THE ASSISTANT SECRETARY OF DEFENSE

1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

JUN 0 8 2005

The Honorable John W. Warner
Chairman, Committee on Armed Services
United States Senate
Washington, DC 20510-6050

Dear Mr. Chairman:

The enclosed report responds to House Armed Services Committee Report 108-491 requesting that a study be conducted to identify disparities between benefits and administrative methodologies within the Medicare and TRICARE programs. This report provides the results of a systematic comparison of benefits and administrative requirements of Medicare and TRICARE.

We examined the current state of program effectiveness, provider participation, and beneficiary understanding of TRICARE. In summary, we find that TRICARE for Life is operating effectively as a supplement to Medicare, providing an outstanding benefit to dually eligible beneficiaries.

a) Unlike many non-DoD Medicare beneficiaries, TRICARE beneficiaries already have a robust pharmacy benefit with no monthly premium and minimal co-pays for retail and TRICARE Mail Order Pharmacy; no costs for prescription drugs at military treatment facilities.
b) Medicare participating providers are deemed TRICARE providers and receive very similar payments from TRICARE and Medicare. This minimizes confusion and enhances TRICARE participation.
c) The Department is concerned, however, about the long-term sustainability of the TRICARE For Life benefit. Even though TRICARE For Life expenses are funded through the Medicare-Eligible Military Retiree Health Care Fund rather than through the Defense Health Program appropriation, we feel it is very important to explore ways to make the benefit more cost effective.
d) The Department will be assessing the ongoing changes in the Medicare program to determine how we might improve coordination of benefits between the two programs and identify opportunities for enhanced quality, access and efficiency. For example, Medicare Part D pharmacy benefits are being implemented, beginning in 2006, and may provide an opportunity to coordinate the very rich TRICARE Senior pharmacy benefit with the new, more modest, Medicare prescription drug benefits. The Medicare Modernization Act introduced new opportunities for Medicare Advantage organizations to offer health maintenance

or preferred provider-type plans to Medicare beneficiaries, and these emerging programs are of great interest to us as we explore ways to keep our beneficiaries healthier and thus reduce their reliance on expensive medical care.

The principal finding of our study is that disparities are minimal and do not present difficulties for providers, beneficiaries, or the Department.

Thank you for your continued support of the Military Health System.

Sincerely,

for William Winkenwerder, Jr., MD

Enclosure:
As stated

cc:
Senator Carl Levin

Report to Congress on
Coordination of TRICARE and Medicare Benefits
and Provider Payments

House Report 108-491, accompanying H.R. 4200, the National Defense Authorization Act for FY05, requests that DoD conduct a study and submit a report on "Coordination of TRICARE and Medicare Benefits and Provider Payments." Specifically, the request focuses on potential administrative and benefit disparities between Medicare and TRICARE for Medicare-eligible military beneficiaries that may have arisen as a result of recent changes to the Medicare program. The study is to include:

- an assessment of the impact of such disparities on program effectiveness, provider participation, and beneficiary understanding;
- a summary of actions taken to reduce those disparities;
- identification of the rationale for any differences that the Secretary deems necessary;
- and recommendations for legislative or other action needed to reduce such disparities.

In order to respond to this requirement, DoD conducted a systematic comparison of benefits and administrative requirements of Medicare and TRICARE. The results of that comparison are presented in Appendix A. The principal finding is that the disparities are minimal and do not present difficulties for providers, beneficiaries, or for the Department.

Some of the key design features of TRICARE for Life (TFL) serve to minimize the effects of any programmatic differences between Medicare and TRICARE. These include:

- **Electronic crossover claims** – Providers file claims with Medicare intermediaries, who process the claims and forward them to TRICARE for further processing. This minimizes paperwork and claims filing burdens on providers and beneficiaries, and enables prompt payment.
- **TRICARE payment of out-of-pocket costs after Medicare payment** – The statutory authority for TFL specifies that DoD cover the beneficiary's out-of-pocket costs for services covered by both Medicare and TRICARE. This simplifies the program for beneficiaries and providers.
- **Reliance on Medicare medical necessity determinations** – TRICARE does not conduct a reassessment of medical necessity if Medicare has already determined it on a claim. This ensures administrative consistency between the programs.

- **Adherence to TRICARE coverage for TRICARE payment determinations** – TRICARE processes TFL claims according to its own coverage rules. This ensures that beneficiaries obtain the maximum benefit obtainable by law.
- **TRICARE linkage to Medicare provider payment methodologies** – For over 10 years, TRICARE's payments to physicians, hospitals, and other providers have been linked to Medicare's approaches. While details of payments for some provider types differ, for the most part providers see very similar payments from TRICARE and Medicare. This minimizes confusion and enhances TRICARE participation.
- **Centralized TRICARE for Life claims processor** – This past year, we implemented a centralized TRICARE for Life claims processor, providing a single source for claims processing, customer service, and administrative claims services for all TRICARE beneficiaries entitled to Medicare Parts A and B.

We also examined the current state of program effectiveness, provider participation, and beneficiary understanding of TRICARE. In summary, we find that TRICARE for Life is operating effectively as a supplement to Medicare, providing an outstanding benefit to dually eligible beneficiaries.

We plan to continue our efforts to enhance system performance, improve customer service and to work toward our goal to make our strong program better.

The Department is concerned, however about the long-term sustainability of the TRICARE For Life benefit. Even though TRICARE For Life expenses are funded through the Medicare-Eligible Military Retiree Health Care Fund rather than through the Defense Health Program appropriation, we feel it is very important to explore ways to make the benefit more cost effective.

In that vein, the Department will be assessing the ongoing changes in the Medicare program to determine how we might improve coordination of benefits between the two programs and identify opportunities for enhanced quality, access and efficiency. For example, Medicare Part D pharmacy benefits are being implemented, beginning in 2006 and may provide an opportunity to coordinate the very rich TRICARE Senior pharmacy benefit with the new, more modest, Medicare benefits. The Medicare Modernization Act introduced new opportunities for Medicare Advantage organizations to offer health maintenance or preferred provider-type plans to Medicare beneficiaries, and these emerging programs are of great interest to us as we explore ways to keep our beneficiaries healthier and thus reduce their reliance on expensive medical care.

We are engaging in discussions with Medicare officials, as well as with health care industry representatives to seek their input as we chart our course. We intend to keep the committees informed as we proceed.

