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TRICARE
MANAGEMENT ACTIVITY

MB&RB

**CHANGE 109
6010.54-M
NOVEMBER 5, 2009**

**PUBLICATIONS SYSTEM CHANGE TRANSMITTAL
FOR
TRICARE POLICY MANUAL (TPM), AUGUST 2002**

The TRICARE Management Activity has authorized the following addition(s)/revision(s).

CHANGE TITLE: EVOLVING PRACTICES - AUGUST 2009

CONREQ: 14857

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): This change implements several policy determinations on evolving health care technologies.

EFFECTIVE AND IMPLEMENTATION DATE: As indicated, otherwise upon direction of the Contracting Officer.

**Reta Michak
Acting Chief, Medical Benefits and
Reimbursement Branch**

**ATTACHMENT(S): 19 PAGE(S)
DISTRIBUTION: 6010.54-M**

CHANGE 109
6010.54-M
NOVEMBER 5, 2009

REMOVE PAGE(S)

CHAPTER 1

Section 2.1, pages 3 and 4

Section 3.1, page 1

Section 17.1, pages 1 and 2

CHAPTER 4

Section 6.1, pages 1 and 2

Section 13.1, pages 1 and 2

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Section 23.1, pages 9 and 10

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Section 2.5, pages 1 through 4

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CHAPTER 1, SECTION 2.1

UNPROVEN DRUGS, DEVICES, MEDICAL TREATMENTS, AND PROCEDURES

l. The following is a partial list of drugs, devices, medical treatments, or procedures considered to be unproven. Other drugs, devices, medical treatments, or procedures also considered to be unproven are listed as specific exclusions in relevant sections of the TRICARE Policy Manual. For example, Cardiomyoplasty for treatment of heart failure is considered unproven and is listed as a specific exclusion in [Chapter 4, Section 9.1](#) (Cardiovascular System). Neither the partial list below nor the exclusions cited in other sections of the TRICARE Policy Manual provide an all inclusive list of unproven drugs, devices, medical treatments, or procedures. Other unproven drugs, devices, medical treatments, or procedures are also excluded although they do not appear in the TRICARE Policy Manual.

1. Adoptive immunotherapy using either Tumor-Infiltrating Lymphocytes (TIL) or Lymphokine-Activated Killer (LAK) cells, activated in vitro by recombinant or natural IL-2 or other lymphokines, for the treatment of cancer.
2. Adrenal tissue transplant to brain.
3. Autolymphocyte Therapy (ALT).
4. Calcium EAP/calcium orotate and selenium (also known as Nieper therapy) - involves inpatient care and use of calcium compounds and other non-FDA approved drugs and special diets. Used for cancer, heart disease, diabetes, multiple sclerosis -- Not a proven treatment for any indication.
5. **Canaloplasty in the treatment of glaucoma is unproven.**
6. Services related to the candidiasis hypersensitivity syndrome, yeast syndrome, or gastrointestinal candidiasis are unproven (i.e., allergenic extracts of *Candida albicans* for immunotherapy and/or provocation/neutralization). Disseminated systemic candidiasis (ICD-9-CM 112.5) is a recognized diagnosis, and medically necessary treatment is covered.
7. Cellular therapy (HCPCS procedure code M0075).
8. Chelation therapy, except when using FDA-approved chelators for FDA-approved indications.
9. Diaphanography (Transillumination Light Scanning).
10. Dynamic Posturography (both static and computerized) (CPT¹ procedure code 92548).
11. Electric reflex salivary stimulation (Salitron® Electrostimulation System) in the treatment of xerostomia (dry mouth) secondary to Sjogren's syndrome (HCPCS procedure code E0755).
12. Eye Movement Desensitization and Reprocessing therapy (EMDR) for treatment of psychiatric and behavioral disorders.

