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TRICARE  
MANAGEMENT ACTIVITY

MB&RB

CHANGE 106  
6010.54-M  
SEPTEMBER 25, 2009

PUBLICATIONS SYSTEM CHANGE TRANSMITTAL  
FOR  
TRICARE POLICY MANUAL (TPM)

The TRICARE Management Activity has authorized the following addition(s)/  
revision(s) to the 6010.54-M, issued August 2002.

CHANGE TITLE: CODING AND REIMBURSEMENT UPDATES

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): See page 3.

EFFECTIVE DATE: As indicated.

IMPLEMENTATION DATE: Upon direction of the Contracting Officer.

This change is made in conjunction with Aug 2002 TRM, Change No. 99.

Reta Michak  
Acting Chief, Medical Benefits and  
Reimbursement Branch

ATTACHMENT(S): 8 PAGE(S)  
DISTRIBUTION: 6010.54-M

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**CHANGE 106**  
**6010.54-M**  
**SEPTEMBER 25, 2009**

**REMOVE PAGE(S)**

**INSERT PAGE(S)**

**CHAPTER 1**

Section 17.1, pages 1 and 2

Section 17.1, pages 1 and 2

**CHAPTER 4**

Section 20.1, pages 1 through 4

Section 20.1, pages 1 through 4

**CHAPTER 7**

Section 2.5, pages 1 and 2

Section 2.5, pages 1 and 2

## SUMMARY OF CHANGES

### CHAPTER 1

1. Section 17.1 (Healthcare Common Procedure Coding System (HCPCS) "C" and "S" Codes). Added S3620 as a payable code.

### CHAPTER 4

2. Section 20.1 (Nervous System). Added the following Current Procedural Terminology (CPT) codes-code ranges as payable: 64505-64560, 64565-64580, 64600-64640, 64695-64720, 64730, 64732, and 64753-64999.

### CHAPTER 7

3. Section 2.5 (Well-Child Care). Added CPT code range as payable: 99460-99463.



## HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS) "C" AND "S" CODES

ISSUE DATE: November 6, 2007

AUTHORITY:

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### I. HCPCS "C" AND "S" CODES

C1000 - C9999; S0000 - S9999

### II. DESCRIPTION

A. HCPCS "C" codes include device categories, new technology procedures, and drugs, biologicals and radiopharmaceuticals that do not have other HCPCS assigned.

B. HCPCS "S" codes are temporary codes used by the private sector to report drugs, services, and supplies for which there are no national codes.

### III. POLICY

A. Upon implementation of TRICARE's Outpatient Prospective Payment System (OPPS), HCPCS "C" codes shall be paid according to OPPS guidelines as outlined in the TRICARE Reimbursement Manual (TRM), [Chapter 13](#). For hospital outpatient department (HOPD) services provided on or before May 1, 2009 (implementation of TRICARE's OPPS), and thereafter, for services by exempt OPPS hospitals, the contractor shall allow payment of HCPCS "C" codes consistent with current policy as stated in the TRM, [Chapter 1, Section 24, paragraph II.B](#).

B. Under TRICARE, "S" codes are not reimbursable except as follows:

1. S9122, S9123, and S9124 for the ECHO respite care benefit and the ECHO Home Health Care (EHHC) benefit; S1040 for ECHO durable equipment; and

2. S0812, S1030, S1031, S2066, S2067, S2068, S2075, S2076, S2077, S2083, S2202, S2235, S2360, S2361, S2400, S2401, S2402, S2403, S2405, S2411, **S3620**, S3818, S3819, S3820, S3822, S3823, S8030, S8185, S8265, S8270, and S9430 for all beneficiaries; and

3. S5108 for direct Educational Interventions for Autism Spectrum Disorders (EIA) services provided to TRICARE beneficiaries under the Department of Defense (DoD) Enhanced Access to Autism Services Demonstration. (See the TRICARE Operations Manual (TOM), [Chapter 20, Section 10](#)).

**TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002**  
CHAPTER 1, SECTION 17.1  
HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS) "C" AND  
"S" CODES

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C. Under TRICARE, HCPCS code S9999 is a recognized code for purposes of reporting sales tax but is not payable.

IV. EXCLUSIONS

HCPCS "C" codes are not allowed to be billed by independent professional providers.

- END -

## NERVOUS SYSTEM

ISSUE DATE: August 26, 1985

AUTHORITY: 32 CFR 199.4(c)(2) and (c)(3)

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### I. CPT<sup>1</sup> PROCEDURE CODES

61000 - 61626, 61680 - 61860, 61863 - 63048, 63055 - 64484, 64505 - 64560, 64565 - 64580, 64600 - 64640, 64695 - 64720, 64730, 64732, 64753 - 64999, 95961, 95962, 95970 - 95975, 95978, 95979

### II. DESCRIPTION

A. The nervous system consists of the central and peripheral nervous systems. The central is comprised of the brain and spinal cord and the peripheral includes all the other neural elements. The nervous system is the organ system which along with the endocrine system, correlates the adjustments and reactions of an organism to internal and environmental conditions.

B. Therapeutic embolization is a type of procedure that is commonly performed by interventional radiologist to occlude blood vessels. A microcatheter or balloon is threaded into a vein, or artery for the purposes of embolization, blocking a pathologic vascular channel.

C. Stereotactic implantation of depth electrodes is an invasive procedure in which needle-like electrodes are implanted through burr holes in the skull into the depths of specific brain areas to localize a seizure focus in patients who are candidates for surgery or to implant a brain stimulator in the thalamus to control tremors.

D. Psychosurgery is brain surgery directed at destroying normal and healthy brain tissue in order to relieve mental and psychic symptoms that other treatment modalities such as drug therapy and psychotherapy have been ineffectual in treating, for the purpose of changing or controlling behavior.

E. The Guglielmi Detachable Coil (GDC) is an extremely fine wire made from platinum, one of the softest metals, at the end of a longer stainless steel wire. In a controlled manner, the surgeon uses a micro-catheter to thread each coil through blood vessels to the aneurysm site. Application of a very-low-voltage electric current detaches and releases the coil into the aneurysm. Once in place, the GDC coils fill the aneurysm, isolating it from circulation to

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reduce the likelihood of rupture and hemorrhagic stroke. By applying a low voltage direct current to a stainless steel wire at the base of the coil, the platinum coil is detached. This applied current not only detaches the coil but also promotes electrothrombosis within the aneurysm.

### III. POLICY

A. Services and supplies required in the diagnosis and treatment of illness or injury involving the nervous system are covered.

B. Therapeutic embolization (CPT<sup>2</sup> procedure code 61624) may be covered for the following indications. The list of indications is not all inclusive. Other indications are covered when documented by reliable evidence as safe, effective and comparable or superior to standard care (proven).

1. Cerebral Arteriovenous Malformations (AVMs).
2. Vein of Galen Aneurysm.
3. Inoperable or High-Risk Intracranial Aneurysms.
4. Dural Arteriovenous Fistulas.
5. Meningioma.

C. Implantation of depth electrodes is covered. Implantation of a U.S. Food and Drug Administration (FDA) approved vagus nerve stimulator as adjunctive therapy in reducing the frequency of seizures in adults and adolescents over 12 years of age, which are refractory to anti-epileptic medication is covered. Battery replacement is also covered.

D. Spinal cord and deep brain stimulation are covered in the treatment of chronic intractable pain. Coverage includes:

1. The accessories necessary for the effective functioning of the covered device.
2. Repair, adjustment, replacement and removal of the covered device and associated surgical costs.

E. The GDC may be cost-shared for embolizing unruptured intracranial aneurysms that, because of their morphology, their location, or the patient's general medical condition, are considered by the treating neurosurgical team to be:

1. Very high risk for management by traditional operative techniques; or
2. Inoperable; or

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3. For embolizing other vascular malformation such as **AVMs** and arteriovenous fistulae of the neurovasculature, to include arterial and venous embolizations in the peripheral vasculature.

