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TRICARE
MANAGEMENT ACTIVITY

MB&RB

**CHANGE 149
6010.54-M
SEPTEMBER 28, 2011**

**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: CODING AND CLARIFICATION UPDATES - OCTOBER 2010

CONREQ: 15092

PAGE CHANGE(S): See pages 2 and 3.

SUMMARY OF CHANGE(S): See pages 4 and 5.

EFFECTIVE AND IMPLEMENTATION DATE: Upon direction of the Contracting Officer.

This change is made in conjunction with Aug 2002 TRM, Change No. 141.

**Ann N. Fazzini
Chief, Medical Benefits and
Reimbursement Branch**

**ATTACHMENT(S): 55 PAGE(S)
DISTRIBUTION: 6010.54-M**

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

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SUMMARY OF CHANGES

CHAPTER 1

1. Section 16.1. Updates the list of CPT Procedure Codes. Deletes codes that are no longer valid. The codes that are now valid and that replaced the deleted codes are in the range of current published policy.
2. Section 17.1. Adds "S" code S0189 to list of reimbursable codes.

CHAPTER 4

3. Section 5.1. Administrative correction of text, changing 'Tropical' to 'Topical.' Updates the list of CPT Procedure Codes. Adds the HCPCS Procedure Code, S0189. Clarifies that testopel pellets are covered for FDA label indications for males. Clarifies that subcutaneous implantable pellets that are custom compounded of estradiol, estrogen, or testosterone in combination with estrogen or estradiol and used for treatment of females are not covered. Adds VI. Effective Dates for dates removed from paragraphs in IV. Policy.
4. Section 15.1. Updates the list of CPT Procedure Codes.
5. Section 20.1. Updates the list of CPT Procedure Codes.

CHAPTER 5

6. Section 1.1. Updates the list of CPT Procedure Codes. Updates the list of HCPCS Procedure Codes.

CHAPTER 7

7. Table of Contents. Administrative edit.
8. Section 2.1. Revises the age at which breast cancer screenings are covered and the frequency of which these screenings are covered. It also revises the risk factors that are considered to put women at greater than average risk of breast cancer. Administrative corrections, IV Policy, to maintain consistency in document format.
9. Section 2.2. Revises the age at which breast cancer screenings are covered and the frequency of which these screenings are covered. It also revises the risk factors that are considered to put women at greater than average risk of breast cancer. Administrative corrections to table.

SUMMARY OF CHANGES (Continued)

CHAPTER 7 (Continued)

10. Section 7.1. 32 CFR (Part 199) change allowing non-physician referral for physical therapy, occupational therapy and speech therapy.
11. Section 18.2. 32 CFR (Part 199) change allowing non-physician referral for physical therapy, occupational therapy and speech therapy.
12. Section 18.3. 32 CFR (Part 199) change allowing non-physician referral for physical therapy, occupational therapy and speech therapy.
13. Section 27.1. Updates list of HCPCS Procedure Codes. Adds the specific names for Botox A & B to existing policy language. Clarifies that Botox use for cosmetic indications is excluded from coverage.

CHAPTER 9

14. Section 12.1. Administrative correction that removes word 'monthly' from sentence.
15. Section 15.1. Clarifies the restrictions regarding use of the ECHO Home Health Care-Respite Care.

CHAPTER 10

16. Section 2.1. Removes reference to former TAMP eligibility periods.

CHAPTER 11

17. Section 3.1. Updates the list of providers.
18. Section 12.1. Administrative correction to text regarding TED record coding.

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19. Administrative updates.

CATEGORY III CODES

ISSUE DATE: March 6, 2002

AUTHORITY: [32 CFR 199.2\(b\)](#) and [32 CFR 199.4\(g\)\(15\)](#)

I. CPT¹ PROCEDURE CODES

0073T, 0075T, 0076T, 0099T, 0184T

II. DESCRIPTION

Category III codes are a set of temporary codes for emerging technology, services, and procedures. These codes are used to track new and emerging technology to determine applicability to clinical practice. When a Category III code receives a Category I code from the American Medical Association (AMA) it does not automatically become a benefit under TRICARE. However, the codes that may have moved from unproven to proven must be forwarded to the Office of Medical Benefits and Reimbursement Branch (MB&RB) for coverage determination/policy clarification.

III. POLICY

A. Category III codes are to be used instead of unlisted codes to allow the collection of specific data. TRICARE has not opted to track Category III codes at this time.

B. Category III codes are excluded from coverage since clinical safety and efficacy or applicability to clinical practice has not been established.

IV. EXCEPTIONS

A. FDA IDE (Category B) clinical trial. See [Chapter 8, Section 5.1](#).

B. Category III code 0073T is a covered service as listed in [Chapter 5, Section 3.1](#).

C. Category III codes 0075T and 0076T are covered codes as outlined in [Chapter 4, Section 9.1](#).

D. Category III code 0099T is a covered code as outlined in [Chapter 4, Section 21.1](#).

E. Category III code 0184T is a covered service as listed in [Chapter 4, Section 13.1](#).

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CHAPTER 1, SECTION 16.1

CATEGORY III CODES

V. EXCLUSIONS

A. Unlisted codes for Category III codes. Effective January 1, 2002.

B. Ultrasound ablation (destruction of uterine fibroids) with Magnetic Resonance Imaging (MRI) guidance (CPT² procedure code 0071T) in the treatment of uterine leiomyomata is unproven.

C. Computer-Aided Detection (CAD) with breast MRI (CPT² procedure code 0159T) is unproven.

D. XSTOP Interspinous Process Decompression System (CPT² procedure codes 0171T and 0172T, HCPCS code C1821) is unproven.

- 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, S1040, S2066, S2067, S2068, S2075, S2076, S2077, S2083, S2202, S2235, **S2325**, 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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HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS) "C" AND
"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](#).

5. S0189 for testosterone pellets as provided in [Chapter 4, Section 5.1](#).

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 -

INTEGUMENTARY SYSTEM

ISSUE DATE: August 26, 1985

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

I. CPT¹ PROCEDURE CODES

10021, 10022, 10040 - 11977, **11980** - 11983, 12001 - 15366, 15400 - 15431, 15570 - 15776, 15840 - 15845, 15851 - 19499, 97601, and 97602

II. HCPCS PROCEDURE CODE

S0189

III. DESCRIPTION

Integumentary system pertains to the skin, subcutaneous tissue and areolar tissue.

IV. POLICY

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

B. Topical Treatment of Skin Ulcers Caused by Venous Insufficiency. Topical application of Alpigraf by a physician for the treatment of skin ulcers caused by venous insufficiency is a covered benefit.

C. **Topical** Treatment of Diabetic Foot Ulcers.

1. Application of tissue cultured skin grafts for diabetic foot ulcers is a covered benefit.

2. Application of Becaplermine Gel (Regranex) is a covered treatment of lower extremity diabetic neuropathic foot ulcers that extend into the subcutaneous tissue or beyond.

D. Negative Pressure Wound Therapy (NPWT) may be covered when certain criteria are met. See [Section 5.8](#).

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E. Testopel pellets (Testosterone pellets) are covered for one of the following U. S. Food and Drug Administration (FDA) label indications:

1. As second-line testosterone replacement therapy in males with congenital or acquired endogenous androgen absence or deficiency associated with primary or secondary hypogonadism when neither oral nor intramuscular testosterone replacement therapy is effective or appropriate; or

2. For treatment of delayed male puberty.

V. EXCLUSIONS

A. Removal of corns or calluses or trimming of toenails and other routine podiatry services, except those required as a result of diagnosed systemic medical disease affecting the lower limbs, such as severe diabetes.

B. Services performed for cosmetic purposes.

C. Subcutaneous **implantable** pellets (CPT² procedure code 11980, HCPCS J3490 and S0189) for Hormone Replacement Therapy (HRT) in females that are made up of estradiol, estrogen, or testosterone in combination with estrogen or estradiol have been custom-compounded by pharmacists are not covered, as these pellets are not approved by the FDA.

VI. EFFECTIVE DATES

A. Effective May 26, 1998, for topical treatment of skin ulcers caused by venous insufficiency.

B. Effective May 8, 2000, for topical treatment of diabetic foot ulcers.

C. Effective December 16, 1997, for topical treatment of diabetic foot ulcers application of Becaplermine Gel (Regranex).

D. Effective November 9, 2007, for NPWT.

- END -

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MALE GENITAL SYSTEM

ISSUE DATE: August 26, 1985

AUTHORITY: [32 CFR 199.4\(c\)\(2\)](#), [\(c\)\(3\)](#), [\(e\)\(3\)\(i\)\(B\)\(3\)](#), [\(e\)\(8\)](#), and [\(e\)\(8\)\(i\)\(E\)](#)

I. CPT¹ PROCEDURE CODES

54000 - 55300, 55450 - **55705**, **55720** - 55866, 55873 - 55899, 55970

II. DESCRIPTION

The male genital system includes the male organs of reproduction.

III. POLICY

A. Medically necessary services and supplies required in the diagnosis and treatment of disease or injury involving the male genital system are covered.

B. A vasectomy, unilateral or bilateral, performed as an independent procedure is a covered service. (See [Chapter 7, Section 2.3](#) for detailed policy concerning sterilization and birth control).

C. For Implantable Urethral Sphincter, see [Chapter 4, Section 14.1](#).

D. Diagnostic studies necessary to establish organic versus psychogenic impotence, such as lab work, a psychiatric evaluation, Doppler ultrasound, arteriography, cavernosography, cavernosometry, or electrophysiological testing may be cost-shared. (Also, see [Chapter 7, Section 1.1](#).)

E. Organic impotence is defined as that which can be reasonably expected to occur following certain diseases, surgical procedures, trauma, injury, or congenital malformation. Impotence does not become organic because of psychological or psychiatric reasons.

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F. Treatment of organic impotency is covered subject to all applicable provisions of [32 CFR 199.4](#).

1. Penile Implant

a. Insertion of an FDA-approved penile implant is covered when performed for organic impotence which has resulted from a disease process, trauma, radical surgery, or for correction of a congenital anomaly, or for correction of sex gender confusion (that is, ambiguous genitalia) which has been documented to be present at birth.

b. Removal and reinsertion of covered penile implants and associated surgical fees may be cost-shared.

2. Hormone injection, non-injectable delivery system or intracavernosal injection for the treatment of organic impotency, may be cost-shared providing the drugs are FDA approved and usage is considered generally accepted medical practice.

3. External vacuum appliance for the treatment of organic impotency may be cost-shared providing the external appliance is FDA approved and usage is considered generally accepted medical practice.

