



OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
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TRICARE
MANAGEMENT ACTIVITY

MB&RB

**CHANGE 173
6010.54-M
FEBRUARY 6, 2013**

**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: CONSOLIDATED CHANGE 12-003

CONREQ: 16182

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): See page 3.

EFFECTIVE DATE: The effective date for Chapter 7, Section 3.18 is August 10, 2012.
All other changes are upon direction of the Contracting Officer.

IMPLEMENTATION DATE: Upon direction of the Contracting Officer.

This change is made in conjunction with Aug 2002 TOM, Change No. 150.

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Chief, Medical Benefits and
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**ATTACHMENT(S): 18 PAGE(S)
DISTRIBUTION: 6010.54-M**

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

CHANGE 173
6010.54-M
FEBRUARY 6, 2013

REMOVE PAGE(S)

CHAPTER 7

Section 2.1, pages 11 - 13
Section 2.2, pages 7 - 9
Section 2.5, pages 1 and 2
Section 3.10, pages 1 - 3
Section 3.18, pages 1 - 3

CHAPTER 8

Section 1.1, pages 1 and 2

INSERT PAGE(S)

Section 2.1, pages 11 - 13
Section 2.2, pages 7 - 10
Section 2.5, pages 1 and 2
Section 3.10, pages 1 - 3
Section 3.18, pages 1 - 4

Section 1.1, pages 1 and 2

SUMMARY OF CHANGES

CHAPTER 7

1. Section 2.1. This change adds clarifying language for services that occur during a preventative office.
2. Section 2.2. This change adds clarifying language for services that occur during a preventative office.
3. Section 2.5. This change clarifies that developmental assessment is a covered service under this policy and adds procedure code 96110 for clarification.
4. Section 3.10. This change clarifies the code range that represent mental health services that, if billed during the first eight mental health visits, requires no pre-authorization.
5. Section 3.18. This change clarifies Rett's Syndrome to be among the five disorders that comprise Autism Spectrum Disorders (ASD) under the basic program effective 8/10/2012.

CHAPTER 8

6. Section 1.1. This change provides clarification that claims for ambulance services to an USMTF are covered and will not be denied on the grounds that there is a nearer civilian institution (hospital) having appropriate facilities to treat the patient.

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.

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 Screening. Age-specific, periodic lipid panel as recommended by the National Heart, Lung, and Blood Institute (NHLBI). Refer to the NHLBI web site (<http://www.nhlbi.nih.gov/guidelines>) for current recommendations.

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

4. Body Measurements. For adults, height and weight typically is measured and Body Mass Index (BMI) calculated at each primary care visit. Individuals identified with a BMI of 25 or above typically receive appropriate nutritional and physical activity counseling as part of the primary care visit. For children and adolescents, height and weight typically is measured and BMI-for-age calculated and plotted at each primary care visit using the CDC "Data Table of BMI-for-age Charts". Children/adolescents with a BMI value greater than the 85th percentile typically receive appropriate nutritional and physical activity counseling as part of the visit.

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.

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CHAPTER 7, SECTION 2.1

CLINICAL PREVENTIVE SERVICES - TRICARE STANDARD

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

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 -

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CHAPTER 7, SECTION 2.2

CLINICAL PREVENTIVE SERVICES - TRICARE PRIME

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 Screening: Age-specific, periodic lipid panel as recommended by the National Heart, Lung, and Blood Institute (NHLBI). Refer to the NHLBI web site (http://www.nhlbi.nih.gov/guidelines) for current recommendations.	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.

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CHAPTER 7, SECTION 2.2

CLINICAL PREVENTIVE SERVICES - TRICARE PRIME

SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT PROCEDURE CODE
<p>Other:</p>	<p>Body Measurement: For children and adolescents: Height and weight typically is measured and Body Mass Index (BMI)-for-age calculated and plotted at each primary care visit using the CDC "Data Table of BMI-for-age Charts". Children/adolescents with a BMI value greater than the 85th percentile typically receive appropriate nutritional and physical activity counseling as part of the primary care visit. Head circumference typically is measured through age 24 months. For adults: Height and weight typically is measured and BMI calculated at each primary care visit. Individuals identified with a BMI of 25 or above typically receive appropriate nutritional and physical activity counseling as part of the primary care visit.</p>	<p>See appropriate level evaluation and management codes.</p>
	<p>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.</p>	<p>CPT¹ codes 92002, 92004, 92012, 92014, 92015, 99172, and 99173.</p>
	<p>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).</p>	
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CHAPTER 7, SECTION 2.2

