Donor cardiectomy-pneumonectomy, with preparation and maintenance of allograft
33935 - Heart-lung transplant
32850 - Donor pneumonectomy with preparation-and maintenance of allograft
32851 - Single lung transplant without cardiopulmonary bypass
32852 - Single lung transplant with cardiopulmonary bypass
32853 - Double lung transplant without cardiopulmonary bypass
32854 - Double lung transplant without cardiopulmonary bypass
(ICD-9-CM - 33.50 for lung transplant, not otherwise specified)
(ICD-9-CM - 33.51 for unilateral lung transplantation)
(ICD-9-CM - 33.52 for bilateral lung transplantation)
(ICD-9-CM - 33.6 for combined heart-lung transplantation)
DRG - 495 for lung transplant

POLICY

A. Preauthorized CHAMPUS benefits are allowed for heart-lung and single and double lung transplantation.

1. A TRICARE Prime enrollee must have a referral from his/her Primary Care Manager (PCM) and an authorization from the Health Care Finder (HCF) before obtaining transplant-related services. If network providers furnish transplant-related services without prior PCM referral and HCF authorization, penalties will be administered according to TRICARE network provider agreements. If Prime enrollees receive transplant-related services from non-network civilian providers without the required PCM referral and HCF authorization, Managed Care Support (MCS) contractors shall reimburse charges for the services on a Point of Service basis. Special cost-sharing requirements apply to Point of Service claims. For specific information on Point of Service cost-shares and catastrophic cap calculations, see Chapter 12, Section 2.2, and Section 10.1, and Chapter 13, Section 14.1.

2. For Standard and Extra patients residing in a Managed Care Support (MCS) region, preauthorization authority is the responsibility of the MCS Medical Director, Health Care Finder, or other designated utilization staff.

3. For Fiscal intermediaries, preauthorization authority is the responsibility of the OCHAMPUS Medical Director.

B. The designated preauthorizing authority shall only use the criteria contained in this policy when preauthorizing lung and heart-lung transplantations.

C. The designated preauthorizing authority may also preauthorize advanced life support for air ambulance and a certified advanced life support attendant for a heart-lung or lung transplantation patient who has received preauthorization.

D. Affirmative Patient Selection Criteria. CHAMPUS may cost-share medically necessary services and supplies related to heart-lung and single and double lung transplantation when the transplant is performed at a CHAMPUS approved heart-lung or lung transplant center, for beneficiaries who:

1. Have irreversible, progressively disabling, end-stage pulmonary or cardiopulmonary disease (for example, less than a 50 percent likelihood of survival for 8 months). Prognosis otherwise must be good for both survival and rehabilitation.

2. Have tried or considered all other medical and surgical therapies that might have been expected to yield both short and long-term survival comparable to that of transplantation.

3. Have a realistic understanding of the range of clinical outcomes that may be encountered.

4. Demonstrate plans for a long-term adherence to a disciplined medical regimen are feasible and realistic.

E. In addition to meeting the above patient selection criteria, the following adverse factors must be absent or minimized:

1. Acutely ill patients (i.e., with serious exacerbation of chronic end-stage disease or with nonchronic end-stage disease) or those who currently require mechanical ventilation for more than a very brief period (because there is difficulty in adequate assessment, a propensity for infection and likelihood for poor results).

2. Significant systemic or multi-system disease (because the presence of multi-organ involvement limits the possibility of full recovery and may compromise the function of the newly transplanted organ(s)).

3. Extrapulmonary site of infection (because of the probability of recrudescence once immunosuppression is instituted).

4. Hepatic dysfunction, even secondary to right ventricular failure, such as bilirubin exceeding 2.5 mg/ml (because of hepatotxicity of many post-transplant medications and complications due to coagulopathies, hepatic encepalopathy, infection, poor wound healing, and increased postoperative mortality).

5. Renal dysfunction, such as preoperative serum creatinine greater than 1.5 mg/dl or a 24-hour creatinine clearance less than 50 ml/min, except that with severe pulmonary hypertension creatinine clearance as low as 35 ml/min may be acceptable if intrinsic renal disease is excluded. (Cyclosporine is nephrotoxic).

6. Systemic hypertension that requires multidrug therapy for even moderate control (for example, multidrugs to bring diastolic pressure below 105 mm Hg), either at

transplantation or at the development of end-stage heart-lung disease (because of substantial exacerbation of hypertension with post-transplantation drug regimen).

7. Cachexia, even in the absence of major end organ failure (because of the significantly less favorable survival of these patients).

8. Obesity, with weight being an increasingly severe adverse factor as the patient exceeds by 20 percent of ideal weight for height and sex (because of more difficult post-operative mobilization and impaired diaphragmatic function, as well as the difficulty of weight control once corticosteroid immunosuppressant is instituted).

9. A history of a behavior pattern or psychiatric illness considered likely to interfere significantly with compliance with a disciplined medical regimen (because a lifelong medical regimen is necessary requiring multiple drugs several times a day, with serious consequences in the event of their interruption of excessible consumption).

10. Continued cigarette smoking or failure to have abstained for a sufficient time (e.g., at least 1 or 2 years to indicate low likelihood of recidivism because of the expected detrimental effects of smoking on the transplanted organs).

11. Previous thoracic or cardiac surgery or other bases for pleural adhesions may be a serious adverse factor depending upon site of thoracotomy/sternotomy, the degree of adhesions and the type of transplant anticipated (because of scar tissue and the propensity for inadequately controlled bleeding).

12. Age beyond 50 or 55 becomes increasingly severe adverse factor, that is, a patient has to be extremely “young for his/her age” if a heart-lung or double lung transplantation is envisioned in one who is over 50 or if a single lung transplantation is envisioned in one who is over 55 (because of greater complications beyond these ages unless this standard is used).

13. Recent or current history of gastrointestinal problems (because of common post-operative gastrointestinal problems and hemorrhage).

14. Chronic corticosteroid therapy that cannot be tapered and discontinued prior to transplantation has been considered a serious adverse factor by many (because of the increased risk of tracheal or bronchial dehiscence in the early post-operative period).

15. With chronic pulmonary infection (as with bronchiectasis, chronic or cystic fibrosis), single lung transplantation is contraindicated (because of the great likelihood of the infection extending from the contaminated native lung into the transplanted lung) and the patient must meet the criteria and benefit/risk considerations of double lung or heart-lung transplantation.

16. With significant heart disease (for example, substantial irreversible right ventricular disease or significant coronary artery disease) the patient must meet the criteria and benefit/risk considerations for heart-lung transplantation; lung transplantation and concurrent repair of the cardiac abnormality may be appropriate in unusual circumstances, as in some situations with Eisenmenger’s syndrome.

F. For a properly preauthorized patient, CHAMPUS may cost-share medically necessary services and supplies related to heart-lung or lung transplantation for:

HEART-LUNG AND LUNG TRANSPLANTATION	Chapter: 3
	Section: 1.6B

1. Evaluation of potential candidate's suitability for heart-lung or lung transplantation, whether or not the patient is ultimately accepted as a candidate for transplantation.

2. Pre- and post-transplant inpatient hospital and outpatient services.

3. Pre- and post-operative services of the transplant team.

4. The donor acquisition team, including the costs of transportation to the location of the donor organ and transportation of the team and the donated organ to the location of the transplantation center.

5. The maintenance of the viability of the donor organ after all existing legal requirements for excision of the donor organ have been met.

6. Blood and blood products.

7. FDA approved immunosuppression drugs to include off-label uses when determined to be non-investigational. Refer to Chapter 7, Section 7.1 for requirements for off-label drug use.

8. Complications of the transplant procedure, including inpatient care, management of infection and rejection episodes.

9. Periodic evaluation and assessment of the successfully transplanted patient.

10. Cardiac rehabilitation as outlined in the Chapter 1, Section 18.4.

11. Pulmonary rehabilitation for pre- and post-lung and heart-lung transplants when preauthorized by the appropriate preauthorizing authority as outlined in paragraph A. under Policy.

12. Advanced life support air ambulance, See paragraph C. above regarding preauthorization of this service. Reference to Chapter 7, Section 2.1.

G. CHAMPUS benefits may be allowed for DNA-HLA tissue typing in determining histocompatibility.

EFFECTIVE DATE February 28, 1991

EXCLUSIONS

A. CHAMPUS benefits will not be paid for:

1. Expenses waived by the transplant center, (e.g., beneficiary/sponsor not financially liable).

2. Services and supplies not provided in accordance with applicable program criteria (i.e., part of a grant or research program; investigational procedure).

3. Administration of an experimental or investigational immunosuppressant drug that is not FDA approved or has not received CHAMPUS approval as an appropriate "off

label" drug indication. Refer to Chapter 7, Section 7.3 for CHAMPUS Policy requirements for immunosuppression therapy.

4. Pre- or post-transplant nonmedical expenses, (e.g., out-of-hospital living expenses, to include hotel, meal, privately owned vehicle for the beneficiary or family members).

5. Transportation of an organ donor.

EXCEPTIONS

A. Benefits may be allowed for heart-lung and lung transplantations performed prior to February 28, 1991, (but not before January 1, 1987) only if the patient criteria discussed in paragraph D. under "Policy", and the institutional criteria, outlined in Chapter 11, Section 11.5, were met or would have been met at the time of transplantation.

B. Service and supplies for inpatient or outpatient services that are provided prior to and/or after discharge from hospitalization for a heart-lung or lung transplantation performed in an unauthorized transplant center may be cost-shared subject to applicable Program policy. Pre-admission services rendered by an unauthorized transplant center may also be cost-shared subject to applicable program policies. These exceptions are also applicable to heart-lung and lung transplantations performed prior to the effective date of February 28, 1991.

POLICY CONSIDERATIONS

A. Preauthorization and retrospective authorization of lung and heart-lung transplantations must meet the following two requirements:

1. Patient meets (or would have met) patient selection criteria; and

2. Transplant facility is (or would have been) CHAMPUS-certified at the time of transplant.

B. In those cases where the beneficiary fails to obtain preauthorization, CHAMPUS benefits may be extended if the services of supplies otherwise would qualify for benefits but for the failure to obtain preauthorization. If preauthorization is not received, the appropriate preauthorizing authority as outline in paragraph A. under Policy is responsible for reviewing the claims to determine whether the beneficiary's condition meets the clinical criteria for the heart-lung or lung transplantation benefit. Charges for transplant and transplant-related services provided to TRICARE Prime enrollees who failed to obtain PCM referral and HCF authorization will be reimbursed only under Point of Service rules.

C. Benefits will only be allowed for transplants performed at a CHAMPUS authorized heart-lung or lung transplantation center. The TRICARE contractor is the certifying authority for transplant centers within its region. The OCHAMPUS Medical Director is the certifying authority for transplant centers in regional Fiscal Intermediary areas. Refer to Chapter 11, Section 11.5 for organ transplant certification center requirements.

D. Claims for services and supplies related to heart-lung transplantation will be reimbursed based on billed charges.

E. Claims for services related to lung transplantation through September 30, 1994, will be reimbursed based on billed charges. Effective October 1, 1994, lung transplants will be paid under the DRG. Acquisition costs related to the lung will continue to be paid on a reasonable cost basis and not included in the DRG.

F. Claims for transportation of the donor organ and transplant team shall be adjudicated on the basis of billed charges, but not to exceed the transport service's published schedule of charges, and cost-shared on an inpatient basis. Scheduled or chartered transportation may be cost-shared.

G. Benefits will be allowed for donor costs. Refer to Chapter 3, Section 1.6L for guidelines regarding donor costs associated with organ transplants.

H. Charges made by the donor hospital will be cost-shared on an inpatient basis and must be fully itemized and billed by the transplant center in the name of the CHAMPUS patient.

I. Acquisition and donor costs are not considered to be components of the services covered under the DRG. These costs must be billed separately on a standard UB-92 claim form in the name of the CHAMPUS patient.

J. For beneficiaries who reside in TRICARE regions, the issuance of a Nonavailability Statement (NAS) shall be in accordance with direction of the Lead Agent. For beneficiaries residing in fiscal intermediary regions, an NAS is not required for heart-lung and lung transplants or for the admission for the preoperative evaluation to determine the patient's candidacy for the transplant.

K. When a properly preauthorized transplant candidate is discharged less than 24-hours after admission because of extenuating circumstances, such as the available organ is found not suitable or other circumstances which prohibit the transplant from being timely performed, all otherwise authorized services associated with the admission shall be cost-shared on an inpatient basis, since the expectation at admission was that the patient would remain more than 24 hours.

- END -

Subject: COMBINED LIVER-KIDNEY TRANSPLANTATION	Chapter: 3
	Section: 1.6E
Authority: Pending	Issue Date: October 26, 1994

PROCEDURE CODE RANGE

47150

POLICY

A. Preauthorized CHAMPUS benefits are allowed for combined liver-kidney transplantation (CLKT).

1. A TRICARE Prime enrollee must have a referral from his/her Primary Care Manager (PCM) and an authorization from the Health Care Finder (HCF) before obtaining transplant-related services. If network providers furnish transplant-related services without prior PCM referral and HCF authorization, penalties will be administered according to TRICARE network provider agreements. If Prime enrollees receive transplant-related services from non-network civilian providers without the required PCM referral and HCF authorization, Managed Care Support (MCS) contractors shall reimburse charges for the services on a Point of Service basis. Special cost-sharing requirements apply to Point of Service claims. For specific information on Point of Service cost-shares and catastrophic cap calculations, see Chapter 12, Section 2.2, and Section 10.1, and Chapter 13, Section 14.1.

2. For Standard and Extra patients residing in a Managed Care Support (MCS) region, preauthorization authority is the responsibility of the MCS Medical Director, Health Care Finder, or other designated utilization staff.

3. For fiscal intermediaries, preauthorization authority is the responsibility of the OCHAMPUS Medical Director.

B. The designated preauthorizing authority shall only use the criteria contained in this policy when preauthorizing combined liver-kidney transplantation.

C. Affirmative Patient Selection Criteria. CHAMPUS may cost-share medically necessary services and supplies related to CLKT when the transplant is performed at a CHAMPUS or Medicare approved liver transplant center, for beneficiaries who:

1. Are suffering from concomitant, irreversible hepatic and renal failure; and

2. Have exhausted more conservative medical and surgical treatments for hepatic and renal failure.

3. Have plans for long-term adherence to a disciplined medical regimen that are feasible and realistic.

D. For a properly preauthorized patient, CHAMPUS may cost share medically necessary services and supplies related to CLKT for:

COMBINED LIVER-KIDNEY TRANSPLANTATION	Chapter: 3
	Section: 1.6E

1. Evaluation of a potential candidate's suitability for CLKT whether or not the patient is ultimately accepted as a candidate for transplantation.