4. Orally administered medication for the treatment of male organic impotency may be cost-shared only after a thorough evaluation according to clinical guidelines (see [Chapter 8, Section 9.1](#) for detailed guidelines).

a. Only 6 tablets per month (in accordance with established clinical guidelines) may be dispensed. "Lost," "stolen," or "destroyed" tablets will not be replaced.

b. Prescriptions filled through TRICARE Standard will be reimbursed for only 6 tablets per month and must be accompanied by proof of compliance with clinical guidelines.

5. Aortoiliac reconstruction, endarterectomy, and arterial dilatations for proximal lesions for the treatment of organic impotency may be cost-shared.

G. Insertion of an FDA approved testicular prosthesis is covered when performed following disease, trauma, injury, radical surgery, or for correction of a congenital anomaly, or for correction of sex gender confusion (that is, ambiguous genitalia) which has been documented to be present at birth).

H. Infertility testing and treatment, including correction of the physical cause of infertility may be cost-shared. Hypothalamic disease, pituitary disease, disorders of sperm transport, disorders of sperm motility or function, and/or sexual dysfunction may cause male infertility. Diagnostic Services may include semen analysis, hormone evaluation, chromosomal studies, immunologic studies, special and sperm function tests, and/or bacteriologic investigation. Therapy may include, but is not limited to, hormonal treatment, surgery, antibiotics, administration of HCG, and/or radiation therapy, depending upon the cause.

NERVOUS SYSTEM

ISSUE DATE: August 26, 1985

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

I. CPT¹ PROCEDURE CODES

61000 - 61626, 61680 - ~~62264~~, ~~62268~~ - 62284, 62290 - 63048, 63055 - 64484, 64505 - 64560, 64565 - 64580, 64595, 64600 - 64650, 64680 - 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 reduce the likelihood of rupture and hemorrhagic stroke. By applying a low voltage direct

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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 (CPT² 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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DIAGNOSTIC RADIOLOGY (DIAGNOSTIC IMAGING)

ISSUE DATE: March 7, 1986

AUTHORITY: 32 CFR 199.4(a), (b), (c), and (e)(14) and 32 CFR 199.6(d)(2)

I. CPT¹ PROCEDURE CODES

70010 - 72292, 73000 - 76083, 76086 - 76394, 76400, 76496 - 76499, 95965 - 95967

II. HCPCS PROCEDURE CODES

G0204, G0206

III. DESCRIPTION

Radiology is the science that deals with the use of radiant energy, such as X-rays, radium, and radioactive isotopes, in the diagnosis and treatment of disease. Radiology is an important diagnostic tool useful for the evaluation. The techniques used for diagnostic radiology are as follows:

A. Magnetic Resonance Imaging (MRI), formerly also referred to as Nuclear Magnetic Resonance (NMR), is a non-invasive method of graphically representing the distribution of water and other hydrogen-rich molecules in the human body. MRI uses radio frequency radiation in the presence of a carefully controlled magnetic field to produce high quality cross-sectional images of the head and body in any plane. These tomographic images represent the tissue being analyzed and the environment surrounding it. MRI has become a useful diagnostic imaging modality that is capable of demonstrating a wide variety of soft-tissue lesions with contrast resolution equal or superior to Computerized Tomography (CT) scanning in various parts of the body. Among the advantages of MRI are the absence of ionizing radiation and the ability to achieve high levels of tissue contrast resolution without injected iodinated contrast agents.

B. Magnetic Resonance Angiography (MRA) techniques generate contrast between flowing blood and surrounding tissue, and provide anatomic images that can be provided in a format similar to that of conventional x-ray angiography, and can also provide physiologic information.

C. A Computerized Tomography (CT)/Computerized Axial Tomography (CAT) scan is interchangeably referred to as either a CT or CAT scan. This diagnostic test uses x-ray

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technology to create three-dimensional, computerized images of internal organs. However, unlike a traditional x-ray, CT/CAT scans are able to distinguish between obscured and overlapping parts of the body. CAT scans are also capable of producing images of several different internal components, including soft tissue, blood vessels and bones.

IV. POLICY

A. MRI and MRI with contrast media are covered when medically necessary, appropriate, and the standard of care. (CPT² procedure codes 70336, 70540-70543, 70551-70553, 71550-71552, 72141-72158, 72195-72197, 73218-73223, 73718-73723, 74181-74183, 75552-75556, and 76400.)

B. Breast MRI (CPT² procedure codes 77058 and 77059) is covered for the following indications. This list of indications is not all inclusive. Other indications may be covered when documented by reliable evidence as safe, effective, and comparable to conventional technology (proven):

1. To detect breast implant rupture (the implantation of the breast implants must have been covered by TRICARE).
2. For detection of occult breast cancer in the setting of axillary nodal adenocarcinoma with negative physical exam and negative mammography.
3. For presurgical planning for locally advanced breast cancer before and after completion of neoadjuvant chemotherapy, to permit tumor localization and characterization.
4. For presurgical planning to evaluate the presence of multicentric disease in patients with localized or advanced breast cancer who are candidates for breast conservation treatment.
5. Evaluation of suspected cancer recurrence.
6. To determine the presence of pectoralis major muscle/chest wall invasion in patients with posteriorly located tumor.
7. For guidance of interventional procedures such a vacuum assisted biopsy and preoperative wire localization for lesions that are occult on mammography or sonography and are demonstrable only with MRI.

NOTE: For policy on breast MRI to screen for breast cancer in high risk women, see [Chapter 7, Sections 2.1 and 2.2](#).

C. Open MRI and Open MRI with contrast media are covered when medically necessary, appropriate, and the standard of care.

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CHAPTER 7 - MEDICINE

SECTION	SUBJECT
23.1	Augmentative Communication Devices (ACD)
24.1	Phase I, Phase II, And Phase III Cancer Clinical Trials
25.1	Dermoscopy
26.1	Forensic Examinations Following Sexual Assault or Domestic Violence
27.1	Botulinum Toxin Injections

The contractor need not establish additional edits to identify claims within the age, sex, race, or clinical history parameters included below:

1. Cancer Screening Examinations and Services.

a. Breast Cancer.

(1) **Clinical Breast Examination (CBE).** For women under age 40, **CBE may be performed during a covered periodic preventive health exam.** For women age 40 and older, **CBE should be performed annually.**

(2) **Screening Mammography.**

(a) **Screening mammography (CPT³ procedure codes 77052 and 77057) is covered annually for all women beginning at age 40.**

(b) **Screening mammography is covered annually beginning at age 30 for services rendered on or after September 7, 2010, and at age 35 for services rendered prior to September 7, 2010, for women who have a 15% or greater lifetime risk of breast cancer (according to risk assessment tools based on family history such as the Gail model, the Claus model, and the Tyrer-Cuzick model), or who have any of the following risk factors:**

1 History of breast cancer, Ductal Carcinoma In Situ (DCIS), Lobular Carcinoma In Situ (LCIS), Atypical Ductal Hyperplasia (ADH), or Atypical Lobular Hyperplasia (ALH);

2 Extremely dense breasts when viewed by mammogram;

3 Known BRCA1 or BRCA2 gene mutation;

4 First-degree relative (parent, child, sibling) with a BRCA1 or BRCA2 gene mutation, and have not had genetic testing themselves;

NOTE: Listing of the BRCA1 and BRCA2 gene mutations as additional risk factors here does not imply or constitute TRICARE coverage of BRCA1 or BRCA2 genetic testing as a clinical preventive service.

5 Radiation therapy to the chest between the ages of 10 and 30 years; or

6 History of Li-Fraumeni, Cowden, or hereditary diffuse gastric cancer syndrome, or a first-degree relative with a history of one of these syndromes.

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CHAPTER 7, SECTION 2.1

CLINICAL PREVENTIVE SERVICES - TRICARE STANDARD

NOTE: Screening mammography procedures should be billed using CPT³ procedure code 77057 except when performed in connection with other preventive services, in which case an appropriate comprehensive health promotion and disease prevention examination office visit code (CPT³ procedure codes 99381-99387 and 99391-99397) should be used.

(c) A 30 day administrative tolerance will be allowed for internal requirements between mammograms; e.g., if a woman meeting the above coverage criteria received a screening mammography on September 15, coverage for another screening mammography would be allowed on or after August 17, of the following year.

(d) The effective date for cancer screening mammography is November 5, 1990.

(3) Breast Magnetic Resonance Imaging (MRI).

(c) Breast screening MRI (CPT³ procedure codes 77058 and 77059) is covered annually, in addition to the annual screening mammogram, beginning at age 30 for services rendered on or after September 7, 2010, and at age 35 for services rendered prior to September 7, 2010, for women who have a 20% or greater lifetime risk of breast cancer (according to risk assessment tools based on family history such as the Gail model, the Claus model, and the Tyrer-Cuzick model), or who have any of the following risk factors:

1 Known BRCA1 or BRCA2 gene mutation;

2 First-degree relative (parent, child, sibling) with a BRCA1 or BRCA2 gene mutation, and have not had genetic testing themselves;

NOTE: Listing of the BRCA1 and BRCA2 gene mutations as additional risk factors here does not imply or constitute TRICARE coverage of BRCA1 or BRCA2 genetic testing as a clinical preventive service.

3 Radiation therapy to the chest between the ages of 10 and 30; or

4 History of LiFraumeni, Cowden, or hereditary diffuse gastric cancer syndrome, or first-degree relative with a history of one of these syndromes.

(b) The effective date for breast cancer screening MRI is March 1, 2007.

b. Cancer of Female Reproductive Organs.

(1) Pelvic examination. Pelvic examination should be performed in conjunction with Pap smear testing for cervical neoplasms and premalignant lesions.

(2) Pap smears. Cancer screening Pap tests should be performed for women who are at risk for sexually transmissible diseases, women who have or have had multiple sexual partners (or if their partner has or has had multiple sexual partners), women who smoke cigarettes, and women 18 years of age and older when provided under the terms and conditions contained in the guidelines adopted by the Executive Director, TRICARE

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CLINICAL PREVENTIVE SERVICES - TRICARE STANDARD

Management Activity (TMA). The frequency of the Pap tests will be at the discretion of the patient and clinician but not less frequent than every three years.

(c) Reimbursement for screening Pap smears shall not exceed the reimbursement for the intermediate office level visit except when performed in connection with other preventive services, in which case reimbursement will be allowed for the appropriate comprehensive health promotion and disease prevention examination office visit (CPT⁴ procedure codes 99381-99387 and 99391-99397).