#### IV. EXCLUSIONS

A. N-butyl-2-cyanoacrylate (Histacryl Bleu®), iodinated poppy seed oils (e.g., Ethiodol®), and absorbable gelatin sponges are not FDA approved.

B. Transcutaneous, percutaneous, functional dorsal column electrical stimulation in the treatment of multiple sclerosis or other motor function disorders is unproven.

C. Deep brain neurostimulation in the treatment of insomnia, depression, anxiety, and substance abuse is unproven.

D. Psychosurgery is not in accordance with accepted professional medical standards and is not covered.

E. Endovascular GDC treatment of wide-necked aneurysms and rupture is unproven.

F. Cerebellar stimulators/pacemakers for the treatment of neurological disorders are unproven.

G. Dorsal Root Entry Zone (DREZ) thermocoagulation or microcoagulation neurosurgical procedure is unproven.

H. Epidural steroid injections for thoracic pain are unproven.

I. Extraoperative electrocortigraphy for stimulation and recording in order to determine electrical thresholds of neurons as an indicator of seizure focus is unproven.

J. Neuromuscular **Electrical Stimulation (NMES)** for the treatment of denervated muscles is unproven.

K. Stereotactic cingulotomy is unproven.

L. Sacral nerve neurostimulator (CPT<sup>3</sup> procedure codes 64561, 64581, 64585, and 64590). See [Chapter 4, Section 14.1](#) for coverage policy for the urinary system and the Sacral Nerve Root Stimulation (SNS).

M. Laminoplasty, cervical with decompression of the spinal cord, two or more vertebral segments with reconstruction of the posterior bony elements (CPT<sup>3</sup> procedure codes 63050 and 63051).

N. Balloon angioplasty, intracranial, percutaneous (CPT<sup>3</sup> procedure code 61630) is unproven. Effective January 1, 2006.

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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 4, SECTION 20.1

NERVOUS SYSTEM

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O. Transcatheter placement of intravascular stent(s) intracranial, (e.g., atherosclerotic stenosis) including angioplasty, if performed (CPT<sup>4</sup> procedure code 61635) is unproven. Effective January 1, 2006.

P. Balloon dilation of intracranial vasospasm, initial vessel (CPT<sup>4</sup> procedure code 61640) each additional vessel in same family (CPT<sup>4</sup> procedure code 61641) or different vascular family (CPT<sup>4</sup> procedure code 61642) is unproven. Effective January 1, 2006.

Q. Sphenopalatine ganglion block (CPT<sup>4</sup> procedure code 64505) for the treatment of chronic migraine headaches and neck pain is unproven.

R. Radiofrequency ablation (percutaneous radiofrequency facet denervation, percutaneous facet coagulation, percutaneous radiofrequency neurotomy, radiofrequency facet rhizotomy, radiofrequency articular rhizolysis) (CPT<sup>4</sup> procedure codes 64622, 64623, 64626, 64627) for the treatment of chronic spinal pain is unproven. Pulsed radiofrequency ablation for spinal pain is unproven.

S. **Implantation of Occipital Nerve Stimulator (CPT<sup>4</sup> procedure code 64555) for the treatment of chronic intractable migraine headache is unproven.**

T. Cryoablation of Occipital Nerve (CPT<sup>4</sup> procedure code 64640) for the treatment of chronic intractable headache is unproven.

V. EFFECTIVE DATES

A. January 1, 1989, for PAVM.

B. April 1, 1994, for therapeutic embolization for treatment of meningioma.

C. July 14, 1997, for GDC.

D. The date of FDA approval of the embolization device for all other embolization procedures.

E. June 1, 2004, for Magnetoencephalography.

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## WELL-CHILD CARE

ISSUE DATE: April 19, 1983

AUTHORITY: [32 CFR 199.4\(c\)\(2\)\(xiii\)](#) and [\(c\)\(3\)\(xi\)](#)

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### I. CPT<sup>1</sup> PROCEDURE CODES

54150, 54160, 81000 - 81015, 81099, 83655, 84030, 84035, 85014, 85018, 86580, 90465 - 90468, 90471 - 90474, 90476 - 90748, 92002, 92004, 92012, 92014, 92015, 92551, 92585 - 92588, 99172, 99173, 99381 - 99383, 99391 - 99393, ~~99460 - 99463~~, 99499.