CLINICAL PREVENTIVE SERVICES - TRICARE PRIME

SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT PROCEDURE CODE
Other (Continued):	<p>Hearing Screening: According to the American Academy of Pediatrics (AAP) and the Joint Committee on Infant Hearing (JCIH) all newborns should undergo hearing screening using evoked Otoacoustic Emissions (OAE) testing or automatic Auditory Brainstem Response (ABR) testing before one month of age; preferably, before leaving the hospital. An infant who does not pass the hearing screening should undergo appropriate audiological and medical evaluations to confirm the presence of a hearing loss at no later than three months of age.</p> <p>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.</p>	CPT ¹ codes 92551 and 92585 - 92588.
	<p>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.</p>	CPT ¹ code 83655.
	<p>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.</p>	These are expected components of good clinical practice that are integrated into the appropriate office visit at no additional charge.
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CHAPTER 7, SECTION 2.2

CLINICAL PREVENTIVE SERVICES - TRICARE PRIME

SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT PROCEDURE CODE
<p>Other (Continued):</p>	<p>Immunizations: Age appropriate dose of vaccines that have been recommended and adopted by the Advisory Committee on Immunization Practices (ACIP) and accepted by the Director of the CDC and the Secretary of Health and Human Services (HHS) and published in a CDC <i>Morbidity and Mortality Weekly Report</i> (MMWR). Refer to the CDC's home page (http://www.cdc.gov) for current schedule of CDC recommended vaccines for use in the United States.</p> <p>The effective date of coverage for immunizations recommended by the CDC is the date that the ACIP recommendations for a particular vaccine or immunization are published in CDC MMWR or October 6, 1997, whichever is later.</p> <p>Immunizations recommended specifically for travel outside the United States are NOT covered, EXCEPT for those 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.</p>	
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- END -

WELL-CHILD CARE

ISSUE DATE: April 19, 1983

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

I. CPT¹ PROCEDURE CODES

54150, 54160, 54161, 81000 - 81015, 81099, 83655, 84030, 84035, 85014, 85018, 86580, 90465 - 90468, 90471 - 90474, 90476 - 90748, 92002, 92004, 92012, 92014, 92015, 92551, 92585 - 92588, **96110**, 99172, 99173, 99381 - 99383, 99391 - 99393, 99460 - 99463, 99499.

II. DESCRIPTION

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

III. POLICY

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

IV. POLICY CONSIDERATIONS

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

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

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C. Immunizations are covered for the age appropriate dose of vaccines that have been recommended and adopted by the Advisory Committee on Immunization Practices (ACIP) and accepted by the Director of the Centers for Disease Control and Prevention (CDC) and the Secretary of Health and Human Services (HHS) and published in a CDC *Morbidity and Mortality Weekly Report* (MMWR). Refer to the CDC's home page (<http://www.cdc.gov>) for access to the MMWRs and a current schedule of CDC recommended vaccines for use in the United States. Immunizations recommended specifically for travel outside the United States are not covered. EXCEPT for immunizations required by dependents of active duty military personnel who are traveling outside the United States as a result of an active duty member's duty assignment, and such travel is being performed under orders issued by a Uniformed Service.

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

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

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

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

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

1. History and physical examination and mental health assessment.
2. Developmental and behavioral appraisal.
 - a. Height and weight should be measured regularly throughout infancy and childhood.
 - b. Head circumference should be measured for children through 24 months of age.

TREATMENT OF MENTAL DISORDERS

ISSUE DATE: December 5, 1984

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

I. CPT¹ PROCEDURE CODE RANGE

90801 - 90899

II. POLICY

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

III. POLICY CONSIDERATIONS

A. Professional and institutional providers of mental health services.

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

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

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g. Mental health counselors

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

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

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

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

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

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

5. The first eight outpatient mental health visits (to include CPT² procedure codes 90801 through 90899), per beneficiary in a fiscal year require no Primary Care Manager (PCM) or Health Care Finder (HCF) referral, nor is a preauthorization required (see TRICARE Policy Manual (TPM), Chapter 1, Section 9.1 and the TOM, Chapter 7, Section 2).