(b) Claims for screening Pap smears which are coded at a level greater than the intermediate level office visit and for which no additional preventive services have been provided will be reimbursed at the allowable charge for either CPT⁴ procedure code 99203 or 99213 using the EOB message: "Charge reimbursed at the intermediate office visit level." Separate charges for the preparation, handling, and collection of the screening cervical Pap test are considered to be an integral part of the routine office examination visit and will not be allowed.

(c) Reimbursement for the cytopathology laboratory procedure associated with screening Pap tests should be billed using CPT⁴ procedure codes 88141-88155, 88164-88167, 88174, and 88175. Reimbursement of these procedures is limited to the total CHAMPUS Maximum Allowable Charge (CMAC) and will only be paid once regardless of whether the attending physician or the laboratory bills for the services.

(d) Reimbursement of Resource Sharing claims for the office visit associated with the screening Pap test should follow the same guidelines as civilian providers. Cytopathology laboratory charges billed by a Resource Sharing provider will not be reimbursed, unless the Resource Sharing Agreement states otherwise.

(e) Extra and Standard plans may cost-share services that are rendered during the same office visit of a screening Pap test as long as the services are considered medically necessary and are documented as such, and would not otherwise be considered integral to the office visit.

(f) A 30 day administrative tolerance will be allowed for interval requirements between screening Pap tests.

(g) The effective date for cancer screening for Pap smears is November 5, 1990.

(3) Human Papillomavirus (HPV) Deoxyribonucleic Acid (DNA) testing. HPV DNA testing is covered as a cervical cancer screening only when performed in conjunction with a Pap smear, and only for women aged 30 and older.

(c) To be eligible for reimbursement as a cervical cancer screening, HPV DNA testing (CPT⁴ procedure codes 87620-87622) must be billed in conjunction with a Pap smear (CPT⁴ procedure codes 88141-88155, 88164-88167, 88174, and 88175) that is provided to a woman aged 30 or older.

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(b) The effective date for coverage of HPV DNA testing as a cervical cancer screening is September 7, 2010.

c. Colorectal Cancer.

(1) The following cancer screenings and frequencies are covered for individuals at **average risk** for colon cancer:

(a) Fecal Occult Blood Testing (FOBT). Either guaiac-based or immunochemical-based testing of three consecutive stool samples once every 12 months for beneficiaries who have attained age 50 (at least 11 months have passed following the month in which the last covered screening fecal-occult blood test was done). The effective date for coverage of guaiac-based testing is October 6, 1997. The effective date for coverage of immunochemical-based testing is August 20, 2003.

(b) Proctosigmoidoscopy or Flexible Sigmoidoscopy. Once every three to five years beginning at age 50. The effective date for coverage of proctosigmoidoscopy or sigmoidoscopy for individuals at **average risk** is October 6, 1997.

(c) Optical (Conventional) Colonoscopy. Once every 10 years beginning at age 50. The effective date for coverage of optical colonoscopy for individuals at **average risk** is March 15, 2006.

(2) A family history of colorectal cancer or adenomatous polyps increases an individual's risk of colon cancer. The following identifies these risk factors and the cancer screenings and frequencies covered for individuals at **increased risk** for colon cancer:

(a) One or more first-degree relatives diagnosed with sporadic colorectal cancer or an adenomatous polyp before the age of 60 or in two or more first-degree relatives at any age. Optical colonoscopy should be performed every five years beginning at age 40 or 10 years earlier than the youngest affected relative, whichever is earlier.

(b) One or more first-degree relatives diagnosed with sporadic colorectal cancer or an adenomatous polyp at age 60 or older, or two second degree relatives diagnosed with colon cancer. Either flexible sigmoidoscopy (once every five years) or optical colonoscopy (once every 10 years) should be performed beginning at age 40.

(3) Certain other risk factors put an individual at **high risk** for colon cancer. The following identifies these risk factors and the cancer screenings and frequencies covered for individuals at **high risk** for colon cancer:

(a) Individuals with known or suspected Familial Adenomatous Polyposis (FAP). Annual flexible sigmoidoscopy beginning at age 10 to 12.

(b) Family history of Hereditary Non-Polyposis Colorectal Cancer (HNPCC) syndrome. Optical colonoscopy should be performed once every one to two years beginning at age 20 to 25, or 10 years younger than the earliest age of diagnosis of colorectal cancer, whichever is earlier.

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(c) Individuals diagnosed with Inflammatory Bowel Disease (IBD), Chronic Ulcerative Colitis (CUC), or Crohn's disease. For these individuals, cancer risk begins to be significant eight years after the onset of pancolitis or 10 to 12 years after the onset of left-sided colitis. For individuals meeting these risk parameters, optical colonoscopy should be performed every one to two years with biopsies for dysplasia.

(4) The effective date for coverage of flexible sigmoidoscopy or optical colonoscopy for individuals at **increased** or **high risk** for colon cancer is October 6, 1997.

(5) Computed Tomographic Colonography (CTC).

(a) CTC (Level III procedure code 0066T or 0067T) is covered as a colorectal cancer screening **ONLY** when an optical colonoscopy is medically contraindicated OR cannot be completed due to a known colonic lesion, structural abnormality, or other technical difficulty is encountered that prevents adequate visualization of the entire colon.

(b) The effective date for coverage of CTC as indicated above is March 15, 2006.

(c) CTC is **NOT** covered as a colorectal cancer screening for any other indication or reason.

d. Prostate Cancer.

(1) **Rectal** examination. Digital rectal examination will be offered annually for all men beginning at age 50 who have at least a 10 year life expectancy. It should also be offered to begin for men age 45 and over with a family history of prostate cancer in at least one other first-degree relative (father, brother, or son) diagnosed with prostate cancer at an early age (younger than age 65) and to all African American men aged 45 and over regardless of family history. Testing should be offered to start at age 40 for men with a family history of prostate cancer in two or more other family members.

(2) Prostate-Specific Antigen (PSA).

(a) Annual testing for the following categories of males:

1 All men aged 50 years and older.

2 Men aged 45 years and over with a family history of prostate cancer in at least one (1) other family member.

3 All African American men aged 45 and over regardless of family history.

4 Men aged 40 and over with a family history of prostate cancer in two or more other family members.

(b) Screening will continue to be offered as long as the individual has a 10 year life expectancy.

(3) The effective date for prostate cancer screening is October 6, 1997.

2. Infectious Diseases.

a. Hepatitis B screening. The effective date for screening pregnant women for HBsAG during the prenatal period was March 1, 1992.

b. Human Immunodeficiency Virus (HIV) testing.

(1) Effective July 7, 1995, TRICARE may share the cost of routine HIV screening tests for pregnant women, and

(2) Extra and Standard plans may share the cost of HIV testing when medically necessary; i.e., when performed on individuals with verified exposure to HIV or who exhibit symptoms of HIV infection (persistent generalized lymphadenopathy). Claims for HIV testing must include documentation by the attending physician verifying medical necessity. Claims that meet the criteria for coverage are to be reimbursed following the reimbursement methodology applicable to the provider's geographic location.

(3) HIV testing is covered when done in conjunction with routine pre-operative services by an independent laboratory or clinic. If the HIV testing is done while the patient is in an inpatient setting, the testing should be included in the Diagnostic Related Group (DRG).

c. Prophylaxis. The following preventive therapy may be provided to those who are at risk for developing active disease:

(1) Tetanus immune globulin (human) and tetanus toxoid administered following an injury.

(2) Services provided following an animal bite:

(a) Extra and Standard plans may share the cost of the administration of anti-rabies serum or human rabies immune globulin and rabies vaccine.

(b) Extra and Standard plans may also cost-share the laboratory examination of the brain of an animal suspected of having rabies if performed by a laboratory which is an authorized provider and if the laboratory customarily charges for such examinations. In order for the examination charges to be paid, the animal must have bitten a beneficiary, the charges for the examination must be submitted under the beneficiary's name, and the beneficiary must be responsible for the cost-share on the claim.

NOTE: Charges by any source for boarding, observing, or destroying animals, or for the collection of brain specimens are not covered.

(3) Rh immune globulin when administered to an Rh negative woman during pregnancy and following the birth of an Rh positive child or following a spontaneous or induced abortion.

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(4) For treatment provided to individuals with verified exposure to a potentially life-threatening medical condition (i.e., hepatitis A, hepatitis B, meningococcal meningitis, etc.), claims must include documentation by the attending physician verifying exposure.

(5) Isoniazid therapy for individuals at **high risk** for TB to include those:

(a) With a positive Mantoux test without active disease;

(b) Who have had close contact with an infectious case of TB in the past three months regardless of their skin test reaction; or

(c) Who are members of populations in which the prevalence of TB is greater than 10% regardless of their skin test reaction - including injection drug users, homeless individuals, migrant workers, and those born in Asia, Africa, or Latin America.

NOTE: In general, isoniazid prophylaxis should be continued for at least six months up to a maximum of 12 months.

(6) Immunizations.

(a) Coverage is extended for the age appropriate dose of vaccines that meet the following requirements:

1 The vaccine has been recommended and adopted by the Advisory Committee on Immunization Practices (ACIP) for use in the United States; and

2 The ACIP adopted recommendations have been 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).

3 Refer to the CDC's web site (<http://www.cdc.gov>) for a current schedule of CDC recommended vaccines for use in the United States.

4 The effective date of coverage for CDC recommended vaccines is October 6, 1997, OR the date ACIP recommendation for the vaccine were published in a MMWR, whichever date is LATER.

(b) 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.

3. Genetic Testing.

a. Genetic testing and counseling is covered during pregnancy under any of the following circumstances:

- (1) The pregnant woman is 35 years of age or older;
- (2) One of the parents of the fetus has had a previous child born with a congenital abnormality;
- (3) One of the parents of the fetus has a history (personal or family) of congenital abnormality; or
- (4) The pregnant woman contracted rubella during the first trimester of the pregnancy.
- (5) There is a history of three or more spontaneous abortions in the current marriage or in previous mating of either spouse; or
- (6) The fetus is at an **increased risk** for a hereditary error of metabolism detectable in vitro; or
- (7) The fetus is at an increased risk for neural tube defect (family history or elevated maternal serum alpha-fetoprotein level); or
- (8) There is a history of sex-linked conditions (i.e., Duchenne muscular dystrophy, hemophilia, x-linked mental retardation, etc.).

NOTE: Extra and Standard plans may not cost-share routine or demand genetic testing or genetic tests performed to establish the paternity or sex of an unborn child.