2. Pre- and post-transplant inpatient hospital and outpatient services.

3. Pre- and post-operative services of the transplant team.

4. The donor acquisition team, including the costs of transportation to the location of the donor organ and transportation of the team and the donated organ to the location of the transplantation center.

5. The maintenance of the viability of the donor organ after all existing legal requirements for excision of the donor organ have been met.

6. Blood and blood products.

7. FDA approved immunosuppression drugs to include off-label uses when determined to be medically necessary and generally accepted practice within the general medical community, (i.e., non investigational).

8. Complications of the transplant procedure, including inpatient care, management of infection and rejection episodes.

9. Periodic evaluation and assessment of the successfully transplanted patient.

E. CHAMPUS benefits are allowed for Hepatitis B and pneumococcal vaccines for patients undergoing transplantation.

F. CHAMPUS benefits may be allowed for DNA-HLA tissue typing in determining histocompatibility.

EFFECTIVE DATE November 12, 1992

EXCLUSIONS

Combined liver-kidney transplantation is excluded when:

A. The following contraindications exist:

1. Significant systemic or multisystemic disease (other than hepatorenal failure) which limits the possibility of full recovery and may compromise the function of the newly transplanted organs.

2. Active alcohol or other substance abuse.

a. Benefits may be allowed if:

(1) The patient has been abstinent for at least six months prior to transplantation; and

(2) There is no evidence of other major organ debility (e.g., cardiomyopathy).

(3) There is evidence of ongoing participation in a social support group such as Alcoholics Anonymous; and

(4) There is evidence of a supportive family/social environment.

3. Malignancies metastasized to or extending beyond the margins of the liver and/or kidney.

4. Viral-induced liver disease when evidence of viremia is present, and/or when immunologic evidence of active viremia is present; and

B. For:

1. Expenses waived by the transplant center, (i.e., beneficiary/ sponsor not financially liable.)

2. Services and supplies not provided in accordance with applicable program criteria, (i.e., part of a grant or research program, investigational procedure).

3. Administration of an experimental or investigational immunosuppressant drug that is not FDA approved. Refer to Chapter 7, Section 7.3 for CHAMPUS Policy requirements for immunosuppression therapy.

4. Pre- or post-transplant nonmedical expenses (i.e., out-of-hospital living expenses, to include, hotel, meals, privately owned vehicle for the beneficiary or family members).

5. Transportation of an organ donor.

EXCEPTIONS

A. Services and supplies for inpatient or outpatient services that are provided prior to and/or after discharge from hospitalization for a CLKT performed in an unauthorized CHAMPUS or Medicare liver transplantation center may be cost-shared subject to applicable Program policy. Pre-admission services rendered by an unauthorized transplant center may also be cost-shared subject to applicable program policies. These exceptions are also applicable to CLKTs performed prior to the effective date of November 12, 1992.

B. CLKTs performed on an emergency basis in an unauthorized liver transplant facility may be cost shared by CHAMPUS only when the following conditions have been met:

1. The unauthorized center must consult with the nearest CHAMPUS authorized liver transplantation center regarding the transplantation case; and

2. It must be determined and documented by the transplant team physician(s) at the authorized liver transplantation center that transfer of the patient (to the authorized liver transplantation center) is not medically reasonable, even though transplantation is feasible and appropriate.

C. This policy does not apply to beneficiaries who become eligible for Medicare coverage due to isolated renal disease (refer to Chapter 9, Section 2.2). This policy applies only to those individuals suffering from concomitant hepatic and renal failure. Coordination of benefits with Medicare is not required for CLKTs.

COMBINED LIVER-KIDNEY TRANSPLANTATION	Chapter: 3
	Section: 1.6E

POLICY CONSIDERATIONS

A. Preauthorization and retrospective authorization of CLKT must meet the following two requirements:

1. Patient meets (or as of the date of transplantation would have met) patient selection criteria; and

2. Transplant facility is (or as of the date of transplantation would have been) CHAMPUS or Medicare approved for liver transplantation at the time of transplantation.

B. In those cases where the beneficiary fails to obtain preauthorization, CHAMPUS benefits may be extended if the services or supplies otherwise would qualify for benefits but for the failure to obtain preauthorization. If preauthorization is not received, the appropriate preauthorizing authority as outlined in paragraph A. under Policy is responsible for reviewing the claims to determine whether the beneficiary's condition meets the clinical criteria for the CLKT benefit. Charges for transplant and transplant-related services provided to TRICARE Prime enrollees who failed to obtain PCM referral and HCF authorization will be reimbursed only under Point of Service rules.

C. Benefits will only be allowed for transplants performed at a CHAMPUS or Medicare approved liver transplantation center. The CHAMPUS contractor in whose jurisdiction the center is located is the certifying authority for CHAMPUS approval as a liver transplantation center. Refer to Chapter 11, Section 11.5 for organ transplant certification center requirements.

D. Claims for services and supplies related to the transplant will be reimbursed based on billed charges.

E. Claims for transportation of the donor organ and transplant team shall be adjudicated on the basis of billed charges, but not to exceed the transport service's published schedule of charges, and cost-shared on an inpatient basis. Scheduled or chartered transportation may be cost-shared.

F. Benefits will be allowed for donor costs. Refer to Chapter 3, Section 1.6L for guidelines regarding donor costs associated with organ transplants.

G. Charges made by the donor hospital will be cost-shared on an inpatient basis and must be fully itemized and billed by the transplant center in the name of the CHAMPUS patient.

H. Acquisition and donor costs are not considered to be components of the services covered under the DRG. These costs must be billed separately on a standard UB-92 claim form in the name of the CHAMPUS patient.

I. Transportation of the patient by air ambulance may be cost-shared when determined to be medically necessary. Reference Chapter 7, Section 2.1.

J. For beneficiaries who reside in TRICARE regions, the issuance of a Nonavailability Statement (NAS) shall be in accordance with direction of the Lead Agent. For beneficiaries residing in fiscal intermediary regions, an NAS is not required for CLKT or for the admission for the preoperative evaluation to determine the patient's candidacy for the transplant.

K. When a properly preauthorized candidate is discharged less than 24-hours after admission because of extenuating circumstances, such as the available organ is found not suitable or other circumstances which prohibit the transplant from being timely performed, all otherwise authorized services associated with the admission shall be cost-shared on an inpatient basis, since the expectation at admission was that the patient would remain more than 24 hours.

- END -

Subject: HEART TRANSPLANTATION	Chapter: 3
	Section: 5.3
Authority: DoD 6010.8-R, Chapter 4, E.5.f.	Issue Date: December 11, 1986

PROCEDURE CODE

33945, 33975, 33976, 33977, 33978

POLICY

A. For beneficiaries who reside in TRICARE regions, preauthorized CHAMPUS benefits are allowed for heart transplantation.

1. A TRICARE Prime enrollee must have a referral from his/her Primary Care Manager (PCM) and an authorization from the Health Care Finder (HCF) before obtaining transplant-related services. If network providers furnish transplant-related services without prior PCM referral and HCF authorization, penalties will be administered according to TRICARE network provider agreements. If Prime enrollees receive transplant-related services from non-network civilian providers without the required PCM referral and HCF authorization, Managed Care Support (MCS) contractors shall reimburse charges for the services on a Point of Service basis. Special cost-sharing requirements apply to Point of Service claims. For specific information on Point of Service cost-shares and catastrophic cap calculations, see Chapter 12, Section 2.2, and Section 10.1, and Chapter 13, Section 14.1.

2. For Standard and Extra patients residing in a Managed Care Support (MCS) region, preauthorization authority is the responsibility of the MCS Medical Director, Health Care Finder, or other designated utilization staff.

B. The designated preauthorizing authority shall only use the criteria contained in this policy when preauthorizing heart transplantation.

C. For beneficiaries who reside in fiscal intermediary regions, CHAMPUS benefits are allowed for heart transplantation, however, preauthorization is not available.

D. Affirmative Patient Selection Criteria. CHAMPUS may cost-share medically necessary services and supplies related to heart transplantation when the transplant is performed at a CHAMPUS or Medicare approved transplant center, for beneficiaries who:

1. Have an end-stage cardiac disease which has not responded to or no longer responds to other appropriate medical and surgical therapies which might be expected to yield both short and long-term (3 to 5 year) survival comparable to that of heart transplantation; and

2. Has a very poor prognosis as a result of poor cardiac functional status (e.g., less than a 25 percent likelihood of survival for six months); and

3. Have plans for long-term adherence to a disciplined medical regimen are feasible and realistic.

E. CHAMPUS may cost-share medically necessary services and supplies related to heart transplantation for:

1. Evaluation of a potential candidate's suitability for heart transplantation whether or not the patient is ultimately accepted as a candidate for transplantation.

2. Pre- and post-transplant inpatient hospital and outpatient services.

3. Pre- and post-operative services of the transplant team.

4. The donor acquisition team, including the costs of transportation to the location of the donor organ and transportation of the team and the donated organ to the location of the transplantation center.

5. The maintenance of the viability of the donor organ after all existing legal requirements for excision of the donor organ have been met.

6. Blood and blood products.

7. FDA approved immunosuppression drugs to include off-label uses when determined to be medically necessary and generally accepted practice within the general medical community (i.e., non-investigational).

8. Complications of the transplant procedure, including inpatient care, management of infection and rejection episodes.

9. Periodic evaluation and assessment of the successfully transplanted patient.

10. Cardiac rehabilitation as outlined in Chapter 1, Section 18.4.

F. CHAMPUS benefits may be allowed for DNA-HLA tissue typing in determining histocompatibility.

EFFECTIVE DATE

This policy is effective for services and supplies related to a heart transplantation procedure that was performed on and after November 7, 1986.

September 30, 1994, for the HeartMate® Implantable Pneumatic Left Ventricular Assist System (IPLVAS).

EXCLUSIONS

A. CHAMPUS benefits will not be paid for:

1. Expenses waived by the transplant center (e.g., beneficiary/sponsor not financially liable).

2. Services and supplies not provided in accordance with applicable program criteria (i.e., part of a grant or research program; investigational procedure).

3. Administration of an experimental or investigational immunosuppressant drug that is not FDA approved or has not received CHAMPUS approval as an appropriate "off

label" drug indication. Refer to Chapter 7, Section 7.3 for CHAMPUS Policy requirements for immunosuppression therapy.

4. Pre- or post-transplant nonmedical expenses (e.g., out-of-hospital living expenses, to include hotel, meals, privately owned vehicle for the beneficiary or family members).

5. Transportation of an organ donor.

B. Bridge transplantation, which is the practice of using an artificial heart or an assist device until a donor heart becomes available. Assist devices when used for bridge to transplantation are considered experimental. Refer to Chapter 3, Section 5.3, regarding coverage of ventricular assist devices for uses other than bridge to transplantation.

C. Implantable devices intended for temporary mechanical circulatory support as a bridge to cardiac transplantation are considered experimental and may not be cost-shared under CHAMPUS. For exception to policy see below under EXCEPTIONS paragraph C. Refer to Chapter 3, Section 5.1 regarding coverage of ventricular assist devices for uses other than bridge to transplantation.

D. Services, supplies or devices, even those used in lieu of the transplant, when determined to be related or integral to an experimental or investigational procedure, may not be cost-shared under CHAMPUS (see Chapter 8, Section 14.1, for guidelines on determining coverage for related services).

EXCEPTIONS

A. Services and supplies for inpatient or outpatient services that are provided prior to and/or after discharge from hospitalization for a heart transplantation performed in an unauthorized CHAMPUS or Medicare heart transplantation center may be cost-shared subject to applicable Program policy. Pre-admission services rendered by an unauthorized transplant center may also be cost-shared subject to applicable program policies. These exceptions are also applicable to heart transplantations performed prior to November 7, 1986.

B. Heart transplantations performed on an emergency basis in an unauthorized heart transplant facility may be cost shared by CHAMPUS only when the following conditions have been met:

1. The unauthorized center must consult with the nearest CHAMPUS approved center regarding the transplantation case; and

2. It must be determined and documented by the transplant team physician(s) at the approved center that transfer of the patient (to the approved center) is not medically reasonable, even though transplantation is feasible and appropriate.

C. The HeartMate® IPLVAS is intended for temporary mechanical circulatory support for transplant candidates in nonreversible left ventricular failure as a bridge to cardiac transplantation. The intent of the HeartMate® IPLVAS therapy is to provide hemodynamic support while awaiting transplantation. This device is intended for long-term support until a donor heart is available. Bridge to cardiac transplantation utilizing the HeartMate® IPLVAS may be cost-shared by CHAMPUS only when the following conditions have been met:

1. There is written evidence that, at the time of implantation of the HeartMate® IPLVAS device, the patient had received unrestricted approval for cardiac transplantation from a CHAMPUS or Medicare approved transplantation facility.

NOTE: Approval by the local facility transplantation committee in no way guarantees approval for cardiac transplantation by CHAMPUS.

2. On therapeutic doses of cardiac inotropic medications.

3. On an intra-aortic balloon pump (if possible).

4. Left atrial pressure or pulmonary capillary wedge is equal to or greater than 20 mm Hg with either a systolic blood pressure equal to or less than 80 mm Hg orb. Cardiac index of equal to or less than 2.01/min/m^2.

D. Subject to meeting criteria outlined above under EXCEPTIONS paragraph C. for implantation of the IPLVAS, CHAMPUS will cost-share medically necessary and appropriate services and supplies directly related to the operation, use, and removal of the HeartMate® IPLVAS.

POLICY CONSIDERATIONS

A. For beneficiaries who reside in fiscal intermediary regions, benefits for heart transplantation, to include the HeartMate® IPLVAS, are subject to the Contractor's third level medical review by a cardiologist or cardiothoracic surgeon in order to determine medical necessity or appropriateness when any of the following conditions exist:

1. Advancing age (because of diminished capacity to withstand postoperative complications). The selection of any patients for transplantation beyond age 50 must be done with particular care to ensure an adequately young physiologic age and the absence or insignificance of coexisting disease.