Comparison of Benefit Coverage and Administrative Requirements between Medicare and TRICARE Programs

Service or Supply	Medicare Coverage	TRICARE Coverage
Acupuncture	Not covered by Medicare.	TRICARE coverage is equivalent to Medicare.
Ambulance Services	Medicare covers limited ambulance services. If you need to go to a hospital or skilled nursing facility (SNF), ambulance services are covered only if transportation in any other vehicle would endanger your health. Generally, transportation from a hospital or SNF isn't covered. If the care you need isn't available locally, Medicare helps pay for necessary ambulance transportation to the closest facility outside your local area that can provide the care you need. If you choose to go to another facility farther away, Medicare payment is based on how much it would cost to go to the closest facility. All ambulance suppliers must accept assignment. Medicare doesn't pay for ambulance transportation to a doctor. Air ambulance is paid only in emergency situations. If you could have gone by land ambulance without serious danger to your life or health, Medicare pays only the land ambulance rate and you are responsible for the difference.	TRICARE coverage is equivalent to Medicare.
Ambulatory Surgical Centers (ASC)	Medicare covers services given in an Ambulatory Surgical Center for a covered surgical procedure.	As Medicare, TRICARE covers approved ambulatory surgical procedures in either a freestanding or hospital associated ASC. TRICARE has adopted and utilizes the Medicare listing of procedures approved to be performed in an ASC setting. Both TRICARE and Medicare pay via a prospectively determined "grouper" rate. Medicare maintains 9 grouper rates. TRICARE maintains 11 grouper rates. Medicare permits their Fiscal Intermediary to review and approve procedures not on the approved list (see above) to be performed in an ASC. TRICARE permits their Contractor to make like decisions.
Anesthesia	Anesthesia services (outside of doctor's charges) are covered along with medical and surgical benefits. Medicare Part A covers anesthesia you get while in an inpatient hospital. Medicare Part B covers anesthesia you get as an outpatient.	TRICARE coverage is equivalent to Medicare.
Artificial Limbs and Eyes	Medicare helps pay for artificial limbs and eyes. For more information, see Prosthetic Devices.	TRICARE coverage is equivalent to Medicare. TRICARE covers artificial limbs and eyes under the category of Prosthetic Devices.

Service or Supply	Medicare Coverage	TRICARE Coverage
Blood	Medicare will cover all but the first three pints of blood. Part A covers blood you get as an inpatient, and Part B covers blood you get as an outpatient and in a freestanding Ambulatory Surgical Center.	TRICARE covers transfusion services for whole blood and blood components (as supplies or laboratory services) as well as blood derivatives (as prescription drugs). There is no limitation on coverage as long as the blood or blood components are actually administered to the patient.
Bone Mass Measurement	Medicare covers bone mass measurements ordered by a doctor or qualified practitioner who is treating you if you meet one or more of the following conditions: (Women) • You are being treated for low estrogen levels and are at clinical risk for osteoporosis, based on your medical history and other findings. (Men and Women) • Your x-rays show previous osteoporosis, osteopenia, or vertebrae fractures. • You are on prednisone or steroid-type drugs or are planning to begin such treatment. • You have been diagnosed with primary hyperparathyroidism. • You are being treated with a drug for osteoporosis, to see if the therapy is working. The test is covered every 24 months for qualified individuals, and more frequently if medically necessary.	TRICARE coverage is equivalent to Medicare.
Braces (arm, leg, back, and neck)	Medicare covers arm, leg, back, and neck braces. For more information, see Prosthetic Devices.	TRICARE coverage is equivalent to Medicare. TRICARE covers braces under the categories of medical supply, DME, or Prosthetic Device.
Breast Prostheses	Medicare covers breast prostheses (including a surgical brassiere) after a mastectomy. For more information, see Prosthetic Device.	TRICARE coverage is equivalent to Medicare.
Canes/Crutches	Medicare covers canes and crutches. Medicare doesn't cover white canes for the blind. For more information, see Durable Medical Equipment.	TRICARE coverage is equivalent to Medicare. TRICARE covers canes and crutches under the category of medical supply or DME.
Cardiac Rehabilitation Programs	Exercise programs are covered for patients, referred by a doctor, who have: 1) had a heart attack in the last 12 months, 2) had coronary bypass surgery, and/or 3) stable angina pectoris. These programs may be given by the outpatient department of a hospital or in doctor-directed clinics.	TRICARE coverage is equivalent to Medicare.

Service or Supply	Medicare Coverage	TRICARE Coverage
Chemotherapy	Chemotherapy is covered for patients who are hospital inpatients or outpatients in a doctor's office or in free-standing clinics. In a hospital inpatient setting, Part A covers chemotherapy. In a hospital outpatient setting or a free-standing facility or a doctor's office, chemotherapy is covered by Part B.	TRICARE covers chemotherapy drugs used for their labeled indication and the administration of these drugs. TRICARE will also consider coverage of off-label drug use for chemotherapy when such use is determined to be proven safe and effective.
Chiropractic Services	Medicare covers manipulation of the spine to correct a subluxation when provided by chiropractors or other qualified providers.	Chiropractic care is excluded under TRICARE with the exception of those services available to active duty service members in specifically designated military treatment facilities.
Clinical Trials	Medicare covers routine costs, like doctor visits and tests, if you take part in a qualifying clinical trial. In most cases, Medicare doesn't pay for the experimental item being investigated. Clinical trials test new types of medical care, like how well a new cancer drug works. Clinical trials help doctors and researchers see if the new care works and if it is safe.	TRICARE regulation is being revised to allow coverage of routine costs and treatment of complications. Research costs, including the investigational item or treatment itself, services and supplies provided by research sponsors free of charge, data collection and analysis, and services and supplies performed to determine eligibility to participate in the clinical trial are not covered. TRICARE covers Phase II and III National Cancer Institute (NCI) sponsored cancer treatment and prevention clinical trials and under a Demonstration covers in-utero fetal surgical repair of myelomeningocele.
Colorectal Cancer Screening	Medicare covers several colorectal cancer screening tests. All people age 50 and older with Medicare are covered. However, there is no minimum age for having a colonoscopy. Colorectal cancer is the second leading cancer killer in the United States, but is also one of the most preventable cancers. Screening tests can help prevent colorectal cancer by finding pre-cancerous polyps so they can be removed before they turn into cancer. More than one-third of colorectal deaths could be avoided if people over 50 had regular screening tests. **Colonoscopy:** Medicare covers this test once every 24 months if you are at high risk for colorectal cancer. If you aren't at high risk for colorectal cancer, the test is covered once every 10 years, but not within 48 months of a screening flexible sigmoidoscopy. **Fecal Occult Blood Test:** Medicare covers this test once every 12 months.	**Colonoscopy:** The coverage parameters (i.e., the frequency and age restrictions) for at-risk individuals exceed those for screening colonoscopies under Medicare. TRICARE covers colonoscopies every 2 years beginning at age 25, or 5 years younger than the earliest age of diagnosis of colorectal cancer, whichever is earlier and then annually after age 40 for individuals with hereditary non-polyposis colorectal cancer syndrome. Individuals with familial risk of sporadic colorectal cancer (i.e., individuals with first degree relatives with sporadic colorectal cancer or adenomas before age 60 or multiple first degree relatives with colorectal cancer or adenomas may receive a colonoscopy every 3 to 5 years beginning at age 10 years earlier than the youngest affected relative. **Fecal Occult Blood Test:** Coverage is the same as Medicare. **Protosigmoidoscopy or Sigmoidoscopy:** Frequency of testing is similar to that of Medicare; i.e., diagnostic procedures may be performed every 3-5 years beginning at age 50.