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IV. EXCLUSIONS

- A. Sexual dysfunctions, paraphilias and gender identity disorders.
- B. Drug maintenance programs when one addictive drug is substituted for another on a maintenance basis.
- C. Specific developmental disorders.
- D. Home visits for individual, family, or marriage counseling (CPT³ procedure code 99510).
- E. Microcurrent Electrical Therapy (MET), Cranial Electrotherapy Stimulation (CES), or any therapy that uses the non-invasive application of low levels of microcurrent stimulation to the head by means of external electrodes for the treatment of anxiety, depression or insomnia, and electrical stimulation devices used to apply this therapy.
- F. Transcranial Magnetic Stimulation (TMS) (also referred to as repetitive TMS (rTMS)) for the treatment of major depressive disorder (CPT³ procedure codes 90867 and 90868), is unproven

V. EFFECTIVE DATE November 13, 1984.

- END -

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APPLIED BEHAVIORAL ANALYSIS (ABA)

ISSUE DATE: August 10, 2012

AUTHORITY: [32 CFR 199.4\(c\)](#) and 10 USC 1079(a)

I. CPT¹ PROCEDURE CODES

90887, 99080

II. HCPCS CODE

S5108

III. DESCRIPTION

Through U.S. District Court order, TRICARE Management Activity (TMA) has been ordered to cover Applied Behavior Analysis (ABA) therapy under the TRICARE Basic Program. This is an interim benefit in effect until litigation is complete.

IV. POLICY

A. TRICARE covers ABA services for all eligible beneficiaries, including retirees and their dependent family members, with a diagnosis of Autism Spectrum Disorder (ASD).

B. **The covered ASD diagnoses are described under the Pervasive Developmental Disorders (PDD) category of the most current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). Presently, a covered diagnosis of ASD includes Pervasive Developmental Disorders (PDD) and their associated DSM, Fourth Edition, Text Revision, (DSM-IV-TR) diagnostic code: Autistic Disorder (299.00), Rett's Disorder (299.80), Childhood Disintegrative Disorder (CDD) (299.10), Asperger's Disorder (299.80), and Pervasive Development Disorder Not Otherwise Specified (PDDNOS) (including Atypical Autism) (299.80). These five DSM-IV-TR diagnostic codes are converted to corresponding codes in the currently used edition of the International Classification of Diseases, Clinical Modification manual (currently ICD-9 CM) as part of the claims process under TRICARE. The ICD-9 CM codes for the five ASDs are: Autistic Disorder (299.0), Rett's Syndrome (330.8) (found under "Other Specific Cerebral Degenerations"), Childhood Disintegrative Disorder (299.1), Asperger's Disorder (299.8) and PDD NOS (to include Atypical Autism) (299.9).**

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NOTE: The DSM-IV-TR and the ICD-9-CM use the same numeric diagnosis codes for three of the five ASD diagnoses (Autistic Disorder, CDD, and Asperger's). The DSM-IV-TR uses one code 299.80 to refer to Rett's Disorder, PDD and Asperger's Disorder whereas the ICD-9-CM designates a unique code for each diagnosis and therefore has a different code for Rett's and PDD.

C. Payable services include:

1. An initial beneficiary assessment;
2. Development of a treatment plan;
3. One-on-one ABA interventions with an eligible beneficiary, training of immediate family members to provide services in accordance with the treatment plan; and
4. Monitoring of the beneficiary's progress toward treatment goals.

D. ABA services will be provided only for those beneficiaries with an ASD diagnosis rendered by a TRICARE-authorized Primary Care Provider (PCP) or by a specialized ASD provider defined as:

1. Physician board-certified or board-eligible in behavioral developmental pediatrics, neurodevelopmental pediatrics, pediatric neurology or child psychiatry; or
2. Ph.D. clinical psychologist working primarily with children.

V. REIMBURSEMENT

A. Claims for ABA services will be submitted by an authorized provider on Centers for Medicare and Medicaid Services (CMS) 1500 (08/05) as follows:

1. Functional Behavioral Assessment and Analysis.
 - a. The Functional Behavioral Assessment and Analysis and initial treatment plan will be billed using Healthcare Common Procedure Coding System (HCPCS) code S5108, "Home care training to home care client, per 15 minutes".
 - b. Reimbursement for the Functional Behavioral Assessment and Analysis includes the intellectual work and diagnostic evaluation required to establish the initial Behavioral Plan (BP).
2. ABA services rendered by an authorized provider, in-person, will be billed using HCPCS code S5108, "Home care training to home care client, per 15 minutes".
3. Development of an updated treatment plan will be billed using Current Procedural Terminology² (CPT) procedure code 99080, "Special reports such as insurance

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forms, more than the information conveyed in the usual medical communications or standard reporting form”.

4. Conducting progress meetings will be billed using CPT² procedure code 90887, “Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible person, or advising them how to assist patient”.

B. Reimbursement of claims will be the lesser of:

1. The CHAMPUS Maximum Allowable Charge (CMAC); or
2. One hundred and twenty-five dollars (\$125) per hour for services provided by the authorized provider; or
3. The negotiated rate; or
4. The billed charge.