### II. DESCRIPTION

Well-child care includes routine newborn care, health supervision examinations, routine immunizations, periodic health screening, and developmental assessment in accordance with the American Academy of Pediatrics (AAP) guidelines.

### III. POLICY

Well-child care is covered for beneficiaries from birth to age six when services are provided by the attending pediatrician, family physician, ophthalmologist or optometrist, certified Nurse Practitioner (NP), or certified Physician Assistant (PA). Well-child services are considered preventive and are subject to the same cost sharing/copayment and authorization requirements prescribed under the TRICARE Prime and Standard Clinical Preventive Services benefits, except as described in the TRICARE Reimbursement Manual (TRM), [Chapter 2, Section 1, paragraph I.C.3.j.](#) and [paragraph I.D.3.](#) (see [paragraph IV.H.](#) and [Sections 2.1](#) and [2.2](#)).

### IV. POLICY CONSIDERATIONS

A. Visits for diagnosis or treatment of an illness or injury are not included in the well-child benefit. Benefits should be extended on the basis of the medical necessity for the services.

B. For children whose health screening and immunizations may not be current, payment may be made for well-child visits and immunizations up to midnight of the day prior to the day the child turns six years old, and thereafter under the TRICARE Preventive Services (see [Sections 2.1](#) and [2.2](#)).

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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 7, SECTION 2.5

WELL-CHILD CARE

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C. Immunizations are covered for age appropriate dose of vaccines that have been recommended and adopted by the Advisory Committee on Immunization Practices (ACIP) and accepted by the Director of the Centers for Disease Control and Prevention (CDC) and the Secretary of Health and Human Services (HHS) and published in a CDC *Morbidity and Mortality Weekly Report* (MMWR). Refer to the CDC's home page (<http://www.cdc.gov>) for access to the MMWRs and a current schedule of CDC recommended vaccines. Immunizations required by dependents of active duty military personnel who are traveling outside the United States as a result of an active duty member's duty assignment, and such travel is being performed under orders issued by a Uniformed Service, are covered.

NOTE: The procedure codes in this policy are not necessarily an all-inclusive list of vaccines currently recommended by the CDC's ACIP.

D. Well-child care for newborns includes the routine care of the newborn in the hospital, newborn circumcision, and newborn screening as recommended by the AAP. Covered newborn screenings include, but are not limited to, testing for hypothyroidism, phenylketonuria (PKU) hemoglobinopathies (refer to [paragraph IV.G.2.](#) for further details), and galactosemia. Only routine well-child care for newborns is covered as part of the mother's maternity episode, i.e., a separate cost-share is not required for the infant. If a circumcision is performed after the child has been discharged from the hospital, the service is cost-shared as an outpatient service (unless it qualifies for the special cost-sharing for ambulatory surgery). Separate professional claims must be submitted for the newborn and the mother.

E. A program of well-child care conducted according to the most current Guidelines for Health Supervision, AAP, is covered. Significant deviation from the guidelines requires justification. In any case, no more than nine well-baby visits in two years are covered.

F. Each office visit for well-child care includes the following services:

1. History and physical examination and mental health assessment.
2. Developmental and behavioral appraisal.
  - a. Height and weight should be measured regularly throughout infancy and childhood.
  - b. Head circumference should be measured for children through 24 months of age.
  - c. Sensory screening: vision, hearing (by history).
    - (1) Eye and vision screening by primary care provider during routine examination at birth, and approximately six months of age.
    - (2) All high risk neonates (as defined by the Joint Committee on Infant Hearing) should undergo audiology screening before leaving the hospital. If not tested at birth, high-risk children should be tested before three months of age using Evoked Otoacoustic Emission (EOE) and/or Auditory Brainstem Response (ABR) testing.