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13. Growth factor, including platelet-derived growth factors, for treating non-healing wounds. This includes Procuren®, a platelet-derived wound-healing formula.
14. Hand transplant from a cadaver donor.
15. Histamine therapy.
16. Holding therapy - involves holding the patient in an attempt to achieve interpersonal contact, and to improve the patient's ability to concentrate on learning tasks.
17. Hyperosmotic blood-brain barrier disruption produced by infusion of Manitol to increase drug delivery to brain tumors.
18. Hyperventilation Provocation Test (HVPT) for diagnosing hyperventilation syndrome.
19. Immunotherapy for malignant disease except when using drugs approved by the FDA for this purpose.
20. Intracavitary administration of cisplatin for malignant disease is unproven, except for patients with optimally debulked Stage III ovarian cancer and pseudomyxoma peritonei resulting from appendiceal carcinoma.
21. Iridology (links flaws in eye coloration with disease elsewhere in the body).
22. Light therapy for Seasonal Depression (also known as seasonal affective disorder (SAD)). This therapy uses varying degrees of light to treat depression.
23. Neurofeedback.
24. All organ transplants not listed as covered in the TRICARE Policy Manual or [32 CFR 199.4\(e\)\(5\)](#).
25. Portable nocturnal hypoglycemia monitors.
26. Pupillometry.
27. Sensory Afferent Stimulation (SAS) devices for relief of nausea (e.g., Relief Band®).
28. Spinoscopy. Use of a Spinoscope with skin markers to assess the function of the spine.
29. Synaptic 2000 for acute and chronic pain.
30. Tinnitus Masker.
31. Transdermal nicotine therapy used to treat ulcerative colitis.

RARE DISEASES

ISSUE DATE: May 18, 1994

AUTHORITY: 32 CFR 199.2(b) and 32 CFR 199.4(g)(15)

I. DESCRIPTION

TRICARE defines a rare disease as any disease or condition that affects less than 200,000 persons in the United States.

II. POLICY

A. Coverage for treatment of rare diseases may be considered on a case-by-case basis. Case-by-case review is not required for drugs, devices, medical treatments, and procedures that have already been established as safe and effective for treatment of rare diseases.

B. In reviewing the case, any or all of the following sources may be used to determine if the proposed benefit is considered safe and effective.

1. Trials published in refereed medical literature.
2. Formal technology assessments.
3. National medical policy organization positions.
4. National professional associations.
5. National expert opinion organizations.

C. If case review indicates that the proposed benefit for a rare disease is safe and effective for that disease, benefits may be allowed. If benefits are denied, an appropriate appealing party may request an appeal.

D. Off-label use of rituximab may be considered for cost-sharing for the treatment of recurrent nodular CD20 positive lymphocyte predominant Hodgkin's disease. The effective date is January 1, 2003.

E. Off-label use of rituximab may be considered for cost-sharing in reducing proteinuria for the treatment of Immunoglobulin A (IgA) nephropathy (proliferative glomerulonephritis). The effective date is May 1, 2007.

F. Effective May 13, 2009, Intraperitoneal Hyperthermic Chemotherapy (IPHC) (CPT¹ procedure codes 77600, 77605, and 96445) in conjunction with cytoreductive surgery or peritonectomy for treatment of pseudomyxoma peritonei resulting from appendiceal carcinoma may be covered on a case-by-case basis for adult patients when all of the following criteria are met:

1. There is no evidence of distant metastasis.
2. There is evidence of low histological aggressiveness of the disease.
3. The patient has not undergone preoperative systemic chemotherapy.
4. The patient's condition does not preclude major surgery.
5. The chemotherapeutic agents used are mitomycin C, cisplatin (also known as cisplatinum), or fluorouracil.

- END -

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

ISSUE DATE: November 6, 2007

AUTHORITY:

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; and

2. S0812, S1030, S1031, S2066, S2067, S2068, S2075, S2076, S2077, S2083, S2202, S2235, S2360, S2361, 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](#)).

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"S" CODES

4. S2400 for prenatal surgical intervention of temporary tracheal occlusion of Congenital Diaphragmatic Hernia (CDH) for fetuses with prenatal diagnosis of CDH shall be determined on a case-by-case basis, based on the Rare Disease policy, effective October 1, 2009. Procedural guidelines for review of rare disease are contained in [Chapter 1, Section 3.1](#).