4. School Physicals.

a. Physical examinations are covered for beneficiaries ages five through 11 that are required in connection with school enrollment. The effective date for coverage of school enrollment physicals is October 30, 2000.

b. Cost-sharing and deductibles are to be applied as prescribed under the beneficiary's respective coverage plan (i.e., in accordance with the cost-sharing and deductible guidelines and either TRICARE Standard or Extra coverage plans).

c. Standard office visit evaluation and management CPT codes (i.e., CPT⁵ procedure code ranges 99201-99205 and 99211-99214) may be used in billing for school physicals; however, payment may not exceed what would have otherwise been reimbursed under the comprehensive Preventive Medicine Service codes for beneficiaries ages five through 11 (CPT⁵ procedure codes 99383 and 99393).

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5. Other.

a. Physical examinations and immunizations provided to the spouse and children of active duty service members in conjunction with official travel outside the United States. Claims must include a copy of the travel orders or other official documentation verifying the official travel requirement.

b. Routine chest x-rays and electrocardiograms required for admission when a patient is scheduled to receive general anesthesia on an inpatient or outpatient basis.

NOTE: Extra and Standard plans may not cost-share routine chest x-rays or electrocardiograms for admissions not involving services that require general anesthesia.

B. Health Promotion and Disease Prevention Services Covered in Connection with Immunizations, Pap Smears, Mammograms, or Examinations for Colon and Prostate Cancer.

The following health prevention services are only covered in connection with immunizations, Pap smears, mammograms, or screening examinations for colon and prostate cancer; i.e., preventive services provided during the same comprehensive preventative office visit as the associated immunization, Pap smear, mammogram, or colon and prostate examination or preventive services provided as a result of a referral made during that same office visit. The contractor shall apply all appropriate claims processing and rebundling edits before determining if the following preventive services are individually reimbursable. The contractor need not establish additional edits to identify claims within the age, sex, race, or clinical history parameters included below, or research claims history to ensure that an association exists between the following preventive services and an immunization, Pap smear, mammogram, or colon and prostate cancer examination:

1. Cancer Screening Examinations.

a. Testicular Cancer. Examination of the testis annually for males between the ages of 13 through 39 with history of cryptorchidism, orchiopexy, or testicular atrophy.

b. Skin Cancer. Examination of the skin should be performed for individuals with family or personal history of skin cancer, increased occupational or recreational exposure to sunlight, or clinical evidence of precursor lesions.

c. Oral Cavity and Pharyngeal Cancer. A complete oral cavity examination should be part of routine preventive care for adults at **high risk** due to exposure to tobacco or excessive amounts of alcohol. Oral examination should also be part of a recommended annual dental check-up.

d. Thyroid Cancer. Palpation for thyroid nodules should be performed in adults with a history of upper body irradiation.

2. Infectious Diseases.

a. TB Screening. Screen annually, regardless of age, for all individuals at **high risk** for TB (as defined by CDC) using Mantoux tests.

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b. Rubella Antibodies. Test females once, between the ages of 12 through 18, unless history of adequate rubella vaccination with at least one dose of rubella vaccine on or after the first birthday is documented.

3. Cardiovascular Disease.

a. Cholesterol. A lipid panel at least once every five years, beginning at age 18.

b. Blood Pressure Screening. Blood pressure screening at least every two years after age six.

4. Body Measurements. Height and weight should be measured periodically. The optimal frequency is a matter of clinical discretion. Those individuals who are 20% or more above desirable weight should receive appropriate nutritional and exercise counseling.

5. Vision Screening. Vision screening continues to be excluded from coverage under the Extra and Standard plans except for the one routine eye examination per calendar year per person for family members of active duty members and vision screening allowed under the well-child benefit.

6. Audiology Screening. Preventive hearing examinations are only allowed under the well-child care benefit.

7. Counseling Services.

a. Patient and parent education counseling for:

- (1) Dietary assessment and nutrition;
- (2) Physical activity and exercise;
- (3) Cancer surveillance;
- (4) Safe sexual practices;
- (5) Tobacco, alcohol and substance abuse;
- (6) Promoting dental health;
- (7) Accident and injury prevention; and
- (8) Stress, bereavement and suicide risk assessment.

b. These are expected components of good clinical practice that are integrated into the appropriate office visit at no additional charge.

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V. EFFECTIVE DATE

Unless otherwise stated, the effective date of health promotion and disease prevention services covered in connection with immunizations, Pap smears, mammograms, or examinations for colon and prostate cancer is October 6, 1997.

- END -

CLINICAL PREVENTIVE SERVICES - TRICARE PRIME

ISSUE DATE: May 15, 1996
 AUTHORITY: [32 CFR 199.17](#)

I. POLICY

A. TRICARE Prime enrollees may receive Prime Clinical Preventive Services from any network provider without referral, authorization, or preauthorization from the Primary Care Manager (PCM), or any other authority. If a Prime Clinical Preventive Service is not available from a network provider (e.g., a network provider is not available within prescribed access parameters), an enrollee may receive the service from a non-network provider with a referral from the PCM and authorization from the contractor. If an enrollee uses a non-network provider without first obtaining a referral from the PCM and authorization from the Health Care Finder (HCF) payment is made under the Point of Service (POS) option only for services that are otherwise covered under TRICARE Standard. Payment will not be made under the POS option for clinical preventive services that are not otherwise covered under TRICARE Standard.

B. There shall be no co-payments associated with the individually TRICARE reimbursable services listed below. The contractor shall apply all appropriate claims processing and rebundling edits before determining if the below listed CPT procedure code is individually reimbursable. The contractor need not establish additional edits to identify claims within the age, sex, race or clinical history perimeters included below. However, a 30 day administrative tolerance will be allowed for any time interval requirements imposed on screening **mammography** and Pap smears; e.g., if an asymptomatic woman 50 years of age or older received a screening mammography on September 15, coverage for another screening mammography would be allowed on or after August 17 of the following year.

SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT PROCEDURE CODE
COMPREHENSIVE HEALTH PROMOTION AND DISEASE PREVENTION EXAMINATIONS	For ages 24 months or older: One comprehensive disease prevention clinical evaluation and follow up during age intervals: 2-4; 5-11; 12-17; 18-39; 40-64.	CPT ¹ codes 99382-99386 and 99392-99396.

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SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT PROCEDURE CODE
TARGETED HEALTH PROMOTION AND DISEASE PREVENTION EXAMINATIONS	The following screening examinations may be performed during either the above periodic comprehensive health promotion examination or as part of other patient encounters. The intent is to maximize preventive care.	
School Physicals:	Physical Examinations: For beneficiaries ages five through 11 that are required in connection with school enrollment. The effective date for coverage of school enrollment physicals is October 30, 2000.	CPT ¹ codes 99201-99205*, 99211-99214*, 99383, and 99393.
	* Standard office visit evaluation and management CPT ¹ procedure codes (i.e., code ranges 99201-99205 and 99211-99214) may be used in billing for school physicals; however, payment may not exceed what would have otherwise been reimbursed under the comprehensive preventive medicine service codes for beneficiaries ages five through 11 (CPT ¹ procedure codes 99383 and 99393).	
Breast Cancer:	Clinical Breast Examination (CBE): For women under age 40, CBE may be performed during a covered periodic preventive health exam. For women age 40 and older, CBE should be performed annually.	See appropriate level evaluation and management codes.
	Screening Mammography: Covered annually for all women beginning at age 40. Covered annually beginning at age 30 for women who have a 15% or greater lifetime risk of breast cancer (according to risk assessment tools based on family history such as the Gail model, the Claus model, and the Tyrer-Cuzick model), or who have any of the following risk factors: 1. History of breast cancer, Ductal Carcinoma In Situ (DCIS), Lobular Carcinoma In Situ (LCIS), Atypical Ductal Hyperplasia (ADH), or Atypical Lobular Hyperplasia (ALH); 2. Extremely dense breasts when viewed by mammogram; 3. *Known BRCA1 or BRCA2 gene mutation; 4. *First-degree relative (parent, child, sibling) with a BRCA1 or BRCA2 gene mutation, and have not had genetic testing themselves; 5. Radiation therapy to the chest between the ages of 10 and 30 years; or	CPT ¹ codes 77052 and 77057 HCPCS codes G0202, G0204, and G0206.
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SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT PROCEDURE CODE
Breast Cancer (Continued):	<p>Screening Mammography (Continued): 6. History of Li-Fraumeni, Cowden, or hereditary diffuse gastric cancer syndrome, or a first-degree relative with a history of one of these syndromes.</p>	
	<p>* Listing of the BRCA1 and BRCA2 gene mutations as additional risk factors here does not imply or constitute TRICARE coverage of BRCA1 or BRCA2 genetic testing as a clinical preventive service.</p>	
	<p>Breast Screening Magnetic Resonance Imaging (MRI): Covered annually, in addition to the annual screening mammogram, beginning at age 30 for women who have a 20% or greater lifetime risk of breast cancer (according to risk assessment tools based on family history such as the Gail model, the Claus model, and the Tyrer-Cuzick model), or who have any of the following risk factors:</p> <ol style="list-style-type: none"> 1. *Known BRCA1 or BRCA2 gene mutation; 2. * First-degree relative (parent, child, sibling) with a BRCA1 or BRCA2 gene mutation, and have not had genetic testing themselves; 3. Radiation to the chest between the ages of 10 and 30; or 4. History of LiFraumeni, Cowden, or hereditary diffuse gastric cancer syndrome, or a first-degree relative with a history of one of these syndromes. <p>The effective date for breast cancer screening MRI is March 1, 2007.</p>	CPT ¹ codes 77058 and 77059.
	<p>* Listing of the BRCA1 and BRCA2 gene mutations as additional risk factors here does not imply or constitute TRICARE coverage of BRCA1 or BRCA2 genetic testing as a clinical preventive service.</p>	
Cancer of Female Reproductive Organs:	<p>Pelvic Examination: Pelvic examination should be performed in conjunction with Pap smear testing for cervical neoplasms and premalignant lesions.</p>	See appropriate level evaluation and management codes.
	<p>Papanicolaou (PAP) Smears: Annually starting at age 18 (or younger, if sexually active) until three consecutive satisfactory normal annual examinations. Frequency may then be less often at the discretion of the patient and clinician but not less frequently than every three years.</p>	CPT ¹ codes 88141-88155, 88164-88167, 88174, 88175, 99201-99215, or 99301-99313.