Service or Supply	Medicare Coverage	TRICARE Coverage
	Flexible Sigmoidoscopy: Medicare covers this test once every 48 months. **Barium Enema:** Doctors can use this instead of a flexible sigmoidoscopy or colonoscopy. It's covered every 24 months if you are at high risk for colorectal cancer and every 48 months if you aren't at high risk.	**Barium Enema:** No specific preventive coverage guidelines for screening barium enemas.
Commode Chairs	Medicare covers durable medical equipment (DME) like commode chairs that your doctor orders for use in your home. For more information, see Durable Medical Equipment.	TRICARE coverage is equivalent to Medicare. TRICARE covers DME that meets DME definition.
Cosmetic Surgery	Cosmetic surgery is generally not covered unless it is needed because of accidental injury or to improve the function of a malformed part of the body.	TRICARE coverage is equivalent to Medicare.
Custodial Care (help with activities of daily living, like bathing, dressing, using the bathroom and eating)	Medicare doesn't cover custodial care when that is the only kind of care you need. "Care" is considered custodial when it's for the purpose of helping you with activities of daily living or personal needs that could be done safely and reasonably by people without professional skills or training. For example, custodial care includes help getting in and out of bed, bathing, dressing, eating, and taking medicine. Medicare does cover limited skilled nursing facility care under certain conditions. For more information, see Skilled Nursing Facility Care.	TRICARE coverage is equivalent to Medicare.
Dental Services	Medicare doesn't cover routine dental care or most dental procedures such as cleaning, fillings, tooth extractions, or dentures. Medicare doesn't pay for dental plates or other dental devices. Medicare Part A will pay for certain dental services that you get when you are in the hospital. Medicare Part A can pay for hospital stays if you need to have emergency or complicated dental procedures, even when the dental care itself isn't covered.	Dental coverage is more extensive under TRICARE, in that prophylactic, restorative, prosthodontic and periodontic procedures qualify for payment under the adjunctive dental benefit when performed in preparation for, or as a result of, trauma to the teeth and supporting structures caused by medically necessary treatment of an injury or disease. Coverage of hospital stays associated with noncovered, nonadjunctive dental care is similar to that of Medicare, in that services must be medically necessary to safeguard the life of the patient from the effects of dentistry on an underlying nondental organic condition.
Diabetes Supplies and Services	**Diabetes Supplies:** Medicare covers some diabetes supplies. These include: • Blood glucose test strips • Blood glucose monitor • Lancet devices and lancets Glucose control solutions for checking the accuracy of test strips and monitors. (See blood glucose monitor coverage under Durable Medical Equipment.)	TRICARE coverage is equivalent to Medicare. TRICARE covers diabetes outpatient self-management training services.

Service or Supply	Medicare Coverage	TRICARE Coverage
	There may be limits on how much or how often you get these supplies. To make sure your Medicare diabetes medical supplies are covered: • Only accept supplies you have ordered. Medicare won't pay for supplies you didn't request. • Make sure you request your supply refills. Medicare won't pay for supplies sent from the supplier to you automatically. • All Medicare-enrolled pharmacies and suppliers must submit claims for glucose test strips. You can't send in the claim yourself. Syringes and insulin (unless used with an insulin pump), insulin pens, needles, alcohol swabs, gauze, eye exams for glasses, and routine or yearly physical exams aren't covered. If you use an insulin pump, insulin and the pump could be covered as durable medical equipment. There may be some limits on covered supplies or how often you get them. **Therapeutic Shoes or Inserts:** Medicare covers therapeutic shoes or inserts for people with diabetes who have severe diabetic foot disease. The doctor who treats your diabetes must certify your need for therapeutic shoes or inserts. The shoes and inserts must be prescribed by a podiatrist or other qualified doctor and provided by a podiatrist, orthotist, prosthetist, or pedorthist. Medicare helps pay for one pair of therapeutic shoes and inserts per calendar year. Shoe modifications may be substituted for inserts. The fitting of the shoes or inserts is covered in the Medicare payment for the shoes. **Diabetes Services:** • **Diabetes Self-Management Training:** Diabetes outpatient self-management training is a covered program to teach you to manage your diabetes. It includes education about self-monitoring of blood glucose, diet, exercise, and insulin. Training is covered if you are newly diagnosed with diabetes, or are newly eligible for Medicare, or are at significant risk for complications from the diabetes, and your doctor gives you a referral for this service. Medicare Part B covers diabetic self-management training from a Medicare-approved training program. **Yearly Eye Exam:** Medicare covers yearly eye exams for diabetic retinopathy.	

Service or Supply	Medicare Coverage	TRICARE Coverage
	• **Foot Exam:** A foot exam is covered every six months for people with diabetic peripheral neuropathy and loss of protective sensations, as long as you haven't seen a foot care professional for another reason between visits. • **Glaucoma Screening:** Medicare covers glaucoma screening every 12 months for people with diabetes or a family history of glaucoma, or African Americans age 50 and older. **Medical Nutrition Therapy Services:** Medical nutrition therapy services are covered for people with diabetes (or kidney disease) when referred by a doctor. Medical nutrition therapy services are covered for three years after a kidney transplant. These services can be given by a registered dietician or Medicare-approved nutrition professional and include a nutritional assessment and counseling to help you manage your diabetes.	
Diagnostic Tests, X-rays, and Lab Services	Medicare covers diagnostic tests like CT scans, MRIs, EKGs, and X-rays. Medicare also covers clinical diagnostic tests and lab services provided by certified laboratories that are participating in Medicare. Diagnostic tests and lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare doesn't cover most routine screening tests, like checking your hearing. Some preventive tests and screenings are covered by Medicare. See Preventive Services (Preventive tests and screenings are done to help prevent an illness or condition, or to diagnose it early, before you have symptoms.)	TRICARE coverage is equivalent to Medicare.
Dialysis (Kidney)	Medicare covers some kidney dialysis services and supplies, including: • Inpatient dialysis treatments (if you are admitted to a hospital for special care). • Certain home support services (may include visits by trained dialysis workers to check on your home dialysis, help in emergencies when needed, and check your dialysis equipment and water supply). • Certain drugs for home dialysis, including Heparin, and antidote for Heparin when medically necessary, topical anesthetics, and Erythropoietin (Epogen) or Epoetin alfa. • Outpatient maintenance dialysis treatments (when you get treatments in any Medicare-approved dialysis facility). • Self-dialysis training (includes training for you and for the person helping you with your home dialysis treatments).	TRICARE covers kidney dialysis services and supplies.

Service or Supply	Medicare Coverage	TRICARE Coverage
	Home dialysis equipment and supplies (like alcohol, wipes, sterile drapes, rubber gloves, and scissors).	
Doctor's Office Visits	Medicare covers medically necessary services you get from your doctor in his or her office, in a hospital, in a skilled nursing facility, in your home, or any other location. Routine annual physicals and gynecological (GYN) exams aren't covered. Some preventive tests and screenings are covered by Medicare. See Preventive Services and Pap Test/Pelvic Exam.	TRICARE coverage is equivalent to Medicare.
Drugs	See Prescription Drugs (Outpatient)	TRICARE dual eligible beneficiaries, age 65 and over, are eligible for the TRICARE Pharmacy Program, and can fill prescription medications at MTF pharmacies, through the TRICARE Mail Order Pharmacy (TMOP), and at retail network and non-network pharmacies.
Durable Medical Equipment (DME)	Medicare covers durable medical equipment (DME) that your doctor prescribes for use in your home. Only your own doctor can prescribe medical equipment for you.	TRICARE coverage is equivalent to Medicare. TRICARE covers DME that meets the DME definition. DME must be medically necessary and prescribed by a physician.
Durable Medical Equipment (DME) (continued)	Durable Medical Equipment is: • Durable (is long lasting). • Used for a medical reason. • Not usually useful to someone who isn't sick or injured. • Used in your home. Covered Durable Medical Equipment includes, but isn't limited to: • Air-fluidized beds • Blood glucose monitors • Canes (white canes for the blind aren't covered) • Commode chairs • Crutches • Home oxygen equipment and supplies • Hospital beds • Infusion pumps (and some medicines used in infusion pumps if considered reasonable and necessary) • Nebulizers (and some medicines used in nebulizers if considered reasonable and necessary) • Patient lifts (to lift patient from bed or wheelchair by hydraulic operation) • Suction pumps • Traction equipment • Walkers • Wheelchairs	TRICARE covered DME includes, but is not limited to: • Air-fluidized beds • Blood glucose monitors • Canes (white canes for the blind aren't covered) • Commode chairs • Crutches • Home oxygen equipment and supplies • Hospital beds • Infusion pumps (and some medicines used in infusion pumps if considered reasonable and necessary) • Nebulizers (and some medicines used in nebulizers if considered reasonable and necessary) • Patient lifts (to lift patient from bed or wheelchair by hydraulic operation) • Suction pumps • Traction equipment • Walkers • Wheelchairs