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 -

MUSCULOSKELETAL SYSTEM

ISSUE DATE: August 26, 1985

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

I. CPT¹ PROCEDURE CODES

20000 - 22505, 22520 - 22525, 22532 - 22534, 22548 - 28825, 28899 - 29863, 29866, 29867, 29870 - 29999

II. HCPCS CODES

S2360, S2361

III. DESCRIPTION

The musculoskeletal system pertains to or comprises the skeleton and the muscles.

IV. POLICY

A. Services and supplies required in the diagnosis and treatment of illness or injury involving the musculoskeletal system are covered. U.S. Food and Drug Administration (FDA)-approved surgically implanted devices are also covered.

B. Effective August 25, 1997, autologous chondrocyte implantation (ACI) surgery for the repair of clinically significant, symptomatic, cartilaginous defects of the femoral condyle (medial, lateral or trochlear) caused by acute or repetitive trauma is a covered procedure. The autologous cultured chondrocytes must be approved by the FDA.

C. Single or multilevel anterior cervical microdiscectomy with allogenic or autogenic iliac crest grafting and anterior plating is covered for the treatment of cervical spondylosis.

D. Percutaneous vertebroplasty (CPT¹ procedure codes 22520-22522, S2360, S2361) and balloon kyphoplasty (CPT¹ procedure codes 22523-22525) are covered for the treatment of painful osteolytic lesions and osteoporotic compression fractures refractory to conservative medical treatment.

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MUSCULOSKELETAL SYSTEM

E. Total Ankle Replacement (TAR) (CPT² procedure codes 27702 and 27703) surgery is covered if the device is FDA approved and the use is for an FDA approved indication. However, a medical necessity review is required in case of marked varus or valgus deformity.

V. EXCLUSIONS

A. Meniscal transplant (CPT² procedure code 29868) for meniscal injury is unproven.

B. Ligament replacement with absorbable copolymer carbon fiber scaffold is unproven.

C. Prolotherapy, joint sclerotherapy and ligamentous injections with sclerosing agents (HCPCS procedure code M0076) are unproven.

D. Trigger point injection (CPT² procedure codes 20552 and 20553) for migraine headaches.

E. IDET (Intradiscal Electrothermal Therapy) for Chronic Discogenic Pain (CPT² procedure codes 0062T and 0063T) is unproven.

F. Botox (chemodenervation) for migraine headaches is unproven.

G. Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace, cervical; single interspace (CPT² procedure code 22856) each additional interspace (CPT² procedure code 0092T) is unproven.

H. Removal of total disc arthroplasty anterior approach cervical; single interspace (CPT² procedure code 22864) each additional interspace (CPT² procedure code 0095T) is unproven. Also see [Chapter 4, Section 1.1](#).

I. Artificial intervertebral disc revision including replacement for degenerative disc disease is unproven (CPT² procedure codes 22861 and 0098T).

J. Extracorporeal shock wave, high energy involving the plantar fascia (CPT² procedure code 28890).

K. X STOP Interspinous Process Decompression System for the treatment of neurogenic intermittent claudication secondary to lumbar spinal stenosis is unproven.

L. Hip core decompression is unproven.

M. Femoroacetabular Impingement (FAI) open surgery, surgical dislocation (CPT² procedure codes 27140 and 27179), for the treatment of hip impingement syndrome or labral tear is unproven.

N. Hip arthroscopy (CPT² procedure code 29862) for the treatment of FAI and debridement of articular cartilage is unproven.

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VI. EFFECTIVE DATE

- A. February 6, 2006, for percutaneous vertebroplasty and balloon kyphoplasty.
- B. May 1, 2008, for Total Ankle Replacement (TAR).