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SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT PROCEDURE CODE
Cancer of Female Reproductive Organs (Continued):	<p>Human Papillomavirus (HPV) Deoxyribonucleic Acid (DNA) Testing: HPV DNA testing is covered as a cervical cancer screening only when performed in conjunction with a Pap smear, and only for women aged 30 and older.</p> <p>To be eligible for reimbursement as a cervical cancer screening, HPV DNA testing must be billed in conjunction with a Pap smear that is provided to a woman aged 30 or older.</p> <p>The effective date for coverage of HPV DNA testing as a cervical cancer screening is September 7, 2010.</p>	CPT ¹ codes 87620-87622.
Testicular Cancer:	Testicular Examination: Clinical testicular exam annually for males age 13-39 with a history of cryptorchidism, orchiopexy, or testicular atrophy.	See appropriate level evaluation and management codes.
Prostate Cancer:	Rectal Examination: Digital rectal examination should be offered annually for all men aged 50 years and over; men aged 45 and over with a family history of prostate cancer in at least one other family member; all African American men aged 45 and over regardless of family history; and men aged 40 and over with a family history of prostate cancer in two or more other family members.	See appropriate level evaluation and management codes.
Prostate Cancer (Continued):	Prostate-Specific Antigen (PSA): Annually for the following categories of males: all men aged 50 years and older; men aged 45 years and over with a family history of prostate cancer in at least one other family member; all African American men aged 45 and over regardless of family history; and men aged 40 and over with a family history of prostate cancer in two or more other family members.	CPT ¹ code 84153.
Colorectal Cancer:	<p>Fecal Occult Blood Testing for Individuals at Average Risk for Colon Cancer: Either guaiac-based or immunochemical-based testing of three consecutive stool samples once every 12 months for beneficiaries who have attained age 50 (at least 11 months must have passed following the month in which the last covered screening fecal-occult blood test was done).</p> <p>The effective date for coverage of guaiac-based testing is October 6, 1997. The effective date for coverage of immunochemical-based testing is August 20, 2003.</p>	CPT ¹ codes 82270 and 82274.

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SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT PROCEDURE CODE
Colorectal Cancer (Continued):	Proctosigmoidoscopy or Flexible Sigmoidoscopy for Individuals at <u>Average Risk</u> for Colon Cancer: Once every three to five years beginning at age 50.	CPT ¹ codes 45300-45321, 45327, and 45330-45339. HCPCS code G0104.
	Proctosigmoidoscopy or Flexible Sigmoidoscopy for Individuals at <u>Increased</u> or <u>High Risk</u> for Colon Cancer: Increased Risk (Individuals with a family history): Once every five years, beginning at age 40, for individuals with a first-degree relative diagnosed with a colorectal cancer or an adenomatous polyp at age 60 or older, or two second-degree relatives diagnosed with colorectal cancer. High Risk: Annual flexible sigmoidoscopy, beginning at age 10 through 12, for individuals with known or suspected Familial Adenomatous Polyposis (FAP). The effective date for coverage of proctosigmoidoscopy or flexible sigmoidoscopy, regardless of risk, is October 6, 1997.	
	Optical (Conventional) Colonoscopy for Individuals at <u>Average</u>, <u>Increased</u>, or <u>High Risk</u> for Colon Cancer: Average Risk: Once every 10 years for individuals age 50 or above. The effective date for coverage of optical colonoscopy for individuals at average risk is March 15, 2006. Increased Risk (Individuals with a family history): 1. Once every five years for individuals with a first-degree relative diagnosed with a colorectal cancer or an adenomatous polyp at age 60 or older, or in two or more first-degree relatives at any age. Optical colonoscopy should be performed beginning at age 40 or 10 years younger than the earliest affected relative, whichever is earlier. 2. Once every 10 years, beginning at age 40, for individuals with a first-degree relative diagnosed with colorectal cancer or an adenomatous polyp at age 60 or older, or colorectal cancer diagnosed in two second degree relatives.	

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SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT PROCEDURE CODE
Colorectal Cancer (Continued):	<p>Optical (Conventional) Colonoscopy for Individuals at Average, Increased, or High Risk for Colon Cancer (Continued):</p> <p>High Risk:</p> <p>1. Once every one to two years for individuals with a genetic or clinical diagnosis of Hereditary Non-Polyposis Colorectal Cancer (HNPCC) or individuals at increased risk for HNPCC. Optical colonoscopy should be performed beginning at age 20 to 25 or 10 years younger than the earliest age of diagnosis, whichever is earlier.</p> <p>2. For individuals diagnosed with Inflammatory Bowel Disease (IBD), Chronic Ulcerative Colitis (CUC), or Crohn's disease, cancer risk begins to be significant eight years after the onset of pancolitis or 10 to 12 years after the onset of left-sided colitis. For individuals meeting these risk parameters, optical colonoscopy should be performed every one to two years with biopsies for dysplasia.</p> <p>The effective date for coverage of optical colonoscopy for individuals at increased or high risk, is October 6, 1997.</p>	<p>CPT¹ codes 45355 and 45378-45385. HCPCS codes G0105 and G0121.</p>
	<p>Computed Tomographic Colonography (CTC) for Individuals in whom an Optical Colonoscopy is Medically Contraindicated or Incomplete: CTC is covered as a colorectal cancer screening ONLY when an optical colonoscopy is medically contraindicated OR cannot be completed due to a known colonic lesion, structural abnormality, or other technical difficulty is encountered that prevents adequate visualization of the entire colon. CTC is NOT covered as a colorectal cancer screening for any other indication or reason.</p> <p>The effective date for coverage of CTC for this indication is March 15, 2006.</p>	<p>CPT¹ Level III codes 0066T or 0067T.</p>
Skin Cancer:	<p>Skin Examination: Examination of the skin should be performed for individuals with a family or personal history of skin cancer, increased occupational or recreational exposure to sunlight, or clinical evidence of precursor lesions.</p>	<p>See appropriate level evaluation and management codes.</p>

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SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT PROCEDURE CODE
Oral Cavity and Pharyngeal Cancer:	Physical Examination: A complete oral cavity examination should be part of routine preventive care for adults at high risk due to exposure to tobacco or excessive amounts of alcohol. Oral examination should also be part of a recommended annual dental check-up.	See appropriate level evaluation and management codes.
Thyroid Cancer:	Physical Examination: Palpation for thyroid nodules should be performed in adults with a history of upper body irradiation.	See appropriate level evaluation and management codes.
Infectious Diseases:	Tuberculosis (TB) Screening: Screen annually, regardless of age, all individuals at high risk for tuberculosis (as defined by CDC) using Mantoux tests.	CPT ¹ codes 86580 and 86585.
	Rubella Antibodies: Test females once between the ages of 12 and 18, unless history of adequate rubella vaccination with at least one dose of rubella vaccine on or after the first birthday is documented.	CPT ¹ code 86762.
	Hepatitis B Screening: Screen pregnant women for HBsAG during prenatal period.	CPT ¹ code 87340.
Cardiovascular Diseases:	Cholesterol: A lipid panel at least once every five years, beginning at age 18.	CPT ¹ code 80061.
	Blood Pressure Screening: For children: annually between three and six years of age, and every two years thereafter. For adults: a minimum frequency of every two years.	See appropriate level evaluation and management codes.
	Abdominal Aortic Aneurysm (AAA): One time AAA screening by ultrasonography for men, age 65-75, who have ever smoked.	CPT ¹ code 76999.
Other:	Body Measurement: For children: Height and weight should be measured regularly throughout infancy and childhood. Head circumference should be measured through age 24 months. For adults: Height and weight should be measured periodically. The optimal frequency is a matter of clinical discretion. Those individuals who are 20% or more above desirable weight should receive appropriate nutritional and exercise counseling.	See appropriate level evaluation and management codes.

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CLINICAL PREVENTIVE SERVICES - TRICARE PRIME

SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT PROCEDURE CODE
Other (Continued):	Vision Care: Pediatric vision screening at birth and approximately six months of age to include determination of vision on visual acuity, ocular alignment and red reflex, along with external examination of ocular abnormalities. Routine eye examination once every two years for all TRICARE Prime enrollees age three and older. Diabetic patients, at any age, should have routine eye examinations at least yearly.	CPT ¹ codes 92002, 92004, 92012, 92014, 92015, 99172, and 99173.
	NOTE: Routine eye examinations are meant to be more than the standard visual acuity screening test conducted by the member's primary care physician through the use of a standard Snellen wall chart. Self-referral will be allowed for routine eye examinations since PCMs are incapable of providing this service (i.e., a Prime beneficiary will be allowed to set up his or her own appointment for a routine eye examination with any network optometrist or ophthalmologist).	
	Hearing Screening: 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. A hearing evaluation should be a part of routine examinations for all children, and those with possible hearing impairment should be referred for appropriate testing.	CPT ¹ codes 92551, 92587, and 92588.
	Pediatric Blood Lead: Assessment of risk for lead exposure by structured questionnaire based on Centers for Disease Control and Prevention (CDC) Preventing Lead Poisoning in Young Children (October 1991) during each well child visit from age six months through six years. Screening by blood lead level determination for all children at high risk for lead exposure per CDC guidelines.	CPT ¹ code 83655.
	Patient & Parent Education Counseling: Dietary Assessment & Nutrition; Physical Activity & Exercise; Cancer Surveillance; Safe Sexual Practices; Tobacco, Alcohol and Substance Abuse; Accident & Injury Prevention; Promoting Dental Health; Stress, Bereavement, & Suicide Risk Assessment.	These are expected components of good clinical practice that are integrated into the appropriate office visit at no additional charge.

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SPEECH SERVICES

ISSUE DATE: April 19, 1983

AUTHORITY: [32 CFR 199.6\(c\)](#), and Public Law 107-107

I. CPT¹ PROCEDURE CODES

92506 - 92508, 92630 - 92633

II. DESCRIPTION

Speech-language pathology services that provide evaluation, treatment, habilitation, and rehabilitation of communication disorders resulting from congenital anomalies, disease, injury, hearing loss, pervasive developmental disorders or a therapeutic process, or other condition, such as pragmatic language impairment, that prevents or diminishes an individual's ability to communicate.

III. POLICY

A. Speech-language pathology services prescribed and supervised by a physician, **certified Physician Assistant (PA) working under the supervision of a physician, or certified Nurse Practitioner (NP)** may be cost-shared.

B. Speech-language pathology services to improve, restore, or maintain function, or to minimize or prevent deterioration of function of a patient when prescribed by a physician, **certified PA working under the supervision of a physician, or certified NP** is covered in accordance with the rehabilitative therapy provisions found in [Chapter 7, Section 18.1](#).

IV. EXCLUSIONS

A. Services provided to address speech, language, or communication disorders resulting from occupational or educational deficits.