2. Severe pulmonary hypertension (because of the limited work capacity of the typical donor right ventricle). A pulmonary vascular resistance above 5 Wood units or pulmonary artery systolic pressure over 65 mm Hg is considered to be severe pulmonary hypertension.

3. Renal or hepatic dysfunction not explained by the underlying heart failure and not deemed reversible (because of the nephrotoxicity and hepatotoxicity of cyclosporin).

4. Acute severe hemodynamic compromise at the time of transplantation if accompanied by compromise or failure of a vital end-organ (because of a substantially less favorable prognosis for survival than for the average transplant recipient).

5. Symptomatic peripheral or cerebrovascular disease (because of accelerated progression in some patients after cardiac transplantation and chronic corticosteroid treatment).

6. Chronic obstructive pulmonary disease or chronic bronchitis (because of poor postoperative course and likelihood of exacerbation of infection with immunosuppression).

7. Active systemic infection (because of the likelihood of exacerbation with initiation of immunosuppression).

8. Recent and unresolved pulmonary infarction or pulmonary roentgenographic evidence of infection or of abnormalities of unclear etiology (because of the likelihood that this represents pulmonary infection).

9. Systemic hypertension, either at transplantation or prior to development of end-stage cardiac disease, that requires multi-drug therapy for even moderate control (multi-drugs to bring diastolic pressure below 105 mm Hg).

10. Other systemic disease considered likely to limit or preclude survival and rehabilitation after transplantation.

11. Cachexia, even in the absence of major end-organ failure (because of the significantly less favorable survival of such patients).

12. The need for or prior transplantation of a second organ such as lung, liver, kidney, or marrow (because this represents the coexistence of significant disease).

13. A history of a behavior pattern or psychiatric illness considered likely to interfere significantly with compliance with a disciplined medical regimen (because a lifelong medical regimen is necessary, requiring multiple drugs several times a day, with serious consequences in the event of their interruption or excessive consumption).

14. The use of a donor heart, the long-term effectiveness of which might be compromised by such actions as the use of substantial vasopressors prior to its removal from the donor, its prolonged or compromised maintenance between the time of its removal from the donor and its implantation into the patient, or pre-existing disease.

15. Insulin-requiring diabetes mellitus (because the diabetes is often accompanied by occult vascular disease and because the diabetes and its complications are exacerbated by chronic corticosteroid therapy).

16. Asymptomatic severe peripheral or cerebrovascular disease (because of accelerated progression in some patients after cardiac transplantation and chronic corticosteroid treatment).

17. Peptic ulcer disease (because of the likelihood of early postoperative exacerbation); and

18. Current or recent history of diverticulitis (considered as a source of active infection which may be exacerbated with the initiation of immunosuppressant therapy).

B. For beneficiaries who reside in TRICARE regions, if any of the conditions listed under paragraph A. above exist, the designated preauthorizing authority must take these conditions into consideration when determining medical necessity or appropriateness for a heart transplantation.

C. Services and supplies that may be cost-shared are limited to those listed in DoD 6010.8-R, Chapter 4, E.5.f.(2).

D. Benefits will only be allowed for transplants performed at a CHAMPUS or Medicare approved heart transplantation center. Additionally, the HeartMate® IPLVAS will be covered only at a CHAMPUS or Medicare approved heart transplantation center. The CHAMPUS contractor in whose jurisdiction the center is located is the certifying authority for CHAMPUS authorization as a heart transplantation center. Refer to Chapter 11, Section 11.5 for specific criteria heart transplantation centers must meet for CHAMPUS authorization.

E. CHAMPUS benefits will not be allowed for procedure code 33960, prolonged extracorporeal circulation for cardiopulmonary insufficiency, as this procedure is not considered a bridge assist device.

F. For beneficiaries who reside in TRICARE regions, preauthorization and retrospective authorization of heart transplantation must meet the following two requirements.

1. Patient meets (or as of the date of transplantation, would have met) patient selection criteria; and

2. Transplant facility is (or as of the date of transplantation, would have been) CHAMPUS or Medicare approved for heart transplantation at the time of transplant.

G. For beneficiaries who reside in TRICARE regions but fail to obtain preauthorization for heart transplantation, CHAMPUS benefits may be extended if the services or supplies otherwise would qualify for benefits but for the failure to obtain preauthorization. If preauthorization is not received, the appropriate preauthorizing authority as outline in paragraph A. under Policy is responsible for reviewing the claims to determine whether the beneficiary's condition meets the clinical criteria for the heart transplant. Charges for transplant and transplant-related services provided to TRICARE Prime enrollees who failed to obtain PCM referral and HCF authorization will be reimbursed only under Point of Service rules.

H. Benefits will only be allowed for transplants performed at a CHAMPUS or Medicare approved heart transplantation center. The CHAMPUS contractor in whose jurisdiction the center is located is the certifying authority for CHAMPUS authorization as a heart transplantation center. Refer to Chapter 11, Section 11.5 for organ transplant certification center requirements.

I. Claims for services and supplies related to the transplant will reimbursed based on billed charges.

J. Claims for transportation of the donor organ and transplant team shall be adjudicated on the basis of billed charges, but not to exceed the transport service's published schedule of charges, and cost-shared on an inpatient basis. Scheduled or chartered transportation may be cost-shared.

K. Benefits will be allowed for donor costs. Refer to Chapter 3, Section 1.6L for guidelines regarding donor costs associated with organ transplants.

L. Charges made by the donor hospital will be cost-shared on an inpatient basis and must be full itemized and billed by the transplant center in the name of the CHAMPUS patient.

M. Acquisition and donor costs are not considered to be components of the services covered under the DRG. These cost must be billed separately on a standard UB-92 claim form in the name of the CHAMPUS patient.

N. Transportation of the patient by air ambulance may be cost-shared when determined to be medically necessary. Reference Chapter 7, Section 2.1.

O. For beneficiaries who reside in TRICARE regions, the issuance of a Nonavailability Statement (NAS) shall be in accordance with direction of the Lead Agent. For beneficiaries residing in fiscal intermediary regions, an NAS is not required for heart transplantation or for the admission for the preoperative evaluation to determine the patient's candidacy for the transplant.

P. When a properly preauthorized transplant candidate is discharged less than 24-hours after admission because of extenuating circumstances, such as the available organ is found not suitable or other circumstances which prohibit the transplant from being timely performed, all otherwise authorized services associated with the admission shall be cost-shared on an inpatient basis, since the expectation at admission was that the patient would remain more than 24 hours.

- END -

Subject: HIGH DOSE CHEMOTHERAPY AND STEM CELL TRANSPLANTATION	Chapter: 3
Authority: DoD 6010.8-R, Chapter 4, E.5.	Section: 6.1
	Issue Date: November 1, 1983

PROCEDURE CODE RANGE

38230, 38240, 38241

DESCRIPTION

A. CHAMPUS defines high dose chemotherapy (HDC) as the use of cytotoxic therapeutic agents (that are otherwise approved by the FDA for general use in humans) in dosages and/or frequencies of dosage that exceed the FDA labelling for the agent. HDC is generally considered when conventional regimens of chemotherapeutic agents have failed to arrest disease progression. One of the major adverse effects of HDC is that of bone marrow suppression, itself a potentially lethal process.

B. Stem cells are multipotential, blood-cell producing agents important in immune defenses against disease.

C. CHAMPUS defines stem cell "transplantation" or "rescue" as a technique for collecting stem cells from a donor (either from the bone marrow or from the bloodstream), preparing and storing the collected stem cells, then reinfusing the prepared stem cells into the bloodstream of a patient in the treatment of oncologic, hematologic or lymphoproliferative disease with curative potential. The goal of stem cell "transplantation" or "rescue" is to reverse the bone marrow suppression caused by either HDC or by a primary bone marrow disease process (e.g., aplastic anemia).

There are three general types of stem cell "transplantation" or "rescue":

1. Autologous bone marrow transplant (ABMT), where the patient is both donor and recipient of stem cells harvested from the bone marrow.

2. Peripheral stem cell therapy (PSCT), where the patient is both donor and receipient of stem cells harvested from the bloodstream using the apheresis process. This technique is generally reserved for those patients who have disease involvement of their bone marrow, making ABMT less satisfactory.

3. Allogeneic bone marrow transplantation (BMT), where stem cells from a histocompatible donor (other than the patient) are harvested, then later infused into the bloodstream of the patient. With BMT, the patient may have either a related or unrelated donor who has the same or closely matched human leukocyte antigen (HLA) typing necessary for successful transplantation.

POLICY

A. Preauthorized CHAMPUS benefits are allowed for HDC with ABMT or PSCT.

HIGH DOSE CHEMOTHERAPY AND STEM CELL TRANSPLANTATION	Chapter: 3
	Section: 6.1

1. TRICARE Prime enrollee must have a referral from his/her Primary Care Manager (PCM) and an authorization from the Health Care Finder (HCF) before obtaining transplant-related services. If network providers furnish transplant-related services without prior PCM referral and HCF authorization, penalties will be administered according TRICARE network provider agreements. If Prime enrollees receive transplant-related services from non-network civilian reporters without the required PCM referral and HCF authorization, Managed Care Support (MCS) contractors shall reimburse charges for the services on a Point of Services basis. Special cost-sharing requirements apply to Point of Service claims. For specific information on Point of Service cost-shares and catastrophic cap calculations, see Chapter 12, Section 2.2, and Section 10.1, and Chapter 13, Section 14.1.

2. For Standard and Extra patients residing in a Managed Care Support (MCS) region, preauthorization authority is the responsibility of the MCS Medical Director, Health Care Finder, or other designated utilization staff.

3. For fiscal intermediaries, preauthorization authority is the responsibility of the OCHAMPUS Medical Director.

B. Preauthorizations and initial management of all requests for allogeneic stem cell transplantations (with or without HDC) are provided by:

Wilford Hall Medical Center (WHMC)
Bone Marrow Transplantation Program
2200 Bergquist Drive, Suite 1
Lackland AFB, TX 78236-5300
Voice: (210) 670-7080
Fax: (210) 670-7686

CHAMPUS benefits for allogeneic stem cell transplantation will only be allowed when WHMC has provided written authorization. (See also COM-FI Part Two, Chapter 20, Section II.A. and OPM Part Two, Chapter 20, Section I.A.)

C. The designated preauthorizing authority shall only use the criteria contained in this policy when preauthorizing HDC with ABMT or PSCT (with or without HDC), and allogeneic BMT (with or without HDC).

D. HDC with ABMT or PSCT is covered in the treatment of the following malignancies:

1. Non-Hodgkin's lymphoma, intermediate or high grade (see Exclusions for low grad lymphomas); and Hodgkin's disease when:

a. Conventional dose chemotherapy has failed; or

b. The patient has relapsed following a course of radiation therapy, and has also failed at least one course of conventional dose chemotherapy subsequent to the failed radiation therapy; and

c. In the case of ABMT, the patient has adequate marrow function and no evidence of marrow involvement with lymphoma.

NOTE: *For purposes of CHAMPUS coverage, mantle cell lymphomas will be considered as intermediate grade, non-Hodgkin's lymphomas.*

2. Neuroblastoma, Stage III or IV, when the patient is one for whom further treatment with a conventional dose therapy is not likely to achieve a durable remission.

3. Acute lymphocytic or nonlymphocytic leukemias;

4. Primitive neuroectodermal tumors (PNET), to include peripheral PNETs, provided that:

a. Standard dose chemotherapy has failed; and

b. In the case of ABMT, the patient has adequate marrow function with no evidence of tumor involvement in the marrow.

5. Gliofibromas (also known as desmoplastic astrocytoma; desmoplastic glioblastoma).

6. Glioblastoma multiforme.

7. Posterior fossa teratoid brain tumors.

8. Rhabdomyosarcoma and undifferentiated sarcomas when the medical record documents that the patient has failed the course of therapy recommended by the Intergroup Rhabdomyosarcoma Study.

9. Multiple myeloma.

10. Metastatic breast cancer that has relapsed after responding to first-line treatment.

E. Allogeneic stem cell transplantation, with or without HDC, is covered in the treatment of the following disease processes when either a related or unrelated donor is used:

1. Aplastic anemia

2. Acute lymphocytic or nonlymphocytic leukemias; chronic myelogenous leukemia (CML); or preleukemic syndromes. Treatment with unirradiated donor lymphocytes (buffy coat) is covered for CML patients who relapse following their first or subsequent course of HDC with allogeneic BMT. The medical record must document that the patient:

a. Is in relapse following an adequate trial of HDC with allogeneic BMT of CML; and

b. Qualified (or would have qualified) for authorization for HDC with allogeneic BMT according to the provisions set forth in this policy.

3. Severe combined immunodeficiency; e.g., adenosine deaminase deficiency and idiopathic deficiencies. Partially matched-related donor stem cell transplantation (without regard for the number of antigens mismatched in determining histocompatibility) in the treatment of Bare Lymphocyte Syndrome.

a. Partially matched-related donor stem cell transportation (without regard for the number of mismatched antigens) in the treatment of Bare Lymphocyte Syndrome.

b. Unrelated donor and/or related donor (without regard for mismatched antigens) with or without T cell lymphocyte depletion in the treatment of familial erythrophagocytic lymphohistiocytosis, (FEL; generalized lymphohistiocytic infiltration; familial lymphohistiocytosis; familial reticuloendotheliosis; familial hemophagocytic lymphohistiocytosis; FHL) for patients whose medical records document failure of conventional therapy (etoposide; corticosteroids; intrathecal methotrexate; and cranial irradiation).

c. Partially matched-related donor stem cell transplantation (without regard for the number of mismatched antigens) in the treatment of X-linked severe combined immunodeficiency syndrome (X-Linked SCID).

4. Wiskott-Aldrich syndrome

5. Infantile malignant osteopetrosis (Albers-Schonberg syndrome or marble bone disease)

6. Thalassemia major

7. Intermediate and high grade lymphoma with bone marrow involvement

8. Myeloproliferative/dysplastic syndromes

9. Congenital mucopolysaccharidoses

10. Congenital amegakaryocytic thrombocytopenia

11. Metachromatic leukodystrophy

12. Sickle cell disease

F. Review of WHMC Denials for allogeneic transplantation.

1. If the initial review from WHMC results in a denial of authorization, and the beneficiary resides in a fiscal intermediary region, the patient or provider is offered further review rights by the OCHAMPUS Medical Director.