- END -

DIGESTIVE SYSTEM

ISSUE DATE: August 26, 1985

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

I. CPT¹ PROCEDURE CODES

40490 - 40831, 40899 - 43644, 43647, 43648, 43651 - 43761, 43800, 43810, 43820, 43842, 43846, 43848, 43880 - 43882, 43999, 44005 - 47362, 47370, 47371, 47379 - 47382, 47399 - 49999, 91123, 96570, 96571

II. DESCRIPTION

The digestive system involves the organs associated with the ingestion, digestion, and absorption of nutrients, and the elimination of solid waste.

III. POLICY

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

B. Gastric electrical stimulation (CPT¹ procedure codes 43647, 43648, 43881, and 43882) for treatment of symptoms of nausea and vomiting from chronic gastroparesis that is refractory to medical management may be considered for coverage as a Humanitarian Use Device (HUD).

C. Radiofrequency Ablation (RFA) (CPT¹ procedure codes 47370, 47380, and 47382) for treatment of unresectable hepatocellular carcinoma or unresectable liver metastases from colorectal cancer is proven and may be covered when all of the following conditions are met:

1. Tumors are less than five centimeters in diameter;
2. There are five or fewer tumors; and
3. There is no evidence of extrahepatic metastasis.

All procedures must be performed using an Food and Drug Administration (FDA) approved electrosurgical cutting and coagulation device.

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D. Intraperitoneal Hyperthermic Chemotherapy (IPHC) (CPT² procedure codes 77600, 77605, and 96445) in conjunction with cytoreductive surgery or peritonectomy for treatment of pseudomyxoma peritonei resulting from appendiceal carcinoma may be covered under the Rare Diseases policy on a case-by-case basis for adult patients when all of the following criteria are met:

1. There is no evidence of distant metastasis.
2. There is evidence of low histological aggressiveness of the disease.
3. The patient has not undergone preoperative systemic chemotherapy.
4. The patient's condition does not preclude major surgery.
5. The chemotherapeutic agents used are mitomycin C, cisplatin (also known as cisplatinum), or fluorouracil.

IV. EXCLUSIONS

A. Vestibuloplasty (CPT² procedure code range 40840-40845) EXCEPT for adjunctive dental care ([Chapter 8, Section 13.1](#)).

B. The Stretta System (Curon Medical, Sunnyvale, CA), and Bard Endoscopic Suturing System, and Transoral Incisionless Fundoplication using EsophyX (EndoGastric Solutions, Redmond, WA) for the treatment of refractory gastroesophageal reflux disease (GERD) are unproven (CPT² procedure codes 43201 and 43257).

C. For bariatric procedures, see [Section 13.2](#).

V. EFFECTIVE DATES

A. RFA (CPT² procedure codes 47370, 47380, and 47382) for treatment of unresectable hepatocellular carcinoma or unresectable liver metastases from colorectal cancer is proven and covered, effective April 28, 2004.

B. IPHC (CPT² procedure codes 77600, 77605, and 96445) in conjunction with cytoreductive surgery or peritonectomy for treatment of pseudomyxoma peritonei arising from appendiceal carcinoma may be covered under the Rare Diseases policy on a case-by-case basis for adult patients, effective May 13, 2009.

- END -

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FETAL SURGERY

ISSUE DATE:

AUTHORITY: [32 CFR 199.4\(c\)\(2\)\(i\)](#)

I. HCPCS PROCEDURE CODES

S2401 - S2403, S2405, S2411

II. DEFINITION

Fetal surgery is defined as an intervention consisting of opening of the gravid uterus (by either a traditional cesarean surgical incision or through single or multiple fetoscopic port incisions), surgically correcting a fetal abnormality, and either returning the fetus to the uterus (or restoring uterine closure, if the intervention has been accomplished without removal of the fetus) for completion of gestational development.