B. For beneficiaries under the age of three, services and items provided in accordance with the beneficiary's Individualized Family Service Plan as required by Part C of the Individuals with Disabilities Education Act, and which are otherwise allowable under the TRICARE Basic Program or the Extended Care Health Option (ECHO) but determined not to be medically or psychologically necessary, are excluded.

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SPEECH SERVICES

C. For beneficiaries ages **three** to 21 who are receiving special education services from a public educational agency, cost-sharing of outpatient speech services that are required by the **IDEA** and which are indicated in the beneficiary's Individualized Education Program (IEP), may not be cost-shared except when the intensity or timeliness of speech services as proposed by the educational agency are not appropriate medical care.

D. Myofunctional or tongue thrust therapy.

E. Maintenance therapy that does not require a skilled level after a therapy program has been designed (see [Chapter 7, Section 18.1](#)).

F. Videofluoroscopy evaluation in speech pathology.

G. Speech therapists (speech pathologists) are not authorized to bill using Evaluation and Management (E&M) codes listed in the Physicians' Current Procedural Terminology (CPT).

- END -

PHYSICAL MEDICINE/THERAPY

ISSUE DATE: April 19, 1983

AUTHORITY: 32 CFR 199.4(b)(2)(xi), (b)(3)(vii), and (c)(3)(x)

I. CPT¹ PROCEDURE CODES

93668, 96000 - 96004, 97001 - 97002, 97012 - 97530, 97532, 97533, 97542 - 97750, and 97799

II. DESCRIPTION

A. The treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles, and devices to relieve pain, restore maximum function, and prevent disability following disease, injury or loss of a body part.

B. Physical therapy services consist of the physical evaluation of a patient by muscle testing and other means and the prescribed therapeutic treatment and services of a definite functional nature.

C. Physical therapy to improve, restore, or maintain function, or to minimize or prevent deterioration of function of a patient when prescribed by a physician is covered in accordance with the rehabilitative therapy provisions found in [Chapter 7, Section 18.1](#).

III. POLICY

A. Benefits are payable for inpatient or outpatient physical therapy services that are determined to be medically necessary for the treatment of a covered condition, and that are directly and specifically related to an active written regimen.

B. Physical therapy services must be prescribed by a physician, **certified Physician Assistant (PA) working under the supervision of a physician, or certified Nurse Practitioner (NP)** and professionally administered to aid in the recovery from disease or injury to help the patient in attaining greater self-sufficiency, mobility, and productivity through exercises and other modalities intended to improve muscle strength, joint motion, coordination, and endurance.

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C. If physical therapy is performed by other than a physician, a physician (or other authorized individual professional provider acting within the scope of his/her license) should refer the patient for treatment and supervise the physical therapy.

D. Reimbursement for covered physical therapy services is based on the appropriate CPT² procedure codes for the services billed on the claim.

E. Physical therapists are not authorized to bill using Evaluation and Management (E&M) codes listed in the Physician's Current Procedural Terminology (CPT).

IV. EXCLUSIONS

A. The following services are not covered:

1. Diathermy, ultrasound, and heat treatments for pulmonary conditions.
2. General exercise programs, even if recommended by a physician (or other authorized individual professional provider acting within the scope of their license).
3. Electrical nerve stimulation used in the treatment of upper motor neuron disorders such as multiple sclerosis.
4. Separate charges for instruction of the patient and family in therapy procedures.
5. Repetitive exercise to improve gait, maintain strength and endurance, and assistive walking such as that provided in support of feeble or unstable patients.
6. Range of motion and passive exercises which are not related to restoration of a specific loss of function, but are useful in maintaining range of motion in paralyzed extremities.
7. Maintenance therapy that does not require a skilled level after a therapy program has been designed (see [Chapter 7, Section 18.1](#)).
8. Services of chiropractors and naturopaths whether or not such services would be eligible for benefits if rendered by an authorized provider.
9. Acupuncture with or without electrical stimulation.
10. Athletic training evaluation (CPT² procedure codes 97005 and 97006).
11. CPT² procedure code 97532 or 97533 is not a covered benefit when used as a restorative approach. That is, cognitive function improves as a result of neuronal growth, which is enhanced through the repetitive exercise of neuronal circuits and that recovery of functions is determined by biological events.

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12. CPT³ procedure codes 97532 and 97533 for sensory integration training.

NOTE: This policy does not exclude multidisciplinary services, such as physical therapy, occupational therapy, or speech therapy after traumatic brain injury, stroke and children with an autistic disorder.

13. Nonsurgical spinal decompression therapy (including Internal or Intervertebral Disc Decompression (IDD), Decompression Reduction Stabilization (DRS), or Vertebral Axial Decompression (VAX-D) therapy) provided by mechanical or motorized traction for the treatment of low back and/or neck pain is unproven. The use of powered traction devices (including, but not limited to, the Accu-SPINA™, VAX-D, and DRX9000) are likewise unproven.

14. For beneficiaries under the age of three, services and items provided in accordance with the beneficiary's Individualized Family Service Plan (IFSP) as required by Part C of the Individuals with Disabilities Education Act (IDEA), and which are otherwise allowable under the TRICARE Basic Program or the Extended Care Health Option (ECHO) but determined not to be medically or psychologically necessary, are excluded.

15. For beneficiaries aged three to 21, who are receiving special education services from a public education agency, cost-sharing of outpatient physical therapy services that are required by the IDEA and which are indicated in the beneficiary's Individualized Education Program (IEP), may not be cost-shared except when the intensity or timeliness of physical therapy services as proposed by the educational agency are not sufficient to meet the medical needs of the beneficiary.

16. Low Level Laser Therapy (LLLT) (also known as low level light therapy or cold laser therapy) for treatment of soft tissue injuries, pain, or inflammation is unproven.

17. Spinalator therapy and use of a Spinalator Table for the treatment of neck and low back pain. Spinalator therapy is defined as a type of traction that uses the patient's weight to create the traction force in the absence of any external pulling force. The Spinalator Table is defined as a table with rollers that applies consistent pressure and movement under the patient in the absence of any external pulling devices.

- END -

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OCCUPATIONAL THERAPY

ISSUE DATE: July 3, 1997

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

I. CPT¹ PROCEDURE CODES

97003 - 97004, 97150, 97532, 97533, 97535, 97799

II. DESCRIPTION

Occupational therapy is the prescribed use of specific purposeful activity or interventions designed to promote health, prevent injury or disability, and which develop, improve, sustain, or restore functions which have been lost or reduced as a result of injury, illness, cognitive impairment, psychosocial dysfunction, mental illness, or developmental, learning or physical disability(ies), to the highest possible level for independent functioning.

III. POLICY

A. Occupational therapy prescribed and supervised by a physician, **certified Physician Assistant (PA) working under the supervision of a physician, or certified Nurse Practitioner (NP)** is covered.

B. Occupational therapy to improve, restore, or maintain function, or to minimize or prevent deterioration of function of a patient when prescribed by a physician is covered in accordance with the rehabilitative therapy provisions found in [Chapter 7, Section 18.1](#).

IV. EXCLUSIONS

A. The following occupational therapy services are not covered:

1. Vocational assessment and training.
2. General exercise programs.
3. Separate charges for instruction of the patient and family in therapy procedures.
4. Repetitive exercise to improve gait, maintain strength and endurance, and assisted walking such as that provided in support of feeble or unstable patients.

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OCCUPATIONAL THERAPY

B. Maintenance therapy that does not require a skilled level after a therapy program has been designed (see [Chapter 7, Section 18.1](#)).

1. Range of motion and passive exercises which are not related to restoration of a specific loss of function.

2. CPT² procedure code 97532 or 97533 is not a covered benefit when used as a restorative approach. That is, cognitive function improves as a result of neuronal growth, which is enhanced through the repetitive exercise of neuronal circuits and that recovery of functions is determined by biological events.

3. CPT² procedure codes 97532 and 97533 for sensory integration training is excluded.

NOTE: This policy does not exclude multidisciplinary services, such as physical therapy, occupational therapy, or speech therapy after traumatic brain injury, stroke and children with an autistic disorder.

C. Occupational therapists are not authorized to bill using Evaluation and Management (E&M) codes listed in the Physicians' Current Procedural Terminology (CPT).

D. For beneficiaries under the age of three, services and items provided in accordance with the beneficiary's Individualized Family Service Plan (IFSP) as required by Part C of the Individuals with Disabilities Education Act (IDEA), and which are otherwise allowable under the TRICARE Basic Program or the Extended Care Health Option (ECHO) but determined not to be medically or psychologically necessary, are excluded.

E. For beneficiaries aged three to 21, who are receiving special education services from a public education agency, cost-sharing of outpatient occupational therapy services that are required by the IDEA and which are indicated in the beneficiary's Individualized Education Program (IEP), may not be cost-shared except when the intensity or timeliness of occupational therapy services as proposed by the educational agency are not sufficient to meet the medical needs of the beneficiary.

V. EFFECTIVE DATE October 28, 1997.

- END -

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BOTULINUM TOXIN INJECTIONS

ISSUE DATE: October 12, 1998

AUTHORITY: 32 CFR 199.4(c)(2)(iii) and (c)(2)(iv)

I. CPT¹ PROCEDURE CODES

46505, 64612 - 64614, 64640, 64653, 67345

II. HCPCS PROCEDURE CODES

J0585, J0587

III. DESCRIPTION

These procedures involve the injection of small amounts of botulinum toxin into selected muscles for the nonsurgical treatment of the conditions relating to spasticity, various dystonias, nerve disorders, and muscular tonicity deviations.

IV. POLICY

A. Botulinum toxin A (**AbobotulinumtoxinA/OnabotulinumtoxinA**) and **Botulinum toxin B (RimabotulinumtoxinB)** injections may be considered for cost-sharing for treating conditions such as cervical dystonia (repetitive contraction of the neck muscles) in decreasing the severity of abnormal head position and neck pain for patients 16 years and older.

B. Botulinum toxin A (**OnabotulinumtoxinA**) injections may be considered for cost-sharing for treating conditions such as blepharospasm (spasm of the eyelids/uncontrolled blinking) and strabismus (squinting/eyes do not point in the same direction) associated with dystonia, including benign essential blepharospasm or VII nerve disorders for patients 12 years of age and older.

C. Botulinum toxin A (**OnabotulinumtoxinA**) injections may be considered for cost-sharing for treating conditions such as severe primary axillary hyperhidrosis (severe underarm sweating) that is inadequately managed by topical agents for patients 18 years of age and older.