2. If the beneficiary resides in a Managed CAre Support (MCS) region, the patient or provider is offered further review rights in accordance with the TRICARE contractual requirements.

3. A denial of benefits issued by WHMC is not an initial determination as defined in DoD 6010.8-R, and is; therefore, not appealable through the CHAMPUS appeal process.

4. If the WHMC denial of benefits is overturned by the appropriate preauthorizing authority as outlined in paragraph A. above, written direction shall be provided to WHMC to issue appropriate authorization letter(s). Any written determination by the appropriate preauthorizing authority is considered to be an initial determination as defined in DoD 6010.8-R. In any case when the initial determination is adverse to the beneficiary or

participating provider, the notice shall include a statement of the beneficiary's or provider's right to appeal the determination. The procedure for filing for an appeal also shall be explained.

5. WHMC does not provide authorizations for HDC with ABMT nor HDC with PSCT.

G. In those allogeneic stem cell transplantation cases in which it has been established that a related donor is not possible, and when the only alternative is an unrelated donor, CHAMPUS benefits may be extended only under the following conditions:

1. The patient must use the National Marrow Donor Program (NMDP) for donor searches. (The NMDP (1-800-654-1247) is located in Minneapolis, Minnesota, and is available to anyone needing assistance in locating a suitable donor for unrelated allogeneic bone marrow transplantation). Donor searches through foreign registries must first be initiated or coordinated through NMDP. Prior to using NMDP services, authorization must be obtained through Wilford Hall Medical Center (WHMC).

2. Donor matching must meet the criteria established by the NMDP for identical and mismatched typing (refer to paragraph H. under Policy).

3. Requests for a donor search must be initiated and coordinated through the NMDP, and the transplant must be performed at one of its NMDP certified centers.

4. CHAMPUS will reimburse costs for donor searches only when the search has been initiated and coordinated by the NMDP.

a. Charges for donor searches must be fully itemized and billed by the transplant center.

b. Costs for donor searches will be cost-shared in accordance with CHAMPUS established reimbursement guidelines for outpatient diagnostic testing.

c. Donor search costs may be billed at any time. There is no limit on how many searches a transplant center may request from the search printout.

H. Histocompatibility criteria: In cases where related donor matches are not perfect (e.g., the histocompatibility is less than an identical antigen match) the same criteria and standards for typing mismatched unrelated donors must be used.

1. For the purposes of the NMDP and CHAMPUS coverage, the greatest degree of incompatibility allowed between donor or recipient (for either related or unrelated donors) is a single antigen mismatch at the A, B, or Dr. locus except for:

a. Patients 18 years or younger with undifferentiated leukemia or chronic myelogenous leukemia (CML) where a 2 antigen mismatch is allowed for related donors; and

b. Patients aged 20 years or younger with aplastic anemia who have granulocyte levels below 200 per microliter where a 2 antigen mismatch is allowed for related donors; and

c. Patients with acute myelogenous leukemia (AML) of the M7 type where a 2 antigen mismatch is allowed for related donors.

2. Donor searches accomplished through foreign registries must meet the same typing criteria as established by the NMDP (refer to paragraph G.4. above).

3. DNA-HLA typing to determine histocompatibility.

I. Benefits will not be allowed for stem cell harvesting and/or cryopreservation until the stem cell reinfusion has been completed. In the event that the patient expires prior to the stem cell reinfusion being completed, benefits for the harvesting may be allowed.

J. CHAMPUS benefits are allowed for Hepatitis B and pneumococcal vaccines for patients undergoing transplantation.

K. CHAMPUS benefits may be allowed for DNA-HLA tissue typing in determining histocompatibility.

L. Charges for stem cell preparation and storage shall be billed through the transplantation facility in the name of the CHAMPUS patient.

EFFECTIVE DATE

May 1, 1987, for HDC with ABMT or PSCT for Hodgkin's disease, non-Hodgkin's lymphoma and neuroblastoma.

November 1, 1987, for HDC with ABMT or PSCT for acute lymphocytic and nonlymphocytic leukemias.

November 1, 1983, for HDC with allogeneic bone marrow transplants using related donors.

July 1, 1989, for HDC with allogeneic bone marrow transplants using unrelated donors.

July 11, 1996, for HDC with ABMT for multiple myeloma.

October 1, 1995, for HDC with ABMT for metastatic breast cancer.

EXCLUSIONS

CHAMPUS benefits will not be paid for:

A. HDC with ABMT or PSCT or HDC with allogeneic BMT if the patient has a concurrent condition (other existing illness) that would jeopardize the achievement of successful transplantation.

B. HDC with or without ABMT, HDC with or without PSCT, or HDC with or without allogeneic BMT if not specifically listed as covered in paragraph G. and paragraph H. under Policy above. For example, since ovarian cancer is not specifically listed as a covered indication for HDC with ABMT or PSCT, CHAMPUS benefits are excluded. This is not to imply that exclusions for HDC/ABMT or PSCT are limited solely to the exclusions for ovarian carcinomas.

C. In vitro stem cell processing (purging) as this procedure is considered investigational. See Chapter 8, Section 14.1, for guidance regarding the handling of claims for services or supplies related to investigational procedures.

D. Expenses waived by the transplant center (i.e., beneficiary/sponsor not financially liable).

E. Services and supplies not provided in accordance with applicable program criteria (i.e., part of a grant, or research program; investigational procedure).

F. Administration of an experimental or investigational immunosuppressant drug that is not FDA approved. Refer to Chapter 7, Section 7.3 for CHAMPUS policy requirements for immunosuppression therapy.

G. Pre- or post-transplant nonmedical expenses (i.e., out-of-hospital living expenses, to include, hotel, meals, privately owned vehicle for the beneficiary or family members).

H. Transportation of a donor.

I. HDC with ABMT or PSCT is not a CHAMPUS benefit for treatment of low grade non-Hodgkin's lymphoma.

J. Umbilical cord blood transplantation therapy as this procedure is considered investigational. Refer to TRICARE/CHAMPUS Policy Manual, Chapter 8, Section 14.1 for guidance regarding the handling of claims for services or supplies related to investigational procedures.

EXCEPTIONS

A. If the patient otherwise meets the coverage criteria for HDC with ABMT as listed in paragraph D.1. (under Policy, above), harvesting of the required stem cells by apheresis from peripheral blood (i.e., PSCT) rather than bone marrow can be allowed.

B. A demonstration project is being conducted wherein the DoD will participate in cancer treatment clinical trials under approved National Cancer Institute (NCI) protocols to include high dose chemotherapy with stem cell rescue (HDC/SCR). Refer to the COM-FI Part Two, Chapter 20, Section II.D. and OPM Part Two, Chapter 20, Section II.D. for additional information regarding the demonstration project.

POLICY CONSIDERATIONS

A. Claims for services and supplies related to the HDC and transplant for beneficiaries under the age of 18 will be reimbursed based on billed charges. Claims for HDC and transplant for adult patients, 18 years and older, will be reimbursed under the DRG payment system. Outpatient institutional facility charges will be paid as billed. Professional services are reimbursed under the CHAMPUS Maximum Allowable Charge Methodology. (See Chapter 3, Section 1.5.)

B. Transportation of the patient by air ambulance may be cost-shared when determined to be medically necessary. Benefits for advanced life support air ambulance (to include attendant) may be preauthorized by the appropriate preauthorizing authority on an

individual case basis in conjunction with the preauthorization for the services themselves. See Chapter 7, Section 2.1.

C. In those cases where the beneficiary fails to obtain preauthorization, CHAMPUS benefits may be extended if the services or supplies otherwise would qualify for benefits but for the failure to obtain preauthorization. If preauthorization is not received, the appropriate preauthorizing authority as outlined in paragraph A. and paragraph B. under Policy is responsible for determining if the patient meets the coverage criteria as listed in paragraph D. and paragraph E. under Policy, above. Charges for transplant and transplant-related services provided to TRICARE Prime enrollees who failed to obtain PCM referral and HCF authorization for HDC with ABMT or PSCT will be reimbursed only under Point of Service rules.

D. For beneficiaries who reside in TRICARE regions, the issuance of a Nonavailability Statement (NAS) shall be in accordance with direction of the Lead Agent. For beneficiaries residing in fiscal intermediary regions, an NAS is required for HDC with ABMT or PSCT. A NAS is not required for HDC with allogeneic transplantation. The referral from WHMC takes the place of an NAS for beneficiaries residing within an MTF catchment area.

- END -

Subject: LIVER TRANSPLANTATION	Chapter: 3
	Section: 8.5
Authority: DoD 6010.8-R, Chapter 4, E.5.e.	Issue Date: September 3, 1986

PROCEDURE CODE

47133 - 47136 (ICD 9 CM - 50.51, 50.59)

POLICY

A. Effective July 15, 1996, the Air Force Wilford Hall Medical Center (WHMC) is designated as the national Specialized Treatment Service Facility (STSF) for liver transplantation (excluding living-related donor liver transplantations (LRDLT)). With the same effective date, Walter Reed Army Medical Center (WRAMC) is designated as a collaborating STSF for liver transplantation (excluding LRDLT).

1. All beneficiaries who reside in the continental United States (i.e., 48 contiguous states and the District of Columbia) and are in need of a liver transplantation, must be evaluated by WHMC or WRAMC before receiving a liver transplantation.

2. If the liver transplantation cannot be performed at WHMC or WRAMC an STSF NAS will be issued by WHMC, reference COM-FI Part Two, Chapter 24 and OPM Part Two, Chapter 24.

B. For beneficiaries residing in a Mangaged Care Support (MCS) region, preauthorization for a liver transplantation is required in addition to the requirement for an STSF NAS.

1. A TRICARE Prime enrollee must have a referral from his/her Primary Care Manager (PCM) and an authorization from the Health Care Finder (HCF) before obtaining transplant-related services. If network providers furnish transplant-related services without prior PCM referral and HCF authorization, penalties will be administered according to TRICARE network provider agreements. If Prime enrollees receive health care services from non-network civilian providers without the required PCM referral and HCF authorization, MCS contractors shall reimburse charges for the services on a Point of Service basis. Special cost-sharing requirements apply to Point of Service claims. For specific information on Point of Service cost-shares and catastrophic cap calculations, see Chapter 12, Section 2.2, Section 10.1 and Chapter 13, Section 14.1.

2. For Standard and Extra patients residing in an (MCS) region, preauthorization is the responsibility of the MCS Medical Director, Health Care Finder or other designated utilization staff.

C. For beneficiaries who reside in fiscal intermediary regions, TRICARE/CHAMPUS benefits are allowed for liver transplantation, however, preauthorization is not required.

D. Preauthorized TRICARE/CHAMPUS benefits are allowed for living-related donor liver transplantation (LRDLT).

LIVER TRANSPLANTATION	Chapter: 3
	Section: 8.5

1. A TRICARE Prime enrollee must have a referral from his/her PCM and an authorization from the HCF before obtaining transplant-related services. If network providers furnish transplant-related services without prior PCM referral and HCF authorization, penalties will be administered according to TRICARE network provider agreements. If Prime enrollees receive health care services from non-network civilian providers without the required PCM referral and HCF authorization, MCS contractors shall reimburse charges for the services on a Point of Service basis. Special cost-sharing requirements apply to Point of Service claims. For specific information on Point of Service cost-shares and catastrophic cap calculations, see Chapter 12, Section 2.2, Section 10.1 and Chapter 13, Section 14.1.

2. For Standard and Extra patients residing in an MCS region, preauthorization is the responsibility of the MCS Medical Director, Health Care Finder or other designated utilization staff.

3. For fiscal intermediaries, preauthorization authority is the responsibility of the OCHAMPUS Medical Director.

4. A STSF NAS is not required for LRDLTs.

E. The designated preauthorizing authority shall only use the criteria contained in this policy when preauthorizing liver and LRDLTs.

F. Affirmative Patient Selection Criteria for Liver and LRDLT. CHAMPUS may cost-share medically necessary services and supplies related to liver and LRDLT when the transplantation is performed at a CHAMPUS or Medicare approved transplantation center for beneficiaries who:

1. Are suffering from end-stage hepatic disease; and

2. When the medical record documents that more conservative treatments have failed, and

3. Are approaching the terminal phase of their illness (e.g., death is imminent, irreversible damage to the central nervous system is inevitable, or the quality of life has deteriorated to unacceptable levels).

G. CHAMPUS may cost-share medically necessary services and supplies related to liver and LRDLTs for:

1. Evaluation of a potential candidate's suitability for liver transplantation whether or not the patient is ultimately accepted as a candidate for transplantation.

2. Pre- and post-transplantation inpatient hospital and outpatient services.

3. Pre- and postoperative services of the transplantation team.

4. The donor acquisition team, including the costs of transportation to the location of the donor organ and transportation of the team and the donated organ to the location of the transplantation center.

5. The maintenance of the viability of the donor organ after all existing legal requirements for excision of the donor organ have been met.

6. Blood and blood products.

7. FDA approved immunosuppression drugs to include off-label uses when determined to be medically necessary and generally accepted practice within the general medical community (i.e., non-investigational).

8. Complications of the transplantation procedure, including inpatient care, management of infection and rejection episodes.

9. Periodic evaluation and assessment of the successfully transplanted patient.

H. CHAMPUS benefits may be allowed for Hepatitis B and pneumococcal vaccines for patients undergoing transplantation.

I. CHAMPUS benefits may be allowed for DNA-HLA tissue typing determining histocompatibility.

EFFECTIVE DATE July 1, 1983

August 1, 1992, for LRDLT.

October 26, 1992, for removal of medical indications list.

July 15, 1996, for STSF NAS requirement.

EXCLUSIONS

Liver transplantation and LRDLT is excluded:

A. When any of the following contraindications exist:

1. Significant systemic or multisystemic disease (other than hepatorenal failure) which limits the possibility of full recovery and may compromise the function of the newly transplanted organs.

2. Active alcohol or other substance abuse.

a. Benefits may be allowed if:

(1) The patient has been abstinent for at least six months prior to the transplantation; and

(2) There is no evidence of other major organ debility (e.g., cardiomyopathy).

(3) There is evidence of ongoing participation in a social support group such as Alcoholics Anonymous; and

(4) There is evidence of a supportive family/social environment.