VI. POLICY CONSIDERATIONS

The Managed Care Support Contractor (MCSC) will also consider and advise beneficiaries of the availability of community-based or funded programs and services when authorizing benefits.

VII. EXCLUSIONS

- A. ABA services provided in a group format are not a covered service.
- B. Services rendered by an unauthorized TRICARE provider.

VIII. PROVIDERS

For services provided in conjunction with ABA under the TRICARE Basic benefit, the following are TRICARE-authorized providers when referred by and working under the supervision of those identified in [paragraph IV.D.](#):

- A. Have a current State license to provide ABA services; or
- B. Are currently State-certified as an Applied Behavioral Analyst; or
- C. Where such State license or certification is not available, are certified by the Behavioral Analyst Certification Board (BACB) as a Board Certified Behavior Analyst (BCBA); and
- D. Otherwise meet all applicable requirements of TRICARE-authorized providers.

NOTE: Individuals certified by the BACB as a Board Certified Assistant Behavior Analyst (BCaBA) **are not** TRICARE-authorized ABA providers under the TRICARE Basic Program.

TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 7, SECTION 3.18

APPLIED BEHAVIORAL ANALYSIS (ABA)

IX. EFFECTIVE DATE

February 16, 2010. Except for services overseas which is February 16, 2008.

- END -

AMBULANCE SERVICE

ISSUE DATE: October 25, 1984

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

I. HCPCS PROCEDURE CODES

Level II Codes A0225, A0382, A0384, A0392, A0394, A0396, A0398, A0422, A0424 - A0436, A0999

II. DESCRIPTION

Transportation by means of a specifically designed vehicle for transporting the sick and injured that contains a stretcher, linens, first aid supplies, oxygen equipment, and such other safety and life saving equipment as is required by state and local law and is staffed by personnel trained to provide first aid treatment.

III. POLICY

Coverage is limited to the following:

A. Emergency transfers to or from a beneficiary's place of residence, accident scene, or other location to a civilian hospital, **Military Treatment Facility (MTF)**, or **Veteran Affairs** hospital and transfers between MTFs, VA hospitals and civilian hospitals whether ordered by civilian or military personnel.

B. Ambulance transfers from a hospital based emergency room to a MTF, VA hospital or other civilian hospital more capable of providing the required care whether ordered by civilian or military personnel.

C. Transfers between a MTF, or civilian hospital or skilled nursing facility and a freestanding or another hospital based outpatient therapeutic or diagnostic department/facility whether ordered by civilian or military personnel.

D. Ambulance services by other than land vehicles (such as a boat or airplane) may be considered only when the pickup point is inaccessible by a land vehicle, or when great distance or other obstacles are involved in transporting the patient to the nearest hospital with appropriate facilities and the patient's medical condition warrants speedy admission or is such that transfer by other means is contraindicated. **Transporting to the nearest hospital does not apply when transporting to an MTF as outlined in paragraph III.E.**

TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 8, SECTION 1.1

AMBULANCE SERVICE

E. A claim for ambulance service to a **Uniformed Services Medical Treatment Facility (USMTF)** will not be denied on the grounds that there is a nearer civilian institution (hospital) having appropriate facilities to treat the patient.

F. Ambulance transfer to and from skilled nursing facilities when medically indicated. See the TRICARE Reimbursement Manual (TRM), [Chapter 8, Section 2, paragraph IV.C.13.e](#).

G. Payment of services and supplies provided by ambulance personnel at an accident scene may be allowed when the patient's condition warrants transfer to an inpatient acute setting and medical services and/or supplies are provided solely to stabilize the patient's condition while awaiting the arrival of a more urgent means of transfer; e.g., air ambulance services.

IV. EXCLUSIONS

A. Ambulance service used instead of taxi service when the patient's condition would have permitted use of regular private transportation.

B. Transport or transfer of a patient primarily for the purpose of having the patient nearer to home, family, friends, or personal physician. Except as described in [paragraph III.C.](#), transport must be to the closest appropriate facility by the least costly means.

NOTE: The exclusion of ambulance coverage "primarily for the purpose of having the patient nearer to home, family, friends, or personal physician" does not apply when the ambulance transfer is medically necessary and appropriate. If there is documentation that the ambulance transfer is for reasons of medical necessity (e.g., the need for parental nurturing of an infant as a component of or in furtherance of medical treatment; the need to place a child in an appropriate level of care) then the ambulance service is not "primarily" driven by considerations of family/patient convenience and the exclusion does not apply.

C. Medicabs or ambicabs which function primarily as public passenger conveyances transporting patients to and from their medical appointments.

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