Service or Supply	Medicare Coverage	TRICARE Coverage
Emergency Room Services	A medical emergency is when you believe that your health is in serious danger. You may have a bad injury, or a sudden illness quickly getting much worse. Medicare covers emergency room services. Emergency services aren't covered in foreign countries, except in some instances in Canada and Mexico. For more information, see Travel. Emergency room visits usually include both facility charges and doctors' charges. Note: If you are admitted to the hospital within 1-3 days of the emergency room visit for the same condition, the emergency room visit is included in the inpatient hospital care charges, not charged separately.	TRICARE coverage is equivalent to Medicare. TRICARE covers medical, maternity, or a psychiatric emergency that would lead a "prudent layperson" to believe that a serious medical condition exists or the absence of medical attention would result in a threat to life, limb, or sight. TRICARE covers emergency department services to include both the facility charges and doctors' charges.
Equipment	See Durable Medical Equipment	TRICARE coverage is equivalent to Medicare.
Eye Exams	Medicare doesn't cover routine eye exams Some preventive eye tests and screening are covered by Medicare. See Yearly Eye exams under Diabetes Supplies and Services. See Glaucoma Screening. See Macular Degeneration.	TRICARE's coverage is limited to active duty family members in the Program for Persons with Disabilities, and its follow-on program—the Extended Care Health Option, to be implemented in 2005.
Eyeglasses/Contact Lenses	Generally, Medicare doesn't cover eyeglasses or contact lenses. However, following cataract surgery with an intraocular lens, Medicare helps pay for cataract glasses, contact lenses, or intraocular lenses provided by an optometrist, if the optometrist is authorized to provide this service in your state. Important: • Only standard frames are covered. • Lenses are covered even if you had the surgery before you had Medicare. • Payment may be made for lenses for both eyes even though cataract surgery involved only one eye.	Except for active duty members, lenses or eye glasses are only cost-shared for the following conditions: • Contact lenses for treatment of infantile glaucoma • Corneal or scleral lenses prescribed for treatment of keratoconus • Scleral lenses to retain moisture when normal tearing is not present or is inadequate • Corneal or scleral lenses prescribed to reduce a corneal irregularity other than astigmatism • Intraoculor lenses, contact lenses or eyeglasses to perform the function of the human lens, lost as the result of intraocular surgery, ocular surgery or congenital absence
Flu Shot	Medicare covers one flu shot per flu season. You can get a flu shot in the winter and the fall flu season of the same calendar year. All people with Medicare are covered.	TRICARE coverage is equivalent to Medicare.

Service or Supply	Medicare Coverage	TRICARE Coverage
Foot Care	Medicare generally doesn't cover routine foot care. Medicare Part B covers the services of a podiatrist (foot doctor) for medically necessary treatment of injuries or diseases of the foot (such as hammer toe or bunion deformities and heel spurs). See Therapeutic Shoes and Foot Exam under Diabetes Supplies and Services.	TRICARE coverage is equivalent to Medicare.
Glaucoma Screening	Medicare covers glaucoma screening once every 12 months for people at high risk for glaucoma. This includes people with diabetes, a family history of glaucoma, or African Americans who are age 50 and older. The screening must be done or supervised by an eye doctor who is legally allowed to do this service in your state.	TRICARE coverage is equivalent to Medicare.
Health Education/ Wellness Programs	Medicare generally doesn't cover health education and wellness programs.	TRICARE coverage is equivalent to Medicare.
Hearing Exams/ Hearing Aids	Medicare doesn't cover routine exams or hearing aids. In some cases, diagnostic hearing exams are covered by Part B.	Current TRICARE coverage is only for active duty family members in the Program for Persons with Disabilities. Coverage of hearing aids under the TRICARE Basic Program will be effective on or around September 1, 2005, for active duty family members.
Home Health Care	Home Health Care is skilled nursing care and certain other health care services you get in your home for the treatment of an illness or injury. Medicare covers some home health care if: • Your doctor decided you need medical care in your home and makes a plan for your care at home; and • You need at least one of the following: intermittent (and not full time) skilled nursing care, physical therapy or speech language pathology services, or a continued need for occupational therapy; and • You are homebound. This means you are normally unable to leave home and that leaving home is a major effort. When you leave home, it must be infrequent, for a short time. You may attend religious services. You may leave the house to get medical treatment, including therapeutic or psychosocial care. You can also get care in an adult day care program that is licensed or certified by your state or accredited to furnish adult day care services in your state; and • The home health agency caring for you must be approved by the Medicare program.	TRICARE coverage is equivalent to Medicare. TRICARE adopted Medicare's benefit coverage and prospective payment system for home health care with the phased-in implementation of the new T-NEX contracts.

Service or Supply	Medicare Coverage	TRICARE Coverage
Home Health Care (continued)	Medicare covers durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers). ***Note for Women with Osteoporosis***: Under Medicare's home health coverage, Medicare helps pay for an injectable drug for osteoporosis in women who have Medicare Part B, and who meet the criteria for the Medicare home health benefit, and who have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis. You must also be certified by a doctor as unable to learn, or as physically or mentally unable to give yourself the drug by injection, and that family and/or caregivers are unable or unwilling to give the drug by injection. Medicare also covers the visit by a home health nurse to give the drug.	
Hospice Care	Hospice is a special way of caring for people who are terminally ill and for their families. This care includes physical care and counseling. The goal of hospice is to care for you and your family, not to cure your illness. Medicare covers hospice care if: • You are eligible for Medicare Part A; and • Your doctor and the hospice medical director certify that you are terminally ill and probably have less than six months to live; and • You sign a statement choosing hospice care instead of routine Medicare covered benefits for your terminal illness; and • You get care from a Medicare-approved hospice program. **Rural Hospice Care:** Medicare allows a nurse practioner to serve as an attending physician for a patient who elects the hospice benefit. Nurse practioners are prohibited from certifying a terminal diagnosis. **Respite Care:** Medicare also covers respite care if you are getting covered hospice care. Respite care is inpatient care given to a hospice patient so that the usual caregiver can rest. You can stay in a Medicare-approved facility, such as a hospice facility, hospital or nursing home, up to five days each time you get respite care. There is no limit to the number of times you can get respite care. Medicare will still pay for covered services for any health problems that aren't related to your terminal illness.	TRICARE mirrors the Medicare Hospice benefit. TRICARE incorporated the recent Medicare Hospice enhanced benefit or " the one time hospice physician consult, prior to the formal election of the Hospice benefit". This new benefit was effective January 1, 2005. TRICARE' benefit is more comprehensive in regard to cost shares. The TRICARE program is all inclusive and offers no deductibles under the hospice benefit. Medicare and TRICARE have expanded this benefit to incorporate Urban and Rural areas, effective January 1, 2005.
Hospital Bed	See Durable Medical Equipment.	TRICARE coverage is equivalent to Medicare.