3. Malignancies metastasized to or extending beyond the margins of the liver; or,

4. Viral-induced liver disease when evidence of viremia is still present.

B. For:

1. Expenses waived by the transplantation center (e.g., beneficiary/sponsor not financially liable).

2. Services and supplies not provided in accordance with applicable program criteria (i.e., part of a grant or research program; investigational procedure).

3. Administration of an experimental or investigational immunosuppressant drug that is not FDA approved or has not received CHAMPUS approval as an appropriate "off label" drug indication. Refer to Chapter 7, Section 7.3 for CHAMPUS Policy requirements for immunosuppression therapy.

4. Pre- or post-transplantation nonmedical expenses (e.g., out-of-hospital living expenses, to include hotel, meals, privately owned vehicle for the beneficiary or family members).

5. Transportation of an organ donor.

C. Artificial assist devices. Assist devices are generally used for bridge to transplantation, until a suitable donor becomes available. Assist devices when used for bridge to transplantation are considered experimental.

D. Services, supplies or devices, even those used in lieu of the transplantation, when determined to be related or integral to an experimental or investigational procedure, may not be cost-shared under CHAMPUS (see Chapter 8, Section 14.1, for guidelines on determining coverage for related services).

EXCEPTIONS

A. Services and supplies for inpatient or outpatient services that are provided prior to and/or after discharge from hospitalization for a liver or LRDLT performed in an unauthorized CHAMPUS or Medicare liver transplantation center may be cost-shared subject to applicable Program policy. Preadmission services rendered by an unauthorized transplantation center may also be cost-shared subject to applicable program policies.

B. Aftercare related to a liver or LRDLT performed prior to July 1, 1983. Otherwise authorized services and supplies for transplantation related inpatient or outpatient services which are provided following discharge from hospitalization for a liver or a LRDLT performed prior to July 1, 1983, may be cost-shared subject to applicable program policy.

C. Liver or LRDLT performed on an emergency basis in an unauthorized liver transplantation facility may be cost shared by CHAMPUS only when the following conditions have been met:

1. The unauthorized center must consult with the nearest CHAMPUS authorized liver transplantation center regarding the transplantation case;

2. It must be determined and documented by the transplantation team physician(s) at the authorized liver transplantation center that transfer of the patient (to the authorized

liver transplantation center) is not medically reasonable, even though transplantation is feasible and appropriate; and

3. All other TRICARE contractual requirements have been met.

POLICY CONSIDERATIONS

A. For beneficiaries who reside in fiscal intermediary regions, when there is any question as to whether the beneficiary meets the clinical criteria for a liver transplantation, the claim must be developed and referred to medical review for a determination of clinical eligibility.

B. Services and supplies that may be cost-shared are limited to those listed in DoD 6010.8-R, Chapter 4, B.5.e.(3).

C. For beneficiaries who reside in TRICARE regions, preauthorization and retrospective authorization of liver or LRDLT must meet the following two requirements:

1. Patient meets (or as of the date of transplantation, would have met) patient selection criteria; and

2. Transplantation facility is (or as of the date of transplantation, would have been) CHAMPUS or Medicare approved for liver transplantation at the time of transplantation.

D. For beneficiaries who reside in TRICARE regions but fail to obtain preauthorization for liver or LRDLT, CHAMPUS benefits may be extended if the services or supplies otherwise would qualify for benefits but for the failure to obtain preauthorization. If preauthorization is not received, the appropriate preauthorizing authority as outline in paragraph B. for liver transplantation and paragraph D. for LRDLT, under Policy, is responsible for reviewing the claims to determine whether the beneficiary's condition meets the clinical criteria for the transplantation. TRICARE Prime enrollees who failed to obtain preauthorization will be reimbursed only under Point of Service rules.

E. Benefits will only be allowed for transplantations performed at a CHAMPUS or Medicare approved liver transplantation center. The CHAMPUS contractor in whose jurisdiction the center is located is the certifying authority for CHAMPUS authorization as a liver transplantation center. Refer to Chapter 11, Section 11.5 for organ transplantation certification center requirements.

F. Claims for services and supplies related to the transplantation will reimbursed based on billed charges.

G. Claims for transportation of the donor organ and transplantation team shall be adjudicated on the basis of billed charges, but not to exceed the transport service's published schedule of charges, and cost-shared on an inpatient basis. Scheduled or chartered transportation may be cost-shared.

H. Benefits will be allowed for donor costs. Refer to Chapter 3, Section 1.6L for guidelines regarding donor costs associated with organ transplantations.

LIVER TRANSPLANTATION	Chapter: 3
	Section: 8.5

I. Charges made by the donor hospital will be cost-shared on an inpatient basis and must be full itemized and billed by the transplantation center in the name of the CHAMPUS patient.

J. Acquisition and donor costs are not considered to be components of the services covered under the DRG. These cost must be billed separately on a standard UB-92 claim form in the name of the CHAMPUS patient.

K. Transportation of the patient by air ambulance may be cost-shared when determined to be medically necessary. Reference Chapter 7, Section 2.1.

L. For all DoD beneficiaries who reside in the continental United States (i.e., 48 contiguous states and the District of Columbia), the issuance of a STSF NAS shall be in accordance with COM-FI Part Two, Chapter 24 and OPM Part Two, Chapter 24. An STSF NAS is not required for LRDLT or for the admission for the preoperative evaluation to determine the patient's candidacy for the LRDLT.

NOTE: *Effective for admissions on or after September 23, 1996, an STSF NAS is not required for TRICARE PRIME enrollees (except for the enrollees who use the POS option). For such admissions the enrollees are required to obtain an authorization from the Health Care Finder, reference OPM Part Two, Chapter 24. Prime enrollees are required to obtain an STSF NAS when they use their POS option.*

M. When a properly preauthorized transplantation candidate is discharged less than 24 hours after admission because of extenuating circumstances, such as the available organ is found not suitable or other circumstances which prohibit the transplantation from being timely performed, all otherwise authorized services associated with the admission shall be cost-shared on an inpatient basis, since the expectation at admission was that the patient would remain more than 24 hours.

- END -

BENEFITS AND BENEFICIARY PAYMENTS UNDER THE TRICARE PROGRAM

NOTE 1: *The beneficiary payments in this attachment shall be applied in FY 1996 and FY 1997. In subsequent fiscal years, beneficiary copayments (i.e., beneficiary payments expressed as a specified amount) and enrollment fees may be updated for inflation annually (cumulative effect applied and rounded to the nearest whole dollar) by the national CPI-U medical index (the medical component of the Urban Consumer Price Index). Beneficiary cost shares (i.e., beneficiary payments expressed as a percentage of the provider's fee) will not be similarly updated.*

I. TRICARE Prime Program Annual Enrollment Fees

Does not apply to the TRICARE Extra Program (Also see "Point of Service Option", Section IV., below.):

TRICARE PRIME PROGRAM		
Active Duty Family Members		**Retirees & Their Family Members and Survivors**
El - E4	**E5 & Above**	
None	None	$230 per Retiree or Family Member $460 Maximum per Family

II. TRICARE Extra Program Annual Deductible

Applies to all outpatient services, does not apply to the TRICARE Prime Program. (Also see "Point of Service Option".):

TRICARE EXTRA PROGRAM		
Active Duty Family Members		**Retirees & Their Family Members and Survivors**
El - E4	**E5 & Above**	
$50 per Individual $100 Maximum per Family	$150 per Individual $300 Maximum per Family	$150 per Individual $300 Maximum per Family

III. TRICARE Standard Program Annual Deductible

Applies to all outpatient services, does not apply to the TRICARE Prime or Extra Programs:

TRICARE STANDARD PROGRAM		
Active Duty Family Members		**Retirees & Their Family Members and Survivors**
El - E4	**E5 & Above**	
$50 per Individual $100 Maximum per Family	$150 per Individual $300 Maximum per Family	$150 per Individual $300 Maximum per Family

NOTE 2: *These charts are not intended to be a comprehensive listing of all services covered under TRICARE. All care is subject to review for medical necessity and appropriateness.:*

IV. Outpatient Services:

BENEFICIARY COPAYMENT/COST SHARE (see Point of Service)					
TRICARE BENEFITS	**TRICARE PRIME PROGRAM**				
	Active Duty Family Members		**Retirees & Their Family**		
See Note 6 TYPE OF SERVICE	**El - E4**	**E5 & Above**	**Members & Survivors**	**TRICARE EXTRA PROGRAM**	**TRICARE STANDARD PROGRAM**
INDIVIDUAL PROVIDER SERVICES Office visits; outpatient office-based medical and surgical care; consultation, diagnosis and treatment by a specialist; allergy tests and treatment; osteopathic manipulation; medical supplies used within the office including casts, dressings, and splints.	$6 copayment per visit.	$12 copayment per visit.	$12 copayment per visit.	**Active Duty Family Members:** Cost share--15% of the fee negotiated by contractor. **Retirees and their Family Members and Survivors:** Cost share--20% of the fee negotiated by the contractor.	**Active Duty Family Members:** Cost share--20% of the allowable charge. **Retirees, their Family Members and Survivors:** Cost share--25% of the allowable charge.

IV. Outpatient Services: (Continued)

BENEFICIARY COPAYMENT/COST SHARE (see Point of Service)					
TRICARE BENEFITS	**TRICARE PRIME PROGRAM**			**TRICARE EXTRA PROGRAM**	**TRICARE STANDARD PROGRAM**
	Active Duty Family Members		**Retirees & Their Family**		
See Note 6 TYPE OF SERVICE	**E1 - E4**	**E5 & Above**	**Members & Survivors**		
LABORATORY AND X-RAY SERVICES	$6 copayment per visit. (See Note 3)	$12 copayment per visit. (See Note 3)	$12 copayment per visit. (See Note 2)	**Active Duty Family Members:** Cost share--15% of the fee negotiated by the contractor. **Retirees and their Family Members and Survivors:** Cost share--20% of the fee negotiated by the contractor.	**Active Duty family Members:** Cost share--20% of the allowable charge. **Retirees, their Family Members and Survivors:** Cost share--25% of the allowable charge.
NOTE 3: *If provided as part of an office visit and a copayment is collected for the visit, no additional copayment will be collected for these services. Also, no copayment will be collected for these services when they are billed and provided as clinical preventive services to TRICARE Prime Enrollees.*					
ROUTINE PAP SMEARS Frequency to depend on physician recommendations based on the published guidelines of the American Academy of Obstetrics and Gynecology. (See Note 3)	No copayment.	No copayment.	No copayment.	**Active Duty Family Members:** Cost share--15% of the fee negotiated by the contractor. **Retirees and their Family Members and Survivors:** Cost share--20% of the fee negotiated by the contractor.	**Active Duty family Members:** Cost share--20% of the allowable charge. **Retirees, their Family Members and Survivors:** Cost share--25% of the allowable charge.

IV. Outpatient Services: (Continued)

BENEFICIARY COPAYMENT/COST SHARE (see Point of Service)					
TRICARE BENEFITS	**TRICARE PRIME PROGRAM**				
	Active Duty Family Members		**Retirees & Their Family**		
See Note 6 TYPE OF SERVICE	**E1 - E4**	**E5 & Above**	**Members & Survivors**	**TRICARE EXTRA PROGRAM**	**TRICARE STANDARD PROGRAM**
AMBULANCE SERVICES When medically necessary as defined by the CHAMPUS Policy Manual and the service is a covered benefit.	$10 copayment per occurrence.	$15 copayment per occurrence.	$20 copayment per occurrence.	**Active Duty Family Members:** Cost share--15% of the fee negotiated by the contractor. **Retirees, their Family Members and Survivors:** Cost share--20% of the fee negotiated by the contractor.	**Active Duty Family Members:** Cost share--20% of the allowable charge. **Retirees and their Family Members and Survivors:** Cost share--25% of the allowable charge.
EMERGENCY SERVICES Emergency and urgently needed care obtained on an outpatient basis, both network and non-network, and in and out of the Region.	$10 copayment per emergency room visit.	$30 copayment per emergency room visit.	$30 copayment per emergency room visit.		
DURABLE MEDICAL EQUIPMENT, PROSTHETIC DEVICES, AND MEDICAL SUPPLIES PRESCRIBED BY AN AUTHORIZED PROVIDER WHICH ARE COVERED BENEFITS (If dispensed for use outside of the office or after the home visit.)	Cost-share - 10% of the fee negotiated by the contractor.	Cost-share - 15% of the fee negotiated by the contractor.	Cost-share - 20% of the fee negotiated by the contractor.		

IV. Outpatient Services: (Continued)

BENEFICIARY COPAYMENT/COST SHARE (see Point of Service)					
TRICARE BENEFITS	**TRICARE PRIME PROGRAM**			**TRICARE EXTRA PROGRAM**	**TRICARE STANDARD PROGRAM**
	Active Duty Family Members		**Retirees & Their Family**		
See Note 6 TYPE OF SERVICE	**E1 - E4**	**E5 & Above**	**Members & Survivors**		
HOME HEALTH CARE Part-time skilled nursing care, physical, speech & occupational therapy when medically necessary and which are covered benefits.	$6 copayment per visit.	$12 copayment per visit.	$12 copayment per visit.	**Active Duty Family Members:** Cost-share--15% of the fee negotiated by the contractor. **Retirees, their Family Members and Survivors:** Cost share--20% of the fee negotiated by the contractor.	**Active Duty Family Members:** Cost share--20% of the allowable charge. **Retirees, their Family Members and Survivors:** Cost share--25% of the allowable charge.
FAMILY HEALTH SERVICES Family planning and well baby care (up to 24 months of age). The exclusions listed in the CHAMPUS Policy Manual will apply.	$6 copayment per visit. (See Note 3)	$12 copayment per visit. (See Note 3)	$12 copayment per visit. (See Note 3)		
OUTPATIENT MENTAL HEALTH One hour of therapy, no more than two times each week (when medically necessary).	$10 copayment for individual visits. $6 copayment for group visits.	$20 copayment for individual visits. $12 copayment for group visits.	$25 copayment for individual visits. $17 copayment for group visits.		