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D. Botox® (OnabotulinumtoxinA-chemodenervation-CPT¹ procedure code 46505) may be considered for off-label cost-sharing for the treatment of chronic anal fissure unresponsive to conservative therapeutic measures, effective May 1, 2007.

E. Botulinum toxin A (AbobotulinumtoxinA/OnabotulinumtoxinA) injections may be considered for off-label cost-sharing for the treatment of spasticity resulting from Cerebral Palsy (CP), effective November 1, 2008.

F. Botox® (OnabotulinumtoxinA) and Myobloc® (RimabotulinumtoxinB) injections may be considered for off-label cost-sharing for the treatment of sialorrhea associated with Parkinson disease patients who are refractory to, or unable to tolerate, systemic anticholinergics, effective October 1, 2009.

G. Botulinum toxin A (OnabotulinumtoxinA) injections for prophylaxis of headaches in adult patients with chronic migraine, which is defined as 15 days or more per month with headache lasting four hours a day or longer.

H. Botulinum toxin A (OnabotulinumtoxinA) injections to treat spasticity in flexor muscles of the elbow, wrist, and fingers (upper limb spasticity) in adults.

V. EXCLUSIONS

A. Botulinum toxin A injections are unproven for the following indications:

1. Palmar hyperhidrosis.
2. Urinary urge incontinence.
3. Lower back pain/lumbago.
4. Episodic migraine, chronic daily headache, cluster headache, cervicogenic headache, and tension-type headache.

B. Botox® (OnabotulinumtoxinA-chemodenervation-CPT² procedure code 64612) for the treatment of muscle spasms secondary to cervical degenerative disc disease and spinal column stenosis is unproven.

C. Botox® (OnabotulinumtoxinA) used for cosmetic indications (e.g., frown lines and brow furrows) is excluded from coverage.

VI. EFFECTIVE DATES

A. May 1, 2007, for coverage of chronic anal fissure unresponsive to conservative therapeutic measures (CPT² procedure code 46505).

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B. October 1, 2009, for coverage of sialorrhea associated with Parkinson disease patients who are refractory to, or unable to tolerate systemic anticholinergics (CPT² procedure code 64653).

C. October 15, 2010, coverage for prophylaxis of headaches in adult patients with chronic migraine, which is defined as 15 days or more per month with headache lasting four hours a day or longer.

D. March 9, 2010, coverage for spasticity in flexor muscles of the elbow, wrist, and fingers (upper limb spasticity) in adults.

- END -

ECHO RESPITE CARE

ISSUE DATE: February 14, 2005

AUTHORITY: 32 CFR 199.5(c)(7) and (d)(19)

I. CPT¹ PROCEDURE CODES

99600

II. HCPCS PROCEDURE CODES

S9122 - S9124

III. DESCRIPTION

Respite care is short-term care for a patient in order to provide rest and change for those who have been caring for the patient at home, usually the patient's family.

IV. POLICY

A. ECHO registered beneficiaries are eligible to receive a maximum of 16 hours of respite care in any calendar month in which they also receive any other ECHO-authorized benefit other than the ECHO Home Health Care (EHHC) benefit.

B. Respite care consists of providing skilled and non-skilled services to a beneficiary such that in the absence of the primary caregiver, management of the beneficiary's ECHO-qualifying condition and safety are provided.

C. Respite care services are provided exclusively to the ECHO beneficiary.

D. In order to assure the quality of care for ECHO beneficiaries, all ECHO respite care services will be provided only by Medicare or Medicaid certified home health agencies (HHAs) who have in effect at the time of services a valid agreement to participate in the TRICARE program. Consequently, the EHHC benefit is available only in locations where there are Medicare or Medicaid certified HHAs.

NOTE: HHAs for which Medicare or Medicaid certification is not available due to the specialized categories of individuals they serve, for example, individuals that are under the

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ECHO RESPITE CARE

age of 18 or who are receiving maternity care, must meet the qualifying conditions for corporate services provider status as specified in [Chapter 11, Section 12.1](#).

E. Currently the ECHO respite benefit is limited to the 50 United States, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and Guam.

F. HHAs are not required to use the comprehensive Outcome and Assessment Information Set (OASIS) when determining the services to be provided to a beneficiary under this policy.

G. For the purpose of ECHO respite care, beneficiaries are not required to have a written plan of care. However, at the time respite care is requested, the ECHO beneficiary's sponsor or designee is responsible for providing the Managed Care Support Contractor (MCSC) and the HHA with all information necessary to assure that respite care services are provided in accordance with [paragraph IV.B](#).

H. HHAs will use procedure codes indicated in [paragraphs I. and II.](#), to bill for benefits under this issuance.

I. Reimbursement to HHAs for ECHO respite care will be based on the allowable charge or rates negotiated by the MCSC.

J. The amount of the government's cost for respite care received in any month accrues to the maximum fiscal year ECHO benefit of \$36,000.

K. Because ECHO respite care services are provided by HHAs, the TRICARE exclusion at [32 CFR 199.5\(d\)\(10\)](#) does not apply. That is, beneficiaries seeking ECHO respite care are not required to show that such services are paid for, or eligible for payment, either directly or indirectly, by a public facility, as defined in [32 CFR 199.2](#), or otherwise by Federal, State, or local government sources.

V. EXCLUSIONS

A. Baby-sitting or child care services for other family members or visitors is excluded.

B. ECHO respite care will not be provided to those beneficiaries who are receiving the EHHC benefit or the EHHC-Respite Care benefit.

C. ECHO respite care will not be provided to cover absences of the primary caregiver(s) due to deployment, training, employment, seeking employment, or pursuing education.

D. Except as provided in [paragraph IV.D.](#), ECHO respite care will not be provided in areas where Medicare or Medicaid certified HHAs are not available.

VI. EFFECTIVE DATE September 1, 2005.

- END -

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CHAPTER 9, SECTION 15.1

ECHO HOME HEALTH CARE (EHHC)

NOTE: Although CMS periodically publishes updates to the SNF rates during any given fiscal year, those will not be used to calculate the EHHC cap. Only the SNF reimbursement rates in effect on October 1 of each year will be used to calculate the EHHC cap for the fiscal year beginning on that date.

(2) From the “Table 6A. RUG-IV Case-Mix Adjusted Federal Rates for Urban SNFs by Labor and Non-Labor Component”, determine the highest cost RUG-IV category;

(3) Multiply the labor component obtained in paragraph VI.H.2.a.(2) by the “Table A. FY 2011 Wage Index for Urban Areas Based on CBSA Labor Market Areas” value corresponding to the beneficiary’s location;

(4) Sum the non-labor component from paragraph VI.H.2.a.(2) and the adjusted labor component from paragraph VI.H.2.a.(3); the result is the beneficiary’s EHHC per diem in that location;

(5) Multiply the per diem obtained in paragraph VI.H.2.a.(4) by 365 (366 in leap year); the result is the beneficiary’s fiscal year cap for EHHC in that location.

(6) For beneficiary’s residing in areas not listed in Table 6A, use “Table 7A. RUG-IV Case-Mix Adjusted Federal Rates for Rural SNFs by Labor and Non-Labor Component” and “Table B. FY 2011 Wage Index Based on CBSA Labor Market Areas for Rural Areas” and adjust similarly to paragraph VI.H.2.a.(3) through (5) to determine the EHHC cap for beneficiaries residing in rural areas.

NOTE: See Chapter 9, Addendum A for an example of the EHHC cap based on the FY 2011 rates published in the Federal Register on July 22, 2010 (75 FR 42886).

b. Beneficiaries who seek EHHC at any time during the fiscal year will have their cap calculated as above and prorated by month for the remaining portion of that fiscal year.

c. The maximum amount reimbursed in any month for EHHC services is the amount authorized in accordance with the approved plan of care and based on the actual number of hours of home health care provided and billed at the allowable charge or the negotiated rate. In no case will the amount reimbursed for any month of EHHC exceed one-twelfth (1/12) of the annual fiscal year cap established under paragraph VI.H.2.a. and as adjusted for the actual number of days in the month during which the services were provided.

d. Beneficiaries who move will have their cap recalculated to reflect the wage index for their new location. The maximum amount reimbursed in the remaining months of that fiscal year for EHHC services will reflect the re-calculated EHHC cap.

e. The cost for EHHC services does not accrue to the maximum monthly or fiscal year Government cost-shares indicated in Chapter 9, Section 16.1.

3. The sponsor’s cost-share for EHHC services will be as indicated in Chapter 9, Section 16.1.

I. Transition to EHHC.

1. Following modification of the MCS contracts that incorporates the ECHO, the MCSCs will identify all active duty family members who are currently using, or have used any benefit of the PFPWD within the 12-month period immediately preceding the contract modification. The MCSCs will also identify those active duty family members who are in SNFs.

2. Not less than 60 days prior to the scheduled implementation of the ECHO, the MCSCs will send the government furnished notification and information brochures to all beneficiaries identified in [paragraph VI.I.1](#). The notification announces the conversion of the PFPWD to the ECHO and the brochure highlights the benefit structure, the requirements, and the primary points of contact to access the ECHO.

3. Beneficiaries in SNFs will be afforded the opportunity to relocate to a more natural setting, such as in the sponsor's home, or other primary residence as defined herein.

4. MCSCs will assist EHHC-eligible beneficiaries with initiating the ECHO registration process and developing and approving the plan of care.

5. Those homebound beneficiaries whose need for skilled services can be appropriately met by the HHA-PPS (TRM, [Chapter 12](#)) will be required to access that program for such services.

NOTE: Although it is the intent that eligible beneficiaries complete the registration process and all applicable requirements of this issuance by the date of implementation of the ECHO, it is recognized that certain requirements may not be completed at that time. Therefore, to avoid delaying necessary services, those otherwise ECHO-eligible beneficiaries will be granted provisional eligibility status for a period of not more than 90 days following the date of implementation during which EHHC benefits will be authorized and payable. Beneficiaries failing to complete the ECHO registration process and the requirements of this issuance by the end of that 90 day period will be determined ineligible, at which point authorization and Government liability for all ECHO/EHHC benefits will terminate. The Department will not recoup claims paid for ECHO benefits provided during the provisional period.

6. Following implementation of the ECHO, the MCSCs will make available the Government furnished information brochures to beneficiaries seeking information about or access to the ECHO.

VII. EXCLUSIONS

A. Basic program and the ECHO Respite Care benefit (see [Chapter 9, Section 12.1](#)).

B. EHHC services will not be provided outside the beneficiary's primary residence.

C. **EHHC services and** EHHC respite care services are not available for the purpose of covering primary caregiver(s) absences due to deployment, employment, seeking employment, or to pursue education. **Except for those excluded activities, this exclusion does**

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ECHO HOME HEALTH CARE (EHHC)

not otherwise restrict or prohibit the primary caregiver(s) from engaging in other activities they choose, including those outside the beneficiary's primary residence.