Service or Supply	Medicare Coverage	TRICARE Coverage
Hospital Care (Inpatient)	Medicare Part A covers inpatient hospital care when all of the following are true: • A doctor says you need inpatient hospital care for treatment of your illness or injury. • You need the kind of care that can be given only in a hospital. • The hospital has agreed to participate in the Medicare program. • The Utilization Review Committee of the hospital doesn't approve your stay while you are in the hospital. • A Quality Improvement Organization or an intermediary doesn't disapprove your stay after the bill is submitted. Medicare-covered hospital services include: a semiprivate room, meals, general nursing, and other hospital services and supplies. This includes care you get in critical access hospitals and inpatient mental health care. This doesn't include private duty nursing or a television or telephone in your room. It also doesn't include a private room, unless medically necessary.	TRICARE has an unlimited hospital benefit and pays secondary to Medicare. If Medicare's inpatient hospital benefit is exhausted, TRICARE becomes primary and the following beneficiary cost-sharing is applied: **PRIME Program:** ***Active Duty Family Members (ADFMs):*** No copayment ***Retirees, their family members and survivors:*** $11 per day or $25 minimum charge per admission, whichever is greater. (No separate copayment for separately billed professional charges.) **Extra Program:** ***Active Duty Family Members (ADFMs):*** No copayment ***Retirees, their family members and survivors:*** $11 per day or $25 minimum charge per admission, whichever is greater. (No separate copayment for separately billed professional charges.) **Standard Program:** ***Active Duty Family Members (ADFMs):*** $13.90 per day or $25 minimum charge per admission, whichever is greater. No separate cost-share for separately billed professional charges. ***Retirees, their family members and other survivors:*** $512 per day or 25% cost-share of billed charges, whichever is less, plus 25% cost-share of the maximum allowable charge for separately billed professional charges.
Lab Services	Medicare covers medically necessary diagnostic lab services that are ordered by your treating doctor when they are provided by a Clinical Laboratory Improvement Amendments (CLIA) certified laboratory that participates in Medicare. For more information, see Diagnostic Tests.	TRICARE coverage is equivalent to Medicare.
Macular Degeneration	Medicare covers a treatment for some patients with age-related macular degeneration. This treatment is called ocular photodynamic therapy with verteporfin.	TRICARE coverage is equivalent to Medicare.

Service or Supply	Medicare Coverage	TRICARE Coverage
Mammogram Screening	Medicare covers a mammogram screening once every 12 months (11 full months must have gone by from the last screening) for all women with Medicare age 40 and older. You can also get one baseline mammogram between ages 35 and 39. Medicare covers digital technologies for mammogram screenings.	TRICARE coverage is equivalent to Medicare.
Mental Health Care	Medicare covers mental health care given by a doctor or a qualified mental health professional. Before you get treatment, ask your doctor, psychologist, social worker, or other health professional if they accept Medicare payment. **Inpatient Mental Health Care:** Medicare covers inpatient mental health care services. These services can be given in a general hospital or in a specialty psychiatric hospital that only cares for people with mental health problems. Medicare helps to pay for inpatient mental health services in the same way that it pays for all other inpatient hospital care. **Note:** If you are in a specialty psychiatric hospital, Medicare only helps for a total (lifetime limit) of **190 days** of inpatient care. **Outpatient Mental Health Care:** Medicare covers mental health services on an outpatient basis by a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, or physician assistant in an office setting, clinic, or hospital outpatient department. **Partial Hospitalization:** Partial hospitalization for mental health care is a structured program of active treatment that is more intense than the care you get in your doctor's or therapist's office. For Medicare to cover a partial hospitalization program, a doctor must say that you otherwise need inpatient treatment. Medicare covers the services of specially qualified non-physician practitioners such as clinical psychologists, clinical social workers, nurse practitioners, clinical nurse specialists, physician assistants, certified registered nurse anesthetists, speech-language pathologists, and certified nurse midwives, as allowed by state and local law for medically necessary services.	TRICARE provides coverage and access to the same mental health benefits as Medicare. TRICARE For Life beneficiaries and others covered by Medicare no longer require TRICARE preadmission and continued stay authorizations when Medicare is the first payer and authorized by Medicare. TRICARE limits inpatient mental health care to 30 days per fiscal year (45 days for children). Waivers for extended stays are permitted. Copays are limited to $20 (active duty) or $169.00 (non active duty) per day. No lifetime maximum. CMAC applies for professional payments and covers all authorized providers. Active duty must seek preauthorization for any mental health outpatient services. Non-active duty do not need a preauthorization for the first 8 visits during any fiscal year. Preauthorization is required from the regional contractor for greater than 8 outpatient visits. TRICARE's Partial Hospitalization stays are limited to 60 days per fiscal year and a preauthorization is required. Co-pays are limited to $20.00 (active duty) or 25% of the established per diem (non active duty) per day for TRICARE. TRICARE compensates all approved and authorized providers for covered mental health services at CMAC rates. TRICARE covers child and adolescent treatment in Residential Treatment facilities (Medicare does not) with a 150 day limit per fiscal year. Copays are limited to $25.00 (active duty) or 25% of the per diem per day.

Service or Supply	Medicare Coverage	TRICARE Coverage
		TRICARE covers inpatient substance abuse treatment and limits each 30 day treatment episode to 3 times per beneficiary lifetime. Co-pays mirror mental health inpatient stays (see above) . NOTE: Effective January 1, 2005 Medicare has transitioned from a reasonable cost reimbursement system to a per diem reimbursement system (phased in over 3 years). Such a per diem system has not been fully evaluated (too early) and may cause a restructuring or change in current Medicare mental health benefits. TRICARE has utilized a comprehensive per diem reimbursement system since 1987.
Nursing Home Care	Most nursing home care is custodial care. Generally, Medicare doesn't cover custodial care. Medicare Part A only covers skilled care given in a certified skilled nursing facility (SNF). You must meet certain conditions, and coverage is limited. See Skilled Nursing Facility Care.	TRICARE coverage is equivalent to Medicare.
Nutrition Therapy Services (Medical)	Medicare covers medical nutrition therapy services, when it is ordered by a doctor, for people with kidney disease (but who aren't on dialysis) or who have a kidney transplant, or people with diabetes. These services can be given by a registered dietician or Medicare-approved nutrition professional and include nutritional assessment and counseling. See Diabetes Services and Supplies.	TRICARE covers enteral/parenteral nutritional therapy for beneficiaries with conditions such as inborn errors of metabolism, medical conditions of malabsorption, pathologies of the alimentary or gastrointestinal tract, and physical or psychological conditions that require enteral tube feedings. TRICARE does NOT cover outpatient medical nutrition assessment and counseling services as a separate stand-alone benefit. These services are covered when rendered as part of another covered service (e.g. comprehensive medical exam); however, are not separately reimbursable. TRICARE does cover outpatient diabetes self-management training as a separately reimbursable benefit for persons with diabetes or renal disease when such services are provided by an authorized TRICARE provider.
Occupational Therapy	See Physical/Occupational/Speech Therapy.	TRICARE covers occupational therapy and there is no cap on the number of medically necessary occupational therapy sessions.
Ostomy Supplies	Medicare covers ostomy supplies for people who have had a colostomy, ileostomy, or urinary ostomy. Medicare covers the amount of supplies your doctor says you need, based on your condition.	TRICARE coverage is equivalent to Medicare.