IV. Outpatient Services: (Continued)

BENEFICIARY COPAYMENT/COST SHARE (see Point of Service)					
TRICARE BENEFITS	**TRICARE PRIME PROGRAM**				
	Active Duty Family Members		**Retirees & Their Family**		
See Note 6 TYPE OF SERVICE	**E1 - E4**	**E5 & Above**	**Members & Survivors**	**TRICARE EXTRA PROGRAM**	**TRICARE STANDARD PROGRAM**
PRESCRIPTION DRUGS					When not using a network pharmacy.
RETAIL NETWORK	$5 copayment per Rx up to a 30-day supply.	$5 copayment per Rx up to a 30-day supply.	$9 copayment per Rx up to a 30-day supply.	**Deductible:** None. **Cost-Share:** **Active Duty Family Members—** 15% of the fee negotiated by the contractor. **Retirees, Their Family Members, Survivors, and Others—** 20% of the fee negotiated by the contractor.	**Deductible:** Yes-Standard. **Cost-Share:** **Active Duty Family Members—** 20% of the allowable charge. **Retirees, Their Family Members, Survivors, and Others—** 25% of the allowable charge.
MAIL SERVICE PHARMACY	$4 copayment per Rx up to a 90-day supply.	$4 copayment per Rx up to a 90-day supply.	$8 copayment per Rx up to a 90-day supply.	**Deductible:** None. **Cost-Share:** Same as TRICARE Prime Program.	

IV. Outpatient Services: (Continued)

BENEFICIARY COPAYMENT/COST SHARE (see Point of Service)					
TRICARE BENEFITS	**TRICARE PRIME PROGRAM**				
	Active Duty Family Members		**Retirees & Their Family**		
See Note 6 TYPE OF SERVICE	**E1 - E4**	**E5 & Above**	**Members & Survivors**	**TRICARE EXTRA PROGRAM**	**TRICARE STANDARD PROGRAM**
AMBULATORY SURGERY (same day) Authorized hospital-based or freestanding ambulatory surgical center that is CHAMPUS certified.	$25 copayment for primary surgeon only.	$25 copayment for primary surgeon only.	$25 copayment for primary surgeon only.	**Active Duty Family Members:** Cost-share - $25 cost-share for Ambulatory Surg. **Retirees and their Family Members:** Cost-share 20% of the fee negotiated by the contractor.	**Active Duty Family Members:** $25. **Retirees, their Family Members and Survivors:** 25% of the allowable charge.
IMMUNIZATIONS (See Note 4) Immunizations required for active duty family members whose sponsors have permanent change of station orders to overseas locations.	$6 copayment per visit. (See Note 2)	$12 copayment per visit. (See Note 2)	Not covered under Prime.	**Active Duty Family Members:** Cost-share 15% of the fee negotiated by the contractor. **Retirees, their Family Members and Survivors:** Not covered under TRICARE Extra.	**Active Duty Family Members:** Cost-share 20% of the allowable charge. **Retirees, their Family Members and Survivors:** Not covered under TRICARE Standard.

IV. Outpatient Services: (Continued)

BENEFICIARY COPAYMENT/COST SHARE (see Point of Service)					
TRICARE BENEFITS	**TRICARE PRIME PROGRAM**				
	Active Duty Family Members		**Retirees & Their Family**		
See Note 6 TYPE OF SERVICE	**E1 - E4**	**E5 & Above**	**Members & Survivors**	**TRICARE EXTRA PROGRAM**	**TRICARE STANDARD PROGRAM**
EYE EXAMINATIONS (See Note 4) One routine examination per year for family members of active duty sponsors.	$6 copayment per examination. (See Note 2)	$12 copayment per examination. (See Note 2).	Not covered under Prime. (See Note 4)	**Active Duty Family Members:** Cost-share 15% of the fee negotiated by the contractor. **Retirees, their Family Members, and Survivors:** Not covered under TRICARE Extra.	**Active Duty Family Members:** Cost-share 20% of the allowable charge. **Retirees, their Family Members and Survivors:** Not covered under TRICARE Standard.
NOTE 4: *Additional immunizations and eye examinations are covered under the TRICARE Prime Program's "clinical preventive services". See Chapter 12, Section 8.1.*					

CLINICAL PREVENTIVE SERVICES (See Notes 5 and 6)	BENEFICIARY COPAYMENT
TYPE OF SERVICE	**TRICARE PRIME PROGRAM**
	All beneficiaries categories
Clinical Preventive Services Includes those services listed in Chapter 12, Section 8.1.	No copayment. See Note 5

NOTE 5: *No copayment may be collected for these services when they are billed and provided as specified in Chapter 12, Section 8.1.*

NOTE 6: *No enhanced outpatient benefits under the TRICARE Extra Program.*

V. Inpatient Services

TRICARE STANDARD BENEFITS (see Note 7)	BENEFICIARY COPAYMENT/COST SHARE			
	TRICARE PRIME PROGRAM			
TYPE OF SERVICE	**Active Duty Family Members**	**Retirees & Their Family Members & Survivors**	**TRICARE EXTRA PROGRAM**	**TRICARE STANDARD PROGRAM**

NOTE 7: *No enhanced inpatient benefits under the TRICARE Prime or Extra programs.*

V. Inpatient Services (Continued)

TRICARE STANDARD BENEFITS (see Note 7)	BENEFICIARY COPAYMENT/COST SHARE			
	TRICARE PRIME PROGRAM			
TYPE OF SERVICE	Active Duty Family Members	Retirees & Their Family Members & Survivors	TRICARE EXTRA PROGRAM	TRICARE STANDARD PROGRAM
HOSPITALIZATION Semiprivate room (and when medically necessary, special care units), general nursing, and hospital service. Includes inpatient physician and their surgical services, meals including special diets, drugs and medications while an inpatient, operating and recovery room, anesthesia, laboratory tests, x-rays and other radiology services, necessary medical supplies and appliances, blood and blood products. Unlimited services with authorization, as medically necessary.	$11 per diem charge ($25 minimum charge per admission). No separate copayment/cost-share for separately billed professional charges.	$11 per diem charge ($25 minimum charge per admission). No separate copayment/cost-share for separately billed professional charges.	**Active Duty Family Members:** Per diem charge ($25 minimum charge per admission). **Retirees, their Family Members and Survivors:** Per diem copayment or 25% cost-share of total charges (based on the fee schedule negotiated by the contractor) for institutional services, whichever is less, plus 20% cost-share of separately billed professional charges (based on the fee schedule negotiated by the contractor).	**Active Duty Family Members:** Per diem charge ($25 minimum charge per admission). **Retirees, their Family Members and Survivors:** Per diem copayment or 25% cost-share of billed charges for institutional services, whichever is less, plus 25% cost-share of allowable for separately billed professional charges.
MATERNITY Hospital and professional services (prenatal, postnatal). Unlimited services with authorization as medically necessary.				

V. Inpatient Services (Continued)

TRICARE STANDARD BENEFITS (see Note 7)	BENEFICIARY COPAYMENT/COST SHARE			
	TRICARE PRIME PROGRAM			
TYPE OF SERVICE	Active Duty Family Members	Retirees & Their Family Members & Survivors	TRICARE EXTRA PROGRAM	TRICARE STANDARD PROGRAM
SKILLED NURSING FACILITY CARE Semiprivate room, regular nursing services, meals including special diets, physical, occupational and speech therapy, drugs furnished by the facility, necessary medical supplies, and appliances. Unlimited services with authorization, as medically necessary.	$11 per diem charge ($25 minimum charge per admission). No separate copayment/cost-share for separately billed professional charges.	$11 per diem charge ($25 minimum charge per admission). No separate copayment/cost-share for separately billed professional charges.	**Active Duty Family Members:** Per diem charge ($25 minimum charge per admission). **Retirees, their Family Members and Survivors:** Per diem copayment or 25% cost-share 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).	**Active Duty Family Members:** Per diem charge ($25 minimum charge per admission). **Retirees, their Family Members and Survivors:** 25% cost-share of allowed charges for institutional services, plus 25% cost-share of allowable for separately billed professional charges.

V. Inpatient Services (Continued)

TRICARE STANDARD BENEFITS (see Note 7)	BENEFICIARY COPAYMENT/COST SHARE			
	TRICARE PRIME PROGRAM			
TYPE OF SERVICE	Active Duty Family Members	Retirees & Their Family Members & Survivors	TRICARE EXTRA PROGRAM	TRICARE STANDARD PROGRAM
FOR MENTAL ILLNESS With authorization, up to 30 days per fiscal year for adults (age 19+), up to 45 days per fiscal year for children under age 19; up to 150 days residential treatment for children and adolescents.	$20 per diem charge. No separate copayment/cost-share for separately billed professional charges.	$40 per diem charge ($25 minimum charge per admission). No separate copayment/cost-share for separately billed professional charges.	**Active Duty Family Members:** $20 daily per diem charge. **Retirees and their Family Members and Survivors:** 20% cost-share 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).	**Active Duty Family Members:** Per diem charge ($25 minimum charge per admission). **Retirees, their Family Members and Survivors:** Per diem cost share, that varies according to the facility or 25% cost-share of allowable charges for institutional services, whichever is less, plus 25% cost-share of allowable for separately billed professional charges.
SUBSTANCE USE TREATMENT (Inpatient, partial) With authorization, 7 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.				
PARTIAL HOSPITALIZATION-MENTAL HEALTH With authorization, up to 60 days per fiscal year (minimum of 3 hours/day of therapeutic services).				

VI. Point of Service

TRICARE STANDARD BENEFITS (see Note 7)	BENEFICIARY COPAYMENT/COST SHARE			
	TRICARE PRIME PROGRAM			
TYPE OF SERVICE	Active Duty Family Members	Retirees & Their Family Members & Survivors	TRICARE EXTRA PROGRAM	TRICARE STANDARD PROGRAM
Applies to all non-emergency inpatient and outpatient services received by enrollees without authorization or from a non network provider.	**Deductible:** $300.00 individual $600.00 family. **Cost-Share:** 50% of the allowed charges (See Note 8).	**Deductible:** $300.00 individual $600.00 family. **Cost-Share:** 50% of the allowed charges (See Note 8).	Point of Service Option does NOT apply to TRICARE Extra beneficiaries.	Point of Service Option does NOT apply to TRICARE Standard beneficiaries.
NOTE 8: *CHAMPUS reimbursement will be limited to 50% of the billed/allowed charges.*				

Refer to Chapter 12, Section 2.2 for information on catastrophic loss protection.

Subject: TRICARE PRIME - CATASTROPHIC LOSS PROTECTION	Chapter: 12
	Section: 2.2
Authority: DoD 6010.8-R, Chapter 4 and DoD 6010.8-R, Chapter 17	Issue Date: May 15, 1996

POLICY

Under TRICARE Prime, annual catastrophic caps are calculated for enrollment years as well as for fiscal years. Each enrollment year begins on the Prime enrollment anniversary date.

A. For TRICARE Prime enrollees who are active duty family members.

1. For dates of service prior to October 1, 1996, out-of-pocket expenses accrue toward a $1,000 enrollment year catastrophic cap as well as toward a $1,000 fiscal year catastrophic cap.

2. For dates of service on or after October 1, 1996, out-of-pocket expenses accrue only toward the $1,000 fiscal year catastrophic cap. Calculation for the enrollment year catastrophic cap is eliminated.

B. For TRICARE Prime enrollees who are other than active duty personnel or active duty family members (i.e., retirees, family members of retirees, survivors, etc.), out-of-pocket expenses accrue toward a $3,000 per enrollment year catastrophic cap as well as toward the $7,500 fiscal year catastrophic cap. (TRICARE Standard beneficiaries who are other than active duty family members continue to have a $7,500 fiscal year catastrophic cap.)

C. Prime enrollees will pay no more applicable out-of-pocket expenses for the rest of the fiscal year once the fiscal year catastrophic cap is met (see "Policy Clarifications" below and Chapter 13, Section 14.1).

D. Prime enrollees will pay no more Prime copayments of the rest of the enrollment year once the enrollment year catastrophic cap is met. All family members must reside and be enrolled in the same contract area in order for the contractor to track and calculate catastrophic cap accumulations for the entire family (see OPM Part Three, Chapter 4, Section II.G.). Families with some members enrolled in one area and other members enrolled in another area are responsible for tracking enrollment year catastrophic caps for all family members. A family member must notify one of the involved contractors if the family accumulations meet or exceed the enrollment year catastrophic cap.

POLICY CLARIFICATIONS

A. Only the following expenses may be credited to a Prime beneficiary's enrollment year catastrophic cap:

1. Enrollment fees, and

2. The outpatient and inpatient cost-shares and co-payments defined in Chapter 12, Section 2.1.

NOTE: *Deductibles and cost shares imposed on services provided under the Point of Service option are not creditable to the enrollment year catastrophic cap.*

B. The following expenses may be credited to a Prime beneficiary's fiscal year catastrophic cap:

1. For dates of service prior to October 1, 1996:

a. Deductibles (including those assessed to Point of Service claims), and

b. Copayments and cost-shares (including those assessed to Point of Service claims).

NOTE: *Point of Service claims do not have a catastrophic cap even though Point of Service deductible and cost-share amounts are applied to the fiscal year catastrophic cap. All care paid under the Point of Service option must be cost-shared at 50% of the allowable charge (after meeting the Point of Service deductible), even if the enrollment and fiscal year catastrophic caps are met. Refer to OPM Part Two, Chapter 1, Section VI.C. for guidance on application of expenses to catastrophic caps under Prime and Standard.*

2. For dates of service on or after October 1, 1996:

a. All expenses listed in paragraph B.1., above, and

b. Enrollment fees.

EFFECTIVE DATE

A. The $3,000 retiree, retiree family member, survivor catastrophic loss protection limit is effective November 1, 1995. It will apply to out-of-pocket expenses incurred on and after November 1, 1995.

B. Effective October 1, 1996, enrollment fees accrue toward the fiscal year catastrophic cap;

C. Effective October 1, 1996, the calculation for the enrollment period catastrophic cap for active duty family members enrolled in TRICARE Prime is eliminated.

- END -

BENEFITS AND BENEFICIARY PAYMENTS UNDER THE TRICARE OVERSEAS PROGRAM BEGINNING OCTOBER 1, 1996 TO SEPTEMBER 30, 1997

NOTE 1: *The beneficiary payments in this attachment shall be applied in FY 1996 and FY 1997. In subsequent fiscal years, beneficiary copayments (i.e., beneficiary payments expressed as a specified amount) and enrollment fees may be updated for inflation annually (cumulative effect applied and rounded to the nearest whole dollar) by the national CPI-U medical index (the medical component of the Urban Consumer Price Index). Beneficiary cost shares (i.e., beneficiary payments expressed as a percentage of the provider's fee) will not be similarly updated.*

I. TRICARE Overseas Prime Program Annual Enrollment Fees:

TRICARE OVERSEAS PRIME PROGRAM		
Active Duty Family Members		**Reserved**
El - E4	**E5 & Above**	
None	None	Reserved

II. TRICARE Overseas Standard Program Annual Deductible

Applies to all outpatient services, does not apply to the TRICARE Overseas Program:.