III. POLICY

A. Fetal surgery is covered for the following indications:

1. Prenatal surgical intervention consisting of vesicoamniotic shunting in fetuses with hydronephrosis due to bilateral urinary tract obstruction together with evidence of progressive oligohydramnios and evidence of adequate renal function as generally defined by normal urinary electrolytes, and with no other lethal abnormalities or chromosomal defects.
2. Prenatal intervention of either an open in-utero resection of malformed pulmonary tissue or placement of a thoraco-amniotic shunt in cases of hydrothorax or large cystic lesions for fetuses congenital cystic adenomatoid malformation or extralobar pulmonary sequestration, who are of less than 32 weeks' gestation and who have evidence of progressive hydrops, placentomegaly and/or the beginnings of maternal mirror syndrome.
3. Twin-twin transfusion syndrome, gestation age of less than 25 weeks' gestation at the time of diagnosis.
4. Sacrococcygeal teratoma in the presence of fetal hydrops and/or placentomegaly in fetuses with less than 28 weeks of gestation.

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FETAL SURGERY

B. Other conditions when determined by medical review to be medically necessary and appropriate treatment for the patient's medical condition and that reliable evidence has established in-utero surgery as safe and effective treatment.

IV. CONSIDERATIONS

A. The Department of Defense (DoD) In-Utero Fetal Surgical Repair of Myelomeningocele Clinical Trial Demonstration Project can be referenced in the TRICARE Operations Manual (TOM), [Chapter 20, Section 3](#).

B. For dates of services on or after October 1, 2009, coverage for prenatal surgical intervention of temporary tracheal occlusion of Congenital Diaphragmatic Hernia (CDH) for fetuses with a prenatal diagnosis of CDH (CPT¹ procedure code S2400), shall be determined on a case-by-case basis, based on the Rare Disease policy. Procedural guidelines for review of rare disease are contained in [Chapter 1, Section 3.1](#).

V. EXCLUSIONS

A. The in-utero repair for myelomeningocele (HCPCS S2404) and aqueductal stenosis (HCPCS S2409) and procedures performed in-utero, not otherwise classified.

B. In-utero surgery for other conditions for which the safety and effectiveness has not been established.

- END -

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HIGH DOSE CHEMOTHERAPY AND STEM CELL TRANSPLANTATION

Q. Immunoablative therapy with BMT or PSCT is unproven and not covered for the treatment of rheumatoid arthritis and juvenile idiopathic arthritis.

R. Immunoablative therapy with allogeneic BMT or allogeneic PSCT is not covered for the treatment of systemic lupus erythematosus.

V. EFFECTIVE DATES

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

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

C. November 1, 1983, for HDC with allogeneic BMTs using related donors.

D. July 1, 1989, for HDC with allogeneic BMTs using unrelated donors.

E. July 11, 1996, for HDC with ABMT or PSCT for multiple myeloma.

F. January 1, 1994, for HDC with ABMT and PSCT for Wilms' tumor.

G. January 1, 1995, for allogeneic UCBTs.

H. January 1, 1994, for HDC with ABMT or PSCT for chronic myelogenous leukemia.

I. January 1, 1996, for HDC with ABMT or PSCT for Waldenstrom's macroglobulinemia.

J. January 1, 1996, for allogeneic BMTs using related three antigen mismatch donors for patients with undifferentiated leukemia, Chronic Myelogenous Leukemia (CML), aplastic anemia, Acute Lymphocytic Leukemia (ALL) or Acute Myelogenous Leukemia (AML).