Service or Supply	Medicare Coverage	TRICARE Coverage
Outpatient Hospital Services	Medicare Part B covers medically necessary services you get as an outpatient from a Medicare-participating hospital for diagnosis or treatment of an illness or injury. Covered outpatient hospital services include: • Services in an emergency room or outpatient clinic, including same-day surgery • Laboratory tests billed by the hospital • Mental health care in a partial hospitalization program, if a physician certifies that inpatient treatment would be required without it • X-rays and other radiology services billed by the hospitals • Medical supplies such as splints and casts • Drugs and biologicals that you can't give yourself	TRICARE coverage is equivalent to Medicare.
Oxygen Therapy	Medicare covers rental of oxygen equipment; or if you own your own equipment, Medicare will help pay for oxygen contents and supplies for the delivery of oxygen under these conditions: • Your doctor says you have a severe lung disease or you're not getting enough oxygen and your condition might improve with oxygen therapy. • Your arterial blood gas level falls within a certain range. • Other alternative measures have been tried and failed or weren't helpful for you. Under the above conditions Medicare helps pay for: • Systems for furnishing oxygen • Containers that store oxygen • Tubing and related supplies for the delivery of oxygen • Oxygen contents If oxygen is provided only for use during sleep, portable oxygen wouldn't be covered. Portable oxygen isn't covered when provided only as a backup to a stationary oxygen system.	TRICARE coverage is equivalent to Medicare.

Service or Supply	Medicare Coverage	TRICARE Coverage
Pap Test/Pelvic Exam	Medicare covers Pap tests and Pelvic exams (and a clinical breast exam) for all women once every 24 months. Medicare covers this test and exam once every 12 months if you are at high risk for cervical or vaginal cancer, or if you are of childbearing age and have had an abnormal Pap test in the past 36 months. If you have your Pap test, pelvic exam, and clinical breast exam on the same visit as a routine physical exam, you pay for the physical exam. Routine physical exams aren't covered by Medicare.	TRICARE coverage is equivalent to Medicare.
Physical Exams (Routine)	Routine physical exams aren't covered by Medicare. If your Medicare Part B begins on or after January 1, 2005, Medicare will cover a one-time preventive physical exam within the first six months that you have Medicare Part B.	TRICARE coverage is equivalent to Medicare.
Physical/ Occupational/ Speech Therapy	Medicare helps pay for medically necessary outpatient physical and occupational therapy and speech pathology services when: • Your doctor or therapist sets up the plan of treatment, and • Your doctor periodically reviews the plan to see how long you will need therapy. You can get outpatient services from a participating hospital or skilled nursing facility, or from a participating home health agency, rehabilitation agency, or public health agency. Also, you can get services from a Medicare-approved physical or occupational therapist, in private practice, in his or her office or in your home. (Medicare doesn't pay for services given by a speech pathologist in private practice.) There is no limit to the amount of medically necessary outpatient physical therapy, occupational therapy, or speech-language pathology services you may get. You can get these services from any Medicare-approved outpatient provider.	TRICARE coverage is equivalent to Medicare. TRICARE covers physical, occupational, and speech therapy. No cap on the number of medically necessary therapy sessions.
Prescription Drugs (Outpatient) Very Limited Coverage	Medicare doesn't cover most prescription drugs. Medicare covers a limited number of outpatient prescription drugs. Your pharmacy or doctor must accept assignment on Medicare-covered prescription drugs. Medicare-approved drug discount cards became available for purchase after May 2004. The following outpatient prescription drugs are covered: • **Some Antigens:** Medicare will help pay for antigens if they are prepared by a doctor and given	TRICARE's coverage is limited to "labeled" indications of FDA-approved drugs. Coverage of "off-labeled" uses is dependent on evidence indicating such use is safe and effective. TRICARE coverage is equivalent to Medicare

Service or Supply	Medicare Coverage	TRICARE Coverage
	by a properly instructed person (who could be the patient) under doctor supervision. • **Osteoporosis Drugs:** Medicare helps pay for an injectable drug for osteoporosis for certain women with Medicare. See note for women with osteoporosis under Home Health Care. • **Erythropoietin (Epogen) or Epoetin alfa:** Medicare will help pay for erythropoietin by injection if you have End-Stage Renal Disease (permanent kidney failure) and need this drug to treat anemia. • **Hemophilia Clotting Factors:** If you have hemophilia, Medicare will help pay for clotting factors you give yourself by injection. • **Injectable Drugs:** Medicare covers most injectable drugs given by a licensed medical practitioner. • **Immunosuppressive Drugs:** Medicare covers immunosuppressive drug therapy for transplant patients if the transplant was paid for by Medicare, or paid by private insurance that paid as a primary payer to your Medicare Part A coverage, in a Medicare-certified facility. **Oral Cancer Drugs:** Medicare will help pay for some cancer drugs you take by mouth if the same drug is available in injectable form. Currently, Medicare covers the following cancer drugs you take by mouth: • Capecitabine (brand name Xeloda) • Cyclophosphamide (brand name Cytoxin) • Methotrexate • Temozolomide (brand name Temodar) • Busulfan (brand name Myleran) • Etoposide (brand name VePesid) • Melphalan (brand name Alkeran) As new cancer drugs and brand names become available, these drugs may be added to the list of covered drugs. • **Oral Anti-Nausea Drugs:** Medicare will help pay for oral anti-nausea drugs if you are getting Medicare-covered cancer drugs you take by mouth. Medicare also covers some drugs used in infusion pumps and nebulizers if considered reasonable and necessary. You should check with your Durable Medical Equipment Regional Carrier (DMERC) for specific	