TRICARE OVERSEAS EXTRA PROGRAM		
Active Duty Family Members		**Retirees & Their Family Members and Survivors**
El - E4	**E5 & Above**	
$50 per Individual $100 Maximum per Family	$150 per Individual $300 Maximum per Family	$150 per Individual $300 Maximum per Family

NOTE 2: *These charts are not intended to be a comprehensive listing of all services covered under TRICARE. All care is subject to review for medical necessity and appropriateness.*

III. Outpatient Overseas Services:

BENEFICIARY COPAYMENT/COST SHARE			
TRICARE BENEFITS	**TRICARE OVERSEAS PRIME PROGRAM**		**TRICARE OVERSEAS STANDARD PROGRAM**
TYPE OF SERVICE	**Active Duty Family Members**		
	El - E4	**E5 & Above**	
INDIVIDUAL PROVIDER SERVICES Office visits; outpatient office-based medical and surgical care; consultation, diagnosis and treatment by a specialist; allergy tests and treatment; osteopathic manipulation; medical supplies used within the office including casts, dressings, and splints.	None	None	**Active Duty Family Members:** Cost share--20% of the allowable charge. **Retirees, their Family Members and Survivors:** Cost share--25% of the allowable charge.
LABORATORY AND X-RAY SERVICES	None	None	
ROUTINE PAP SMEARS Frequency to depend on physician recommendations.	None	None	**Active Duty Family Members:** Cost share--20% of the allowable charge. **Retirees, their Family Members and Survivors:** Cost share--25% of the allowable charge.
AMBULANCE SERVICES When medically necessary as defined by the CHAMPUS Policy Manual and the service is a covered benefit.	None	None	Same as above.
EMERGENCY SERVICES Emergency and urgently needed care obtained on an outpatient basis, both network and non-network, and in and out of the Region.	None	None	Same as above.

Subject: TRICARE PRIME - ENROLLMENT	Chapter: 12
	Section: 7.1
Authority: DoD 6010.8-R, Chapter 17	Issue Date: May 15, 1996

POLICY

A. In order to receive the expanded benefits and special cost sharing of Prime, beneficiaries must enroll. Active Duty service members are automatically enrolled; others must take specific action to enroll.

B. No non-active duty beneficiary shall be enrolled unless he/she is shown as eligible for CHAMPUS on the Defense Enrollment Eligibility Reporting System (DEERS). All enrollments shall be recorded on the Defense Enrollment Eligibility Reporting System (DEERS) through the Composite Health Care System (CHCS). Further, all Military Health Services System (MHSS) beneficiaries, including Medicare eligibles over the age of 65, must be registered on CHCS in order to obtain services in MTFs and from Health Care Finders. This is separate from enrollment in Prime.

C. No CHAMPUS-eligible beneficiary who resides in the TRICARE region shall be denied enrollment or re-enrollment in, or be required to disenroll from, the TRICARE Prime program because of a prior or current medical condition.

POLICY CONSIDERATIONS

A. Enrollment may occur at any time and is for a 12 month period.

B. Enrollment may be on an individual or family basis.

C. The Managed Care Support (MCS) contractor is responsible for collecting enrollment fees from Prime enrollees, as appropriate. The MCS contractor retains all such fees. See Chapter 12, Section 2.1 for enrollment fee requirements.

D. Payment of enrollment fees may be made by personal check, major credit card, travelers' check, money order, or cashier's check. Fees may be paid quarterly or annually. No administrative fees are charged to enrollees who choose to pay quarterly.

E. Enrollees shall be automatically processed for re-enrollment each year, unless they choose to disenroll in advance of the renewal date.

F. For emergency cases that should be placed under immediate case management, MTF Commanders (for catchment area residents) and the Lead Agents (for non-catchment area residents) may approve exceptions on a case-by-case basis for retroactive enrollment with an effective date not earlier than the first day of the month that the application is submitted.

G. MHSS beneficiaries who are Medicare eligible or who are not otherwise eligible to enroll in TRICARE Prime shall register for the purpose of accessing care in the MTF and Health Care Finder (HCF) services (Chapter 12, Section 4.1). This registration is NOT enrollment in TRICARE Prime and no TRICARE Prime program benefits or services (other than access to the services of HCFs and network providers) applies to this beneficiary group.

H. Enrollees may transfer enrollment when they move to another TRICARE region where Prime is offered (see OPM Part Three, Chapter 4, Section II.G.). The losing contractor shall provide continuing coverage during the transient period until (1) the enrollee applies for enrollment in the new location, (2) the enrollee disenrolls, or (3) the contractor must disenroll the beneficiary for failure to pay required enrollment fees, whichever occurs first. During the transient period, the authorization and referral rules of the losing contractor will continue to apply. Claims for non-emergency care without an authorization will be processed under the Point Of Service option (see Chapter 12, Section 10.1). In no circumstance will retroactive disenrollment be allowed in order to avoid Point of Service cost-sharing provisions. Even though a Prime enrollee who is relocating must request an authorization for nonemergency care from the losing contractor's HCF, the enrollee shall not be required to use a network provider.

I. Enrollees may disenroll from TRICARE Prime when they move out of the region or any time after 12 months of continuous enrollment. All other voluntary disenrollments require the approval of the MTF Commander (for catchment area residents) or Lead Agent (for non-catchment area residents). If approval is not granted, the enrollee may appeal the decision to the Lead Agent who may approve such requests on a case-by-case basis. There are no refunds of paid enrollment fees with one exception: a contractor may reimburse the unused portion of the Prime enrollment fee to a retired TRICARE Prime enrollee who has been recalled to active duty. If the activated member's family chooses continued enrollment in TRICARE Prime, the family shall begin a new enrollment period and, if possible, shall be offered the opportunity to keep its primary care manager (see OPM Part Three, Chapter 4, Section II.G.).

1. If the beneficiary disagrees with the decision to allow disenrollment, the beneficiary may appeal to the appropriate Lead Agent who shall make the final decision regarding a beneficiary's request to disenroll.

2. Disenrollment shall be required when beneficiaries no longer live within the TRICARE region, when they are no longer eligible for CHAMPUS, or when they do not submit payment for prescribed enrollment fees by the renewal payment date.

3. If an enrollee or enrollee family is disenrolled by the contractor for failure to pay required quarterly enrollment fees, there is a 12-month waiting period before the individual or family may reenroll.

See OPM, Part Three, Chapter 4 for additional information.

- END -

Subject: TRICARE - PRIME AND STATUS CHANGES	Chapter: 12
	Section: 7.2
Authority: DoD 6010.8-R, Chapter 17	Issue Date: May 15, 1996

POLICY

A. Generally, when the CHAMPUS eligibility status changes, eligibility for TRICARE PRIME benefits also changes. The time frames for Prime eligibility parallel CHAMPUS eligibility.

B. In all cases, when CHAMPUS eligibility ends, eligibility for PRIME ceases. This includes retirees, their family members and survivors who turn age 65 and become entitled to Medicare, dependent children who lose CHAMPUS eligibility due to age, remarriage of former spouses, etc.

POLICY CLARIFICATIONS

A. To have continuous Prime Coverage, the enrollee shall notify the contractor before retirement and pay the appropriate enrollment fees within the required time frames. (OPM, Part Three, Chapter 4, Section II.D.7.) Active duty personnel who retire may enroll at the same time as the remaining family members.

B. When an enrollee who has a change in status fails to notify the contractor but submits claims, the contractor will disenroll the beneficiary from Prime (as of the date of his/her change in status), apply TRICARE standard cost sharing and deductible, and notify the enrollee of his/her status change and options for re-enrollment in Prime.

C. When status changes from active duty family member to retiree family member, Prime enrollees shall be offered an opportunity to continue enrollment in Prime, but at the retiree cost-sharing rates. These enrollees must pay the applicable enrollment fees. Upon payment of fees, the enrollees will be given a new enrollment period. Beneficiaries shall be permitted to keep their Primary Care Manager (PCM), if possible. The Lead Agents and Military Treatment Facility (MTF) Commanders shall determine if retiring beneficiaries who enroll in Prime could keep their MTF PCMs, given the MTF's enrollment plan and MTF capacity.

D. Family members of an active duty member who dies while on active duty are authorized to maintain active duty family member status under CHAMPUS (and therefore TRICARE) for one year after the death of the member. These individuals are not distinguished from other active duty family members for Prime eligibility.

E. In situations where an active duty member's rank changes (from E-4 to E-5 or above), family members who are enrolled in Prime can maintain their cost-sharing status until the end of their current enrollment period. At the anniversary date, enrollees can make a decision to continue enrollment in Prime (with the new cost-sharing) or disenroll.

F. When TRICARE Prime enrollment changes from an individual to a family enrollment status prior to annual renewal for beneficiary categories required to pay an enrollment fee,

the unused portion (pro-rated on a quarterly basis) of the fee will be applied toward a new 12 month enrollment period.

1. For active duty family members, single enrollment can be changed to family at any time during the enrollment period. A new enrollment period shall be established for the family.

2. In cases of a change from single status to family based on the birth of a child or adoption, the new family member of the Prime enrollee will be considered enrolled as of the day of birth or adoption and given up to 120 days to decide whether to continue Prime or disenroll the child. For retirees or their family members or survivors who decide to continue enrollment for the child, the unused portion (pro-rated on a quarterly basis) of the single enrollment fee they paid will be applied toward a new 12 month family enrollment period.

G. When a family enrollment status changes to single, there is no refund of the paid enrollment fee. The remaining single enrollee continues to have Prime coverage until the end of the enrollment period.

H. CHAMPUS eligible beneficiaries who have less than 12 months of eligibility remaining (for example, retirees who are 64 years of age) are allowed to enroll in Prime, however, these enrollees will be disenrolled from Prime when they lose their CHAMPUS eligibility. The beneficiary has the choice of paying all of the enrollment fee, which is not refundable, or paying the fees on a quarterly basis. If paid on a quarterly basis, the beneficiary will be required to pay the installments that would cover the period of their eligibility only.

I. Enrollees may disenroll in TRICARE Prime at any time after 12 months or sooner if the enrollee is moving out of the region. All other voluntary disenrollments require approval of the MTF Commander or Lead Agent. If approval is not granted, the enrollee may appeal the decision to the Lead Agent. Enrollment fees are non refundable in all cases except one. A contractor may reimburse the unused portion of the TRICARE Prime enrollment fee to a retired TRICARE Prime enrollee who has been recalled to active duty (see OPM Part Three, Chapter 4, Section II.6.). If the family of the reactivated member chooses continued enrollment in TRICARE Prime, the family shall begin a new enrollment period and shall be offered the opportunity to keep its primary care manager, if possible.

J. If the enrollee is disenrolled by the contractor for failure to pay required enrollment fees, there is a 12 month waiting period before the beneficiary may re-enroll.

- END -

Subject: TRICARE PRIME - CLINICAL PREVENTIVE SERVICES	Chapter: 12
Authority: DoD 6010.8-R, Chapter 17	Section: 8.1
	Issue Date: May 15, 1996

BACKGROUND

The following are clinical preventive services expected of good comprehensive clinical practice in which every patient encounter should be used as an opportunity for preventive care. These preventive services are either (1) screening procedures to detect disease or (2) primary or secondary prevention interventions to protect or restore health. These services may be provided during acute and chronic care visits or during preventive care visits for asymptomatic individuals to maintain and promote good health.

Routine history and physical examination are no longer recommended for health promotion and disease prevention in individuals who are not being monitored as a part of a therapeutic plan for chronic disease. Instead, the U.S. Preventive Services Task Force and other major authorities recommend that every patient encounter be used as an opportunity for preventive care and that a variety of age and sex specific services be combined into these encounters and periodic health promotion disease prevention surveillance examinations.

POLICY

A. There is no preauthorization required for the following services, however, the beneficiary must use a network provider or, if a network provider is not available within the access standards of the contract, a non-network provider to whom the beneficiary is referred by the contractor. The contractor shall clearly and completely explain this requirement in all beneficiary and provider education materials. Payment will not be made under the Point of Service option for clinical preventive services that are not otherwise covered under TRICARE Standard.

B. There shall be no co-payments associated with the individually CHAMPUS reimbursable services listed below. The contractor shall apply all appropriate claims processing and rebundling edits before determining if the below listed CPT procedure code is individually reimbursable. The contractor need not establish additional edits to identify claims within the age, sex, race or clinical history perimeters included below:

.

SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT CPT CODE
SCREENING EXAMINATIONS:		
COMPREHENSIVE HEALTH PROMOTION AND DISEASE PREVENTION EXAMINATIONS	**For ages 24 months or older**: One comprehensive disease prevention clinical evaluation and follow up during age intervals: 2-4; 5-11; 12-17; 18-39; 40-64.	99382-99386 99392-99396

SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT CPT CODE
TARGETED HEALTH PROMOTION AND DISEASE PREVENTION EXAMINATIONS	The following screening examinations may be performed during either the above periodic comprehensive health promotion examination or as part of other patient encounters. The intent is to maximize preventive care.	
Breast Cancer:	**Physical Examination**: For women under age 40, physicians may elect to perform clinical breast examination for those who are at high risk, especially those whose first-degree relatives have had breast cancer diagnosed before menopause. For women age 40 and older, annual clinical examinations should be performed.	See codes for comprehensive health promotion and disease prevention exams.
	Mammography: Baseline mammogram age 40; every two years age 40-50, annually age 50 and over; For high risk women (family history of breast cancer in a first degree relative), baseline mammogram age 35, then annually.	76092
Cancer of Female Reproductive Organs:	**Physical Examination:** Pelvic examination should be performed in conjunction with Pap smear testing for cervical neoplasms and premalignant lesions.	See codes for comprehensive health promotion and disease prevention exams.
	Papanicolaou smears: Annually starting at age 18 (or younger, if sexually active) until three consecutive satisfactory normal annual examinations. Frequency may then be less often at the discretion of the patient and clinician but not less frequently than every three years.	88150, 88151, 88155, 88156, and 88157.
Testicular Cancer:	**Physical Examination:** Clinical testicular exam annually for males age 13-39 with a history of cryptorchidism, orchiopexy, or testicular atrophy.	See codes for comprehensive health promotion and disease prevention exams.
Colorectal Cancer:	**Physical Examination:** Digital rectal examination should be included in the periodic health examination of individuals 40 years of age and older.	See codes for comprehensive health promotion and disease prevention exams.

