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TRICARE
MANAGEMENT ACTIVITY

MB&RB

**CHANGE 118
6010.54-M
FEBRUARY 11, 2010**

**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: WITHDRAWING COVERAGE OF HOME REHABILITATION THERAPIES TO ALTERNATIVE PROVIDERS

CONREQ: 14896

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): This change deletes Aug 2002 TPM Change 102, published July 20, 2009. TPM, Chapter 2, Section 2.1 is not in compliance with the regulation and as such benefits are not allowed under the Basic Program. Two exclusions were relocated elsewhere in the manual.

EFFECTIVE DATE: July 20, 2009.

IMPLEMENTATION DATE: Upon direction of the Contracting Officer.


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Chief, Medical Benefits and
Reimbursement Branch**

**ATTACHMENT(S): 10 PAGE(S)
DISTRIBUTION: 6010.54-M**

CHANGE 118
6010.54-M
FEBRUARY 11, 2010

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MATERNITY CARE

ISSUE DATE: August 26, 1985

AUTHORITY: 32 CFR 199.4(c)(2)(i), (e)(16), (g)(5), (g)(34), and (g)(36)

I. CPT¹ PROCEDURE CODES

59000 - 59899, 82105, 82106, 82731, 84702

II. DESCRIPTION

Maternity care is the medical services related to conception, delivery and abortion, including prenatal and postpartum care (generally through the sixth post-delivery week), and treatment of complications of pregnancy.

III. POLICY

A. Services and supplies associated with antepartum care (including well-being of the fetus), childbirth, postpartum care, and complications of pregnancy may be cost-shared.

B. The mother and child hospital length-of-stay benefit may not be restricted to less than 48 hours following a normal vaginal delivery and 96 hours following a cesarean section. The decision to discharge prior to those minimum length-of-stays must be made by the attending physician in consultation with the mother.

C. Maternity care for pregnancy resulting from noncoital reproductive procedures may be cost-shared.

D. Services and supplies associated with antepartum care, childbirth, postpartum care and complications of pregnancy may be cost-shared where the surrogate mother is a TRICARE beneficiary.

E. Progesterone therapy for the prevention of preterm birth is covered only when the following criteria are met:

1. Weekly injections of 17 alpha-hydroxyprogesterone caproate between 16 and 36 weeks of gestation for pregnant women with a documented history of a previous spontaneous birth at less than 37 weeks of gestation.

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2. Oral progesterone therapy or injections of 17 alpha-hydroxyprogesterone caproate are **NOT** covered for other high risk factors for preterm birth, including, but not limited to multiple gestations, short cervical length, or positive fetal tests for cervicovaginal fetal fibronectin.

IV. EXCLUSIONS

A. Services and supplies related to noncoital reproductive procedures.

B. Home Uterine Activity Monitoring (HUAM), telephonic transmission of HUAM data, or HUAM-related telephonic nurse or physician consultation for the purpose of monitoring suspected or confirmed pre-term labor is unproven.

C. Off-label use of FDA-approved drugs to induce or maintain tocolysis.

D. Lymphocyte or paternal leukocyte immunotherapy in the treatment of recurrent spontaneous fetal loss is unproven.

E. Salivary estriol test for preterm labor is unproven (CPT² procedure code 82677).

F. Home infusion for tocolytic therapy.

- END -

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TREATMENT OF MENTAL DISORDERS

ISSUE DATE: December 5, 1984

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

I. CPT¹ PROCEDURE CODE RANGE

90801 - 90899

II. POLICY

Benefits are payable for services and supplies that are medically or psychologically necessary for the treatment of mental disorders when: (1) the services are rendered by persons who meet the criteria of [32 CFR 199.6](#) for their respective disciplines (whether the person is an individual professional provider or is employed by another authorized provider), and (2) the mental disorder is one of those listed in DSM-IV and is of a severity not only to cause the patient distress but also to interfere with the patient's ability to carry out his or her usual activities.

III. POLICY CONSIDERATIONS

A. Professional and institutional providers of mental health services.

1. List of authorized providers. Only the types of providers listed below are considered qualified providers of mental health services. The person providing the care must meet the criteria of [32 CFR 199.6](#), whether that person is an individual professional provider or is employed by another authorized provider.

- a. Psychiatrists and other physicians
- b. Clinical psychologists
- c. Certified psychiatric nurse specialists
- d. Clinical social workers
- e. Certified marriage and family therapists
- f. Pastoral counselors; and

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g. Mental health counselors

2. Professional staff of institutions providing mental health services. For those types of institutional providers that are certified by TMA, reviewers may assume that all professional staff meet regulatory criteria. Any evidence to the contrary is to be brought to the attention of the Special Contract Operations Office, TMA, immediately. Contractors shall notify institutional providers within their jurisdictions that payment is authorized only for professional services provided by employees meeting the program requirements. In any situation where the contractor obtains evidence that an institution is billing for professional services of unqualified staff, the case is to be submitted to the TMA Office of Program Integrity.

B. Review of Claims for Treatment of Mental Disorders. All claims for treatment of mental disorders are subject to review in accordance with claims processing procedures contained in the TRICARE Operations Manual.

1. Psychotropic drugs. All patients receiving psychotropic drugs must be under the care of a qualified mental health provider authorized by state licensure to prescribe drugs. That provider need not be the attending provider, but there must be evidence in the treatment plan of coordination between the various providers.

2. Electroconvulsive treatment (CPT² procedure codes 90870, 90871). Electroconvulsive treatment is covered when medically or psychologically appropriate and when rendered by qualified providers. However, the use of electric shock as negative reinforcement (aversion therapy) is excluded.

3. Ancillary therapies (no code, as separate reimbursement is not permitted). Includes art, music, dance, occupational, and other ancillary therapies, when included by the attending provider in an approved inpatient treatment plan and under the clinical supervision of a licensed doctoral level mental health professional. These ancillary therapies are not separately reimbursed professional services but are included within the institutional reimbursement.

4. Services by non-medical providers. With the exception of pastoral counselors, and mental health counselors, approved categories of non-medical providers may render covered services independent of physician referral and supervision. All providers, however, are expected to consult with, or refer patients to, a physician for evaluation and treatment of physical conditions that may co-exist with or contribute to a mental disorder. Failure to do so will result in denial of the non-physician provider's services on quality-of-care grounds. Questionable cases will be referred to peer review.

IV. EXCLUSIONS

A. Sexual dysfunctions, paraphilias and gender identity disorders.

B. Drug maintenance programs when one addictive drug is substituted for another on a maintenance basis.

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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 7, SECTION 3.10

TREATMENT OF MENTAL DISORDERS

C. Specific developmental disorders.

D. Home visits for individual, family, or marriage counseling (CPT³ procedure code 99510).

V. EFFECTIVE DATE November 13, 1984.

- END -

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