Service or Supply	Medicare Coverage	TRICARE Coverage
	coverage information about prescription drugs.	
Preventive Services Covered by Medicare	See • Bone Mass Measurement • Colorectal Cancer Screening • Diabetes Supplies and Services • Flu Shot • Glaucoma Screening • Mammogram Screening • Medical Nutrition Therapy • Pap Test/Pelvic Exam • Prostate Cancer Screening • Shots (vaccinations) including ▪ Flu shot ▪ pneumococcal shot ▪ hepatitis B shot	TRICARE coverage is equivalent to Medicare.
Prostate Cancer Screening	Medicare covers screening tests once every 12 months for all men age 50 and older with Medicare (coverage begins the day after your 50th birthday). Covered tests include: ▪ Digital Rectal Examination ▪ Prostate Specific Antigen (PSA) Test	TRICARE coverage is equivalent to Medicare.
Prosthetic Devices	Medicare covers prosthetic devices needed to replace a body part or function. These include Medicare-approved corrective lenses needed after a cataract operation (see Eyeglass/Contact Lenses), ostomy bags and certain related supplies (see Ostomy Supplies), and breast prostheses (including a surgical brassiere) after a mastectomy (see Breast Prostheses). Medicare also covers artificial limbs and eyes, and arm, leg, back, and neck braces. Medicare doesn't pay for orthopedic shoes unless they are a necessary part of the leg brace and the cost is included in the charge for the brace. Medicare doesn't pay for dental plates or other dental devices.	TRICARE coverage is equivalent to Medicare. TRICARE covers Prosthetic Devices necessary because of significant conditions resulting from trauma, congenital anomalies or diseases. This includes, but is not limited to, artificial limbs and eyes, arms, leg, back, and neck braces.
Radiation Therapy	Radiation therapy is covered for patients who are hospital inpatients or outpatients, or patients in freestanding clinics. In the hospital setting, Part A covers radiation therapy. In a freestanding facility, Part B covers radiation therapy.	TRICARE covers standard radiation therapy, and multiple other modalities including brachytherapy, fast neutron, hyperfractionated, radioactive chromic phosphate synoviorthesis, stereotactic radiotherapy (proton beam, gamma knife, linear accelerator, charged particle beam, extracranial), hyperthermia, and frameless stereotaxy.
Respite Care	Medicare covers respite care for hospice patients. For more information, see Hospice Care.	Except as provided under Hospice Care, TRICARE's coverage of respite care will be limited to active duty family members in the Extended Care Health Option, to be implemented in 2005.

Service or Supply	Medicare Coverage	TRICARE Coverage
Second Surgical Opinions	Medicare covers a second opinion before surgery. A second opinion is when another doctor gives his or her view about your health problem and how it should be treated. Medicare will also help pay for a third opinion if the first and second opinions are different.	TRICARE coverage is equivalent to Medicare.
Shots (Vaccinations)	Medicare covers all people with Medicare for: ▪ **Flu Shot** – One per flu season. You can get a flu shot in the fall and the winter flu seasons of the same year. The flu is a serious illness that can lead to pneumonia. It can be dangerous for people age 50 and older. You need a flu shot each year because flu viruses are always changing. The shot is updated each year for the most current flu viruses. Also, the flu shot only helps protect you from the flu for about one year. There is a chance that you may still get the flu, but your symptoms will be less severe. ▪ **Pneumococcal Shot (vaccine)** – One shot may be all you ever need.. Ask your doctor. ▪ **Hepatitis B Shot (vaccine)** – Certain people with Medicare at medium to high risk for Hepatitis B.	TRICARE coverage is equivalent to Medicare.
Skilled Nursing Facility (SNF) Care	Medicare covers skilled care in a skilled nursing facility (SNF) under certain conditions for a limited time. Skilled care is health care given when you need skilled nursing or rehabilitation staff to manage, observe, and evaluate your care. Examples of skilled care include changing sterile dressings and physical therapy. It is given in a Medicare-certified SNF. Care that can be given by non-professional staff isn't considered skilled care. Medicare covers certain skilled care services that are needed daily on a short-term basis (up to 100 days). Medicare will cover skilled care only if **all** these conditions are met: 1. You have Medicare Part A (Hospital Insurance) and have days left in your benefit period to use. 2. You have a qualifying hospital stay. This means an inpatient hospital stay of three consecutive days or more, not including the day you leave the hospital. You must enter the SNF within a short time (generally 30 days) of leaving the hospital and require skilled services related to your hospital stay. After you leave the SNF, if you reenter the same or another SNF within 30 days, you don't need another three-day qualifying hospital stay to get additional SNF benefits. This is also true if you stop getting skilled care while in the SNF and then start getting skilled care again	TRICARE SNF benefit mirrors the Medicare SNF benefit except that there is no limitation to the number of days of coverage under TRICARE and benefit periods are not applicable under TRICARE.

Service or Supply	Medicare Coverage	TRICARE Coverage
	within 30 days. 3. Your doctor has decided that you need daily skilled care. It must be given by, or under the direct supervision of, skilled nursing or rehabilitation staff. If you are in the SNF for skilled rehabilitation services only, your care is considered daily care even if these therapy services are offered just five or six days a week.. 4. You get these skilled services in a SNF that has been certified by Medicare. 5. You need these skilled services for a medical condition that: ▪ Was treated during a qualifying three-day hospital stay, or ▪ Started while you were getting Medicare-covered SNF care. For example, you are in the SNF because you had a stoke, and you develop an infection that requires I.V. antibiotics.	
Speech Therapy	See Physical/Occupational/Speech Therapy	TRICARE coverage is equivalent to Medicare. TRICARE covers speech therapy and there is no limit to the number of medically necessary speech therapy sessions.
Substance Abuse Treatment (Outpatient)	Medicare covers substance abuse treatment in an outpatient treatment center if they have agreed to participate in the Medicare program. See Mental Health Care (Outpatient).	TRICARE covers outpatient substance abuse treatment with TRICARE authorized providers. TRICARE's program is more comprehensive in regard to co-pays and requires a 20% co-insurance (Medicare requires 50%).
Supplies	Common medical supplies like bandages and gauze are generally not covered by Medicare. Medicare covers some diabetes and dialysis supplies. See Diabetes Supplies and Services and Dialysis (Kidney). For items such as walkers, oxygen, and wheelchairs, see Durable Medical Equipment. Supplies furnished as part of a doctor's service are covered by Medicare, and payment is included in Medicare's doctor payment. Doctors don't bill for supplies.	TRICARE coverage is equivalent to Medicare. TRICARE covers medically necessary medical supplies.
Therapeutic Shoes	See Diabetes Supplies and Services (Therapeutic Shoes)	

Service or Supply	Medicare Coverage	TRICARE Coverage
Transplants (Doctor Services)	Medicare covers doctor services for transplants as listed below.	TRICARE covers all services and supplies related to transplants including physician services, evaluation for potential suitability for transplant, pre- and post-transplant inpatient and outpatient services, pre- and post-operative services of transplant team, donor acquisition team (including transportation of the donor organ and transplant team), maintenance of the viability of the donor organ, donor costs, blood and blood products, immunosuppression drugs, treatment of complications, periodic evaluation and assessment of transplanted patients, DNA- HLA tissue typing to determine histocompatibility, Hepatitis B and pneumococcal vaccines, and transportation by air ambulance. Claims are paid under the assigned DRG. Claims for transportation of the donor organ and transplantation team are paid based on billed charges. Acquisition and donor costs are paid based on billed charges.
Transplants (Facility Charges)	Medicare covers transplants of the heart, lung, kidney, pancreas, intestine/multivisceral, bone marrow, cornea, and liver under certain conditions and, for some types of transplants, only at Medicare-approved facilities. Medicare only approves facilities for kidney, heart, liver, lung, and intestine/multivisceral transplants. Bone marrow, pancreas, and cornea transplants aren't limited to approved facilities. Transplant coverage includes necessary tests, labs, and exams before surgery for you and the organ donor, follow-up care for you and a live donor, and procurement of organs and tissues.	TRICARE covers more solid organ transplants including Heart-Lung, Lung, Living Donor Lobar Lung, Heart, Heart-Kidney, Small Intestine, Small Intestine-Liver, Multivisceral, Liver, Living Donor Liver, Liver-Kidney, Pancreas Transplant Alone, Simultaneous Pancreas-Kidney, Pancreas-After-Kidney and Kidney. TRICARE does cover pancreas transplants alone. TRICARE does not cover islet cell transplantation. Transplants must be performed at a transplant center that is certified by TRICARE and/or Medicare. TRICARE covers corneal transplants. TRICARE covers cochlear implantation. TRICARE covers high dose chemotherapy and stem cell transplantation (autologous bone marrow, autologous peripheral stem cell, allogeneic bone marrow, allogeneic peripheral stem cell, allogenic umbilical cord blood). TRICARE's coverage is more extensive than Medicare's. TRICARE covers autologous bone marrow/autologous peripheral stem cell transplantation for follicular, intermediate and high-grade non-Hodgkin's lymphoma, Hodgkin's disease, neuroblastoma, acute lymphocytic or nonlymphocytic leukemias, primitive neuroectodermal tumors, Ewing's Sarcoma, gliofibromas, glioblastoma multiforme, posterior fossa teratoid brain tumors, rhabdomyosarcoma and undifferentiated sarcomas, multiple myeloma, chronic myelogenous leukemia, Waldenstrom's macroglobulinemia, AL Amyloidosis, Wilms' tumor, trilateral retinoblastoma/pineoblastoma, osteosarcoma, and germ cell tumors. Allogeneic bone marrow/allogeneic peripheral stem cell