Subject: TRICARE PRIME - POINT OF SERVICE OPTION	Chapter: 12
	Section: 10.1
Authority: DoD 6010.8-R, Chapter 17	Issue Date: May 15, 1996

POLICY

Although TRICARE Prime enrollees are generally required to receive care from their Primary Care Manager (PCM) or have it authorized by the Health Care Finder (HCF), they are entitled to seek care directly under the Point of Service Option.

POLICY CONSIDERATIONS

A. Non-emergency care provided to a TRICARE Prime enrollee which is not either provided by the patient's PCM or referred by the PCM and specifically authorized by the Health Care Finder is payable only under the Point of Service option.

B. Point of Service claims are subject to customary CHAMPUS provisions regarding coverage. If an NAS is required for the care, one must be present in order for the claim to be paid as Point of Service. If an NAS is required but not present and there is no primary payor, the care is to be denied.

C. The following deductible and cost share amounts apply to all Point of Service claims for both inpatient and outpatient health care services:

1. Enrollment year deductible: $300 per individual; $600 per family.

2. Beneficiary cost-share: 50 percent of the allowable charge after the deductible has been met.

D. Point of Service deductibles and cost shares amounts are NOT creditable to the enrollment year catastrophic cap for TRICARE Prime enrollees. They may be credited ONLY to the $1,000/$7,500 fiscal year catastrophic caps for these beneficiaries. (See Chapter 12, Section 2.2 for information on catastrophic caps under TRICARE.)

E. A TRICARE Prime enrollee shall pay deductible and cost-share amounts for Point of Service claims even after his/her out-of-pocket expenses exceed either the fiscal year or enrollment year catastrophic cap amount. The government will pay no more than 50% of the allowable charge for any care covered under the Point of Service option.

EXCEPTIONS

A. TRICARE enrollees are entitled to receive the first eight mental health sessions without HCF authorization. (See OPM, Part Three, Chapter 3.) If the care is provided by a network provider, the claim is to be processed under TRICARE Prime rules. The network provider will notify the Health Care Finder of the care and obtain authorization on behalf of the beneficiary. This authorization is only to permit claims processing and does not include or represent a clinical review. Point of Service cost sharing applies only if the first eight sessions are provided by a non-network provider.

B. The TRICARE Prime Clinical Preventive Services (Chapter 12, Section 8.1) do not require preauthorization. Most of the services covered as Clinical Preventive Services are provided directly or ordered by the patient's PCM. In those cases that patients can self-refer for services (i.e., eye examinations), patients must use network providers. If the patient does not use a network provider, payment will be made under the Point of Service option ONLY for services that are otherwise covered under TRICARE Standard.

- END -

Subject: CATASTROPHIC LOSS PROTECTION	Chapter: 13
	Section: 14.1
Authority: Sections 1079(b)(5) and 1086(b)(4), Title 10, United States Code	Issue Date: March 21, 1988

DESCRIPTION

The National Defense Authorization Act for Fiscal Years 1988 and 1989 (P.L. 100-180) amended title 10, United States Code, and established catastrophic loss protection for CHAMPUS beneficiary families on a government fiscal year basis. The law placed fiscal year limits or catastrophic caps on beneficiary liabilities for deductibles and cost-shares under the CHAMPUS Basic Program. The Defense Authorization Act for fiscal year 1993 (P.L. 102-484) amended Title 10, United States Code, and reduced the catastrophic cap for beneficiaries other than active duty dependents.

DoD 6010.8-R, Chapter 18, F., authorizes catastrophic loss protection for TRICARE Prime beneficiary families on a one-year enrollment period basis in addition to the protection on a fiscal year basis.

POLICY

POLICY

A. Catastrophic Cap For Family Members of Active Duty Members.

1. Under the CHAMPUS Basic program and the TRICARE Extra and TRICARE Standard programs, the maximum family liability is $1,000 for deductibles and cost-shares based on allowed charges for the Basic Program services and supplies received in a fiscal year.

2. Under the TRICARE Prime Program, in addition to the catastrophic loss protection based on the fiscal year, Prime enrollees also have an enrollment year catastrophic cap:

a. For services received before October 1, 1996, total out-of-pocket TRICARE Prime Program costs, excluding costs involved in Point of Service claims, may not exceed $1,000 per one-year enrollment period. The one-year enrollment period, or enrollment year, begins on the enrollment anniversary date;

b. For services received on or after October 1, 1996, the $1,000 catastrophic cap calculation is based on the fiscal year only. The "enrollment year" calculation is discontinued effective October 1, 1996.

B. Catastrophic Cap For All Other Beneficiaries.

1. Under the CHAMPUS Basic program and under TRICARE, the fiscal year cap is $7,500.

2. For beneficiaries enrolled in TRICARE Prime, out-of-pocket expenses accrue toward an enrollment year catastrophic cap of $3,000 as well as toward the $7,500 fiscal year catastrophic cap.

NOTE: *For additional information regarding TRICARE and catastrophic caps, including which expenses may be applied to the fiscal year cap and which to the enrollment year cap, see Chapter 12, Section 2.2 and Chapter 12, Section 10.1.*

C. Cap Is Met. For CHAMPUS beneficiaries and for TRICARE Standard and Extra beneficiaries, after the fiscal year catastrophic cap is met, the TRICARE/CHAMPUS determined allowable amount shall be paid in full for all covered services and supplies under TRICARE Standard and Extra programs and the CHAMPUS Basic Program for the remainder of the fiscal year. For TRICARE Prime beneficiaries, after either the fiscal year or enrollment year catastrophic cap is met, the TRICARE determined allowable amount shall be paid in full for all covered services and supplies under the TRICARE Prime program for the rest of the enrollment year. See "Exceptions" paragraph D. for information on Point of Service claims.

POLICY CONSIDERATIONS

A. Double Coverage. For purposes of catastrophic loss protection, the full deductible and cost-share calculated according to the TRICARE/CHAMPUS provisions will be credited toward meeting the applicable catastrophic cap (even when double coverage exists). See an illustration below for an inpatient retiree with other insurance who is not enrolled in TRICARE Prime:

Total Amount Billed	$8169.11
Total Amount Allowed	8169.11
Cost-Share (25% of the Total Amount Allowed)	2042.27
Paid By Beneficiary To Provider	0.00
Paid By Other Insurance	7119.11
Total TRICARE/CHAMPUS Payment	1050.00
AMOUNT TO BE CREDITED TOWARD CAP	2042.27

NOTE: *Normal double coverage rules, as provided in Chapter 13, Section 12.1, remain in effect after the cap has been reached. The beneficiary will not have to pay a cost-share after the other health insurance has made payment.*

B. TRICARE/CHAMPUS Supplemental Plans. The so-called TRICARE/CHAMPUS supplemental plans which provide coverage for deductibles, cost-shares, and sometimes for non-covered services, will be ignored. As with double coverage, the full deductible and cost-share will be credited toward meeting the catastrophic cap.

C. Multiple Family Situations. Multiple family situations--e.g., sponsor and new spouse and children live together, and sponsor's children from previous marriage live elsewhere--will be treated as one family. In other words, for a divorced and then remarried sponsor with two sets of family members, their deductibles and cost-shares will be combined to meet the fiscal year catastrophic cap.

NOTE: *When a family's sponsor changes, e.g., a spouse divorces a sponsor and marries another active duty person, then only the new sponsor's liabilities for deductible and*

cost-shares in a fiscal year will count toward meeting the cap. In other words, this spouse cannot carry to the new family those credits accumulated toward the cap under the previous sponsor.

D. Former Spouses. Any TRICARE/CHAMPUS eligible former spouse will be treated as an "other than active duty family member". For the purpose of determining the catastrophic cap, a former spouse will be treated as an independent family and must independently meet the catastrophic cap.

E. Change of Sponsor Status. A change in a sponsor's duty status will have the following effects on application of the catastrophic cap.

1. Claims subject to the CHAMPUS DRG-Based Payment System.

a. When the status changes during a beneficiary's inpatient stay, the appropriate catastrophic cap will apply to that stay according to the beneficiary's cost-sharing status for the stay (see Chapter 13, Section 6.1B). Effective for services provided after 12:00 p.m. (midnight) of the day of discharge from the hospital, the catastrophic cap will be based on the sponsor's current status.

b. When the status changes at any time other than during a beneficiary's inpatient stay, the appropriate catastrophic cap (according to the sponsor's current duty status) will apply for CHAMPUS eligible families for the remaining fiscal year (or until the status changes again) effective for services provided after 12:00 p.m. (midnight) of the day the duty status changes.

c. When the status changes, the full deductible and cost-shares credited toward meeting the previous family cap will be credited toward the new cap as the sponsor's liabilities in the same fiscal year. However, in no case will a change in a sponsor's status from retired to active duty result in an adjustment to previous claims, even if the aggregate cost-share had exceeded the active duty cap.

2. Claims exempt from the CHAMPUS DRG-Based Payment System. When a sponsor's duty status changes, the appropriate cap (according to the sponsor's current duty status) will apply for CHAMPUS eligible families for the remaining fiscal year effective for services provided after 12:00 p.m. (midnight) of the day the duty status changes. The full deductible and cost-shares credited toward meeting the previous family cap will be credited toward the new cap as the sponsor's liabilities in the same fiscal year.

F. Beneficiary Responsibility. In order to get credit toward the family fiscal year catastrophic cap for deductible and cost-shares for services received in another CHAMPUS contractor or contractor jurisdiction, the beneficiary will be responsible to submit appropriate documentation (such as a CHAMPUS Explanation of Benefits) with the current claim to the current CHAMPUS contractor or contractor. The current CHAMPUS contractor will verify the catastrophic cap credit balance with the other CHAMPUS contractor if requested by the beneficiary in writing. See the COM-FI Part Two, Chapter 1, Section VI.C.5., and the OPM Part Two, Chapter 1, Section VI.C.5.

G. Inpatient Care Spanning Two Fiscal Years. When the dates of inpatient care span different fiscal years, it is absolutely necessary that the catastrophic cap application be as

accurate as possible. If for a claim the ending date of care is in a different fiscal year from the beginning date of care, the beneficiary cost-share amount must be allocated between the two fiscal years based on the dates of care. For the purpose of the catastrophic cap application only, the following provisions are applicable:

1. Cost-share when fixed daily amount is known. When the beneficiary cost-share is based on a fixed daily amount (or when such amount can accurately be calculated), the actual daily cost-share amount will be allocated between the two fiscal years according to the days of care received in each fiscal year (FY).

EXAMPLE: DRG claim involving per diem cost-share amounts (Chapter 13, Section 11.2). Retiree admitted on September 25, 1988 [FY88] and discharged on October 3, 1988 [FY89]:

We know that effective October 1, 1988, the cost-share per diem for other than active duty dependents went up from $175 to $210. We also know that no per diem cost-share amount is required for the day of discharge (Chapter 13, Section 11.2).

Step 1: CALCULATE FY 88 CATASTROPHIC CAP CREDIT
FY88 care (from 9/25 through 9/30/88) = 6 days
FY88 cost-share per diem = $175/day
FY88 catastrophic cap credit = $1050.00
[6 days X 175/day = $1050.00]

Step 2: CALCULATE FY 89 CATASTROPHIC CAP CREDIT
FY89 care (from 10/1 through 10/3/88) = 2 days
[excludes day of discharge]
FY89 cost-share per diem = $210/day
FY89 catastrophic cap cost-share credit = $420.00
[2 days X 210/day = $420.00]

2. Cost-share when fixed daily amount is NOT known. When a fixed (or actual) daily amount of cost-share is not known or cannot be accurately determined, the daily cost-share amount will be calculated by proration, that is, by dividing the claim's cost-share amount by the number of days of care (not counting the day of discharge) and the resulting daily amount will be allocated between the two fiscal years according to the days of care received in each fiscal year.

EXAMPLE: Hospital claim involving a cost-share amount that is 25% of the CHAMPUS-determined allowable charge (Chapter 13, Section 11.1). Retiree admitted on September 29, 1988 [FY88] and discharged on October 8, 1988 [FY89] with a CHAMPUS-determined allowable charge of $4,000.00:

Step 1: CALCULATE TOTAL COST-SHARE AMOUNT
25% of $4000.00 allowable charge = $1000.00

Step 2: CALCULATE TOTAL DAYS OF CARE
Care (from 9/29 through 10/8/88) = 9 days
[excludes day of discharge]

Step 3: CALCULATE DAILY COST-SHARE AMOUNT
$1000.00 cost-share amount $111.11/day
9 days of care

Step 4: CALCULATE FY88 CATASTROPHIC CAP CREDIT
FY88 care (from 9/29 through 9/30/88) = 2 days
FY88 catastrophic cap cost-share credit = $222.22
[2 days X 111.11/day = $222.22]

Step 5: CALCULATE FY89 CATASTROPHIC CAP CREDIT
FY89 care (from 10/1 through 10/8/88) = 7 days
[excludes day of discharge]
FY89 catastrophic cap cost-share credit = $777.77
[7 days X 111.11/day = $777.77]

EXCEPTIONS

A. No catastrophic loss protection is available for the NATO dependents.

B. The Program for the Handicapped beneficiary liabilities cannot count toward meeting the catastrophic cap.

C. Beneficiary costs for non-covered services or any beneficiary payments above the CHAMPUS determined allowable charge (see Chapter 13, Section 1.1), shall not count toward meeting the catastrophic cap.

D. For TRICARE Prime enrollees, Point of Service deductible and cost-share amounts do not have a catastrophic cap (see Chapter 12, Section 10.1).

EFFECTIVE DATE

The catastrophic cap of $10,000 is effective for services and supplies received for the periods fiscal year 1988 through fiscal year 1992.

The catastrophic cap reduction to $7,500 for beneficiaries other than Active Duty Dependents is effective for fiscal year 1993.

The catastrophic cap reduction to $3,000 for beneficiaries other than Active Duty Dependents who are enrolled in TRICARE Prime is effective November 1, 1995.

- END -