D. EHHC services and supplies can be provided only to the eligible beneficiary, that is, such services will not be provided to or on behalf of other members of the beneficiary's family nor other individuals who reside in or are visiting in the beneficiary's primary residence.

E. EHHC services and supplies are excluded from those who are being provided continuing coverage of home health care as participants of the former Individual Case Management Program for Persons with Extraordinary Conditions (ICMP-PEC) or previous case management demonstrations.

VIII. EFFECTIVE DATE September 1, 2005.

- END -

twentieth (20th) day of the month, enrollment will begin on the first day of the second month after the month in which they were received by the contractor.

b. Reenrollments for those who were enrolled in Prime immediately prior to a change in their status:

(1) When an active duty member's retirement is effective other than the first of the month. A Prime application to reenroll must be completed within 30 days of the member's retirement. Otherwise, the application shall be considered an initial enrollment in Prime. The effective date of reenrollment shall be the date of retirement which will then result in seamless TRICARE Prime benefits with no break in coverage.

(2) When an active duty member separates other than the first of the month, but continues to be eligible (e.g., is the spouse of an active duty member; or is eligible for TAMP) they and any eligible family members shall be allowed to reenroll in TRICARE Prime with no break in coverage. TAMP eligibles must complete an application for Prime prior to the expiration of their period of TAMP eligibility to reenroll in Prime. Non-TAMP eligibles separating but who remain eligible for TRICARE must complete the application for Prime within 30 days of their change in status. Otherwise, the application shall be considered an initial enrollment in Prime. The effective date of reenrollment shall be the start date of TAMP eligibility or the date of the separation which will then result in seamless TRICARE Prime benefits with no break in coverage.

(3) TAMP eligible family members who were enrolled in Prime immediately prior to their sponsor's change in status to active duty may continue their enrollment in TRICARE Prime with no break in coverage if they reenroll in TRICARE Prime within 30 days of their sponsor's return to active duty status. If they reenroll by completing an enrollment form within 30 days of the sponsor's return to active duty status, the reenrollment will be retroactive to the date of the change in status from TAMP to active duty. If reenrollment and completion of an enrollment form is not accomplished within 30 days of the sponsor's return to active duty status, the twentieth of the month rule will apply. For information on the effective dates of enrollments for ADSMs, see the TRICARE Operations Manual, Chapter 6, Section 1.

5. Beneficiaries shall be disenrolled when they are no longer eligible for TRICARE or when they do not submit payment for prescribed enrollment fees by the required date.

B. Portability. Enrollees may transfer enrollment when they move (within a contract area or outside a contract area). The losing contractor shall provide continuing coverage until (1) the enrollee applies for enrollment in the new location, (2) the enrollee disenrolls, (3) the enrollee is no longer eligible for enrollment in TRICARE Prime, or (4) the contractor must disenroll the beneficiary for failure to pay required enrollment fees, whichever occurs first. The authorization and referral rules of the losing contractor will continue to apply until enrollment is transferred or the beneficiary is disenrolled. Primary Care Manager (PCM) referrals are required only for non-emergency specialty, inpatient, or tertiary care (see [32 CFR 199.17\(n\)\(2\)](#)). Claims for self-referred, non-emergency care without an authorization will be processed under the Point of Service option (see [Chapter 1, Section 4.1](#)). The beneficiary may request retroactive disenrollment based on the beneficiary's assertion that they did not receive the automatic re-enrollment notice. Such assertions must be received within 45

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calendar days of the first notice provided in each enrollment period to the beneficiary (normally an EOB) that a claim was adjudicated as Prime. The beneficiary shall be disenrolled retroactively to the beginning of the enrollment period and all affected claims shall be reprocessed as if the beneficiary were non-enrolled. In no circumstance will retroactive disenrollment be allowed in order to avoid Point of Service cost-sharing provisions. Even though a Prime enrollee who is relocating must request an authorization for non-emergency care from the losing contractor, the enrollee shall not be required to use a network provider.

- END -

PHYSICIAN REFERRAL AND SUPERVISION

ISSUE DATE: December 18, 1985

AUTHORITY: [32 CFR 199.6\(c\)\(3\)\(iii\)\(K\)](#)

I. ISSUE

A. In order to be considered for benefits on a fee-for-service basis, the services of the following individual professional providers of care may be provided only if the beneficiary/patient is referred by a physician for the treatment of a medically-diagnosed condition.

B. A physician must also provide continuing and ongoing oversight and supervision of the program or episode of treatment provided by **the following** individual providers:

1. Licensed Registered Nurses (RNs).
2. Licensed Practical Nurse (LPN) or Licensed Vocational Nurse (LVN).
3. Audiologist.
4. Pastoral Counselors.
5. Mental Health Counselors.

II. POLICY

A. A physician must establish a diagnosis which, in order to be considered for benefits, must describe a covered condition. This means the physician must actually see the patient, do an evaluation and arrive at an initial diagnostic impression prior to referring the patient. Any change in the referral diagnosis must be coordinated with the referring physician.

B. The overall management of the patient rests with the physician and, in order to assure appropriate case management, coordination must be made with the referring physician on an ongoing basis. Physician supervision means the physician provides overall medical management of the case. The referring physician does not have to be physically located on the premises of the provider to whom the referral is made. Communication back to the referring physician is an indication of medical management.

C. Military physicians may refer patients to civilian providers. Because of the mobility of military physicians due to transfers, retirements and discharges, if the original referring physician has relocated, another military physician may assume responsibility for the case

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upon review of the military treatment facility clinical record, a narrative of the patient's present status and the proposed treatment plan.

III. EXCLUSION

Any services provided prior to examination and subsequent referral by a physician.

- END -

supplies which account for only 10 to 20 percent of the total program charges for autologous bone marrow transplants. The remaining 70 to 80 percent of the charges will be attributable to technical and/or facilities fees. The services will include but are not limited to: 1) laboratory charges; 2) pre-conditioning chemotherapy; 3) growth factor; 4) home health; 5) catheter placement; 6) blood products; and 7) recovery post discharge. Under the above alternative reimbursement provisions, contractors will be given the flexibility of negotiating with network providers (i.e., freestanding outpatient bone marrow transplant centers who agree to become network providers) for outpatient bone marrow transplants at rates below those performed in a hospital setting, which would include CMAC rates for professional fees plus the DRG amount.

c. The following minimal requirements should be adhered to in the establishment of alternative reimbursement methodologies for in-system/network corporate services providers in order to ensure quality of care and fiscal accountability:

(1) Alternative reimbursement methodologies may include and/or be a combination of fee schedules, discounts from usual and customary fees or CHAMPUS maximum allowable charge amounts (CMAC), flat fee arrangements (negotiated all inclusive rates), capitation arrangements, discounts off of DRGS, per diems; or such other method as is mutually agreed upon, provided such alternative payments do not exceed what would have otherwise been allowed under Standard TRICARE payment methodologies in another setting (e.g., comparable services rendered in a hospital inpatient or outpatient setting).

(2) Payments in full (e.g., negotiated flat fees, all-inclusive global fees, capitation arrangements, discounts off of DRGs and per diems) are prospective reimbursement systems which may include items related or incidental to the treatment of the patient but for which coverage is not normally extended under TRICARE. These incidental services are to be included in the negotiated prospective payment rate; i.e., they can neither be billed to the beneficiary or deducted from the negotiated global rate.

3. All billing for Corporate Services Providers should be submitted on a CMS 1500 (08/05). TRICARE Management Activity (TMA) will assign pricing rate codes (e.g., assigning pricing rate code "GP" for non-institutional per diem rates) to accommodate approved alternative reimbursement systems. The contractor should designate the coding that it wants to use as part of the alternative reimbursement request submitted to the Executive Director, TMA or designee for review and approval.

4. The contractor will determine the appropriate procedural category of a qualified organization and may change the category based upon the provider's TRICARE claim characteristics. The category determination is conclusive and may not be appealed.

5. The corporate entity will not be allowed additional facility charges that are not already incorporated into the professional services fee structure (i.e., facility charges that are not already included in the overhead and malpractice cost indices used in establishing locally-adjusted CMAC rates).

6. While the expanded provider category will allow coverage of professional services for corporate entities qualifying for provider authorization status under the provisions of this policy, it will at the same time restrict coverage of professional services for

those corporate entities which cannot meet the criteria for corporate services provider status under TRICARE.

C. Conditions for Coverage/Authorization

1. Be a corporation or a foundation, but not a professional corporation or professional association;
2. Be institution-affiliated or freestanding;
3. Provide services and related supplies of a type rendered by TRICARE individual professional providers employed directly or contractually by a corporation, or diagnostic technical services and related supplies of a type which requires direct patient contact and a technologist who is licensed by the state in which the procedure is rendered or who is certified by a Qualified Accreditation Organization;
4. Provide the level of care that does not necessitate that the beneficiary be provided with on-site sleeping accommodations and food in conjunction with the delivery of the services except for sleep disorder diagnostic centers in which on-site sleeping accommodations are an integral part of the diagnostic evaluation process.
5. Render services for which direct or indirect payment is expected to be made by TRICARE only after obtaining written authorization (i.e., comply with applicable TRICARE authorization requirements before rendering designated services or items for which TRICARE cost-share/copayment may be expected);
6. Comply with all applicable organizational and individual licensing or certification requirements that are extent in the state, county, municipality, or other political jurisdiction in which the corporate entity provides services;
7. Maintain Medicare approval for payment when the contractor determines that a category, or type, of provider is substantially comparable to a provider or supplier for which Medicare has regulatory conditions of participation or conditions of coverage, or when Medicare approved status is not required, be accredited by a qualified accreditation organization, as defined in [Chapter 11, Section 12.2](#); and
8. Has entered into a negotiated provider contract with a network provider or a participation agreement with a non-network provider which at least complies with the minimum participation agreement requirements set forth in [Chapter 11, Section 12.3](#). The participation agreement will accompany the application form (Application for TRICARE-Provider Status: CORPORATE SERVICES PROVIDER) sent out as part of the initial authorization process for non-network providers as described below.

D. Application Process

1. The information collected on the "Application for TRICARE-Provider Status: CORPORATE SERVICES PROVIDERS" (i.e., the information collection form for which the provider is seeking TRICARE authorization status) will be used by the contractor in determining whether the provider meets the criteria for authorization as a corporate services

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