K. October 1, 1996, for HDC with ABMT or PSCT for AL Amyloidosis.

L. January 1, 1995, for allogeneic BMT for hypereosinophilic syndrome.

M. May 1, 1997, for HDC with ABMT or PSCT for trilateral retinoblastoma/pineoblastoma.

N. January 1, 1997, for HDC with ABMT or PSCT for follicular lymphoma.

O. January 1, 1997, for HDC with ABMT or PSCT for non-Hodgkin's lymphoma in first complete remission.

P. November 28, 1997, for HDC with ABMT or PSCT for Hodgkin's disease in second or third remission.

Q. January 1, 1996, for HDC with allogeneic BMT for multiple myeloma.

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HIGH DOSE CHEMOTHERAPY AND STEM CELL TRANSPLANTATION

- R. July 1, 1999, for HDC with ABMT or PSCT for germ cell tumors in a second or subsequent relapse.
- S. January 1, 1998, for HDC with ABMT or PSCT for osteosarcoma (osteogenic sarcoma).
- T. June 1, 1995, for allogeneic BMT for Chediak-Higashi syndrome.
- U. January 1, 1998, for allogeneic **PSCT**.
- V. June 1, 2003, for Langerhans Cell Histiocytosis, refractory to conventional treatment.
- W. January 24, 2002, for allogeneic stem cell transplant for Hodgkin's disease.
- X. May 19, 2005, for tandem autologous **PSCT** for high-risk neuroblastoma.
- Y. January 1, 2006, for HDC with ABMT or PSCT for desmoplastic small round cell tumor.
- Z. **April 2, 2009, for immunoablative therapy with ABMT or autologous PSCT for severe systemic lupus erythematosus, refractory to conventional treatment.**

- END -

WELL-CHILD CARE

ISSUE DATE: April 19, 1983

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

I. CPT¹ PROCEDURE CODES

54150, 54160, **54161**, 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 TRICARE Prime and Standard Clinical Preventive Services, except as described in the TRICARE Reimbursement Manual (TRM), [Chapter 2, Section 1, paragraph I.C.3.j.](#) and [paragraph I.D.3.](#) (see [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 **Clinical Preventive Services benefit** (see [Sections 2.1](#) and [2.2](#)).

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C. Immunizations are covered for the 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 for use in the United States. Immunizations recommended specifically for travel outside the United States are not covered. EXCEPT for 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.

NOTE: The procedure codes in this policy are not necessarily an all-inclusive list of vaccines currently recommended for use in the United States 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.

NOTE: Male circumcision performed during newborn period (0 - 30 days) is covered. Male circumcision performed outside the newborn period due to medical complications at birth or during the newborn period that prevented performing the circumcision within the newborn period, may be covered up to 30 days after discharge. Male circumcision performed after the newborn period without medical complications at birth, may be covered if medically necessary and otherwise authorized for benefits.

E. The well-child visits and services covered under this policy are those recommended in the most current AAP Guidelines.

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 neonates should undergo audiology screening before leaving the hospital. **However, if not tested at birth, all infants should undergo audiology screening before one month of age. Those who do not pass the audiologic screening should** be tested before three months of age using Evoked Otoacoustic Emission (EOE) and/or Auditory Brainstem Response (ABR) testing.

(3) All children should undergo hearing screening (by history) at each well-child visit, and children with possible hearing impairments should be referred for appropriate testing.

d. Dental screenings.

e. Discussion with parents, anticipatory guidance.

G. The following specific services are covered in a program of well-child care:

1. Immunizations **as indicated in paragraph IV.C.**

2. Heredity and metabolic screening:

a. Two screening tests for PKU, one prior to discharge from the hospital nursery and the other within one to two weeks after hospital discharge.

b. All neonates should be screened for congenital hypothyroidism prior to discharge from the hospital nursery but not later than day six of life.

c. Screening for hemoglobinopathies should be done for those in high-risk ethnic groups.

3. Tuberculin test: at 12 months of age and once during second year of age.

4. Hemoglobin or hematocrit testing: once during first year of age, once during second year of age.

5. Urinalysis: once during first year of age, once during second year of age.

6. Annual blood pressure screening for children between three and six years of age.

7. Blood lead test: (CPT² procedure code 83655): Assessment of risk for lead exposure by structured questionnaire based on CDC's Preventing Lead Poisoning in Young (October 1991) during each well-child visit from age six months to under six years of age.

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CHAPTER 7, SECTION 2.5

WELL-CHILD CARE

8. Health guidance and counseling, including breast feeding and nutrition counseling.

9. One routine eye examination by an ophthalmologist or optometrist every two years beginning at age three. The routine eye exams offered between the ages of three and six should include screening for amblyopia and strabismus.

10. Additional services or visits required because of specific findings or because the particular circumstances of the individual case are covered if medically necessary and otherwise authorized for benefits.

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