Service or Supply	Medicare Coverage	TRICARE Coverage
		transplantation is covered for aplastic anemia, acute lymphocytic or nonlymphocytic leukemia, chronic myelogenous leukemia, preleukemic syndromes, severe combined immunodeficiency, Wiskott-Aldrich Syndrome, infantile malignant osteopetrosis, Thalassemia major, intermediate and high grade lymphoma, myeloproliferative/dysplastic syndromes, congenital mucopolysaccharidoses, congenital amegakaryocytic thrombocytopenia, metachromatic leukodystrophy, sickle cell disease, chronic lymphocytic leukemia, hyperesinophilic syndrome, multiple myeloma, X-linked hyper-IgM syndrome, Chediak-Higashi Syndrome, Langerhans Cell Histiocytosis, and Hodgkin's disease. Allogeneic umbical cord blood is covered for aplastic anemia, acute lymphocytic or non-lymphotic leukemias, chronic myelogenous leukemia, severe combined immunodeficiency, Wiskott-Aldrich syndrome, infantile malignant osteopetrosis, Blackfan-Diamond anemia, Fanconi anemia, neuroblastoma, X-linked lymphoproliferative syndrome, Hunter syndrome, Hurler syndrome, congenital amegakaryocytic thrombocytopenia, sickle cell anemia, globoid cell leukodystrophy, adrenoleukodystrophy, Kostmann's syndrome, Lesch-Nyhan disease, non-Hodgkin's lymphoma, Thalassemia major, myelodysplastic syndrome, X-linked hyper-IgM syndrome, and Langerhans Cell Histiocytosis. Other indications not specifically listed are covered when documented as safe, effective, comparable to conventional treatment (proven) and the standard of care in the United States. Medicare has not and does not cover allogeneic transplants for neuroblastoma. Medicare and TRICARE cover **autologous** transplants for neuroblastoma. TRICARE does cover allogeneic transplants for Hodgkin's disease and multiple myeloma.)
Transportation (Routine)	Medicare generally doesn't cover transportation to get routine health care. For more information, see Ambulance Services.	TRICARE's coverage of transportation is limited to active duty family members in the Program for Persons with Disabilities, and its follow-on program—the Extended Care Health Option, to be implemented in 2005.

Service or Supply	Medicare Coverage	TRICARE Coverage
Travel Outside of the United States (Health Care Coverage During Travel)	The Original Medicare Plan generally doesn't cover health care while you are traveling outside the United States. Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands are considered part of the United States. There are some exceptions. In rare cases, Medicare can pay for inpatient hospital services that you get in Canada or Mexico. Medicare can pay only if: 1. You are in the United States when a medical emergency occurs and the Canadian or Mexican hospital is closer than the nearest United States hospital that can treat the emergency. 2. You are traveling through Canada withou unreasonable delay by the most direct route between Alaska and another state when a medical emergency occurs and the Canadian hospital is closer than the nearest United States hospital that can treat the emergency. 3. You live in the United States and the Canadian or Mexican hospital is closer to your home than the nearest United States hospital that can treat your medical condition, regardless of whether an emergency exists. Medicare also pays for doctor and ambulance services you get in Canada or Mexico as part of a covered inpatient hospital stay.	More liberal than Medicare for travel outside the U.S. TRICARE covers care outside of the United States through the (1) TRICARE overseas prime plan which includes preventive and specialty care, with no co-payments and deductibles or (2) the TRICARE overseas standard plan which is a point of service plan with the applicable cost-shares. TRICARE For Life is available overseas to beneficiaries who are Medicare eligible and enrolled in Part B Medicare. Overseas TRICARE For Life will cost share 75% of billed charges for covered TRICARE benefits.
Walker/Wheelchair	Medicare covers walkers and wheelchairs as durable medical equipment (DME) that your doctor prescribes for use in your home. For more information, see Durable Medical Equipment. **Power Wheelchair:** You must have a face-to-face examination and a written prescription from a physician before Medicare helps pay for a power wheelchair.	TRICARE coverage is equivalent to Medicare. TRICARE covers walkers and wheelchairs.
X-rays	Medicare covers medically necessary diagnostic x-rays that are ordered by your treating doctor. For more information see Diagnostic Tests.	TRICARE coverage is equivalent to Medicare.

NOTE: In regard to Positron Emission Tomography (PET). TRICARE is no longer listing all covered indications. TRICARE covers PET for all indications that are documented by reliable evidence as safe, effective, comparable to conventional technology (proven) and the standard of care in the United States. There are no listed exclusions.

TRICARE – MEDICARE ADMINISTRATIVE COMPARISON Feb '05

There are major differences between traditional indemnity Medicare and TRICARE's managed care program that must be taken into consideration in any comparison of the two programs. Administratively, the TRICARE program involves such functions as prior authorization, referrals and utilization management that are not part of traditional Medicare, but are essential to managed care programs. The challenge of integrating TRICARE optimally with the Military Treatment Facilities also adds complexities not faced by Medicare. Taking these differences into consideration, TMA has streamlined requirements and processes to the fullest extent possible to eliminate any unnecessary administrative burden, particularly through the emphasis on best practices and customer service in the new TRICARE contracts.

TRICARE claims require substantially the same data, and can be submitted in the same formats as Medicare. All TRICARE health care contracts require that the contractors implement HIPAA protocols, accept the standard HCFA forms (HCFA 1500 and UB-92), and accommodate the HCFA standard electronic data set for claims submission. Additional data elements required for TRICARE claims processing are developed internally by the claims processors through the Defense Enrollment Eligibility Reporting System (DEERS) or other resources to avoid placing any extra burden on the claim submitter. The TRICARE Management Activity (TMA) has prepared for prompt implementation of the National Provider Identifier, and continues to partner with all TRICARE contractors to investigate additional options for administrative simplification throughout the program.