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TRICARE
MANAGEMENT ACTIVITY

MB&RS

CHANGE 58
6010.54-M
JUNE 28, 2007

PUBLICATIONS SYSTEM CHANGE TRANSMITTAL
FOR
TRICARE POLICY MANUAL (TPM)

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

CHANGE TITLE: TRICARE POLICY CHANGE - JUNE 2007

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

SUMMARY OF CHANGE(S): Policy changes or revisions involving electronic bone
stimulation, immunizations, certification of organ transplant centers, and others.

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

A handwritten signature in black ink, appearing to read "Reta Michak".

Reta Michak
Chief, Office of Medical Benefits
and Reimbursement Systems

ATTACHMENT(S): 91 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 4

1. Table of Contents, page i. Added Section 6.2.
2. Section 6.1, page 2. Revised CPT codes.
3. Section 6.2, pages 1 and 2. Reissued from TRICARE Policy Manual 6010.47-M, March 2002.
4. Section 20.1, page 2. Removed the provision for coverage of vagus nerve stimulator for beneficiaries under the age of 12.
5. Section 24.4, page 1. Add a note on multivisceral transplantation.
6. Section 24.7, pages 2 - 4. Revised the criteria for pancreas-transplant-alone (PTA) to comply with Medicare's policy.
7. Section 24.8, page 2. Clarified that Medicare approved transplant centers applies to care inside CONUS.

CHAPTER 5

8. Section 1.1, pages 2 and 3. Clarified coverage for 3D rendering.

CHAPTER 7

9. Section 2.1, pages 7 and 8. Added clarification regarding TRICARE coverage of vaccines: ACIP recommendations must be published in CDC MMWR before coverage may be extended.
10. Section 2.2, pages 1 and 6. Added clarification regarding TRICARE coverage of vaccines: ACIP recommendations must be published in CDC MMWR before coverage may be extended.
11. Section 2.3, pages 1 and 2. Adds note about implantable prescription contraceptives.
12. Section 2.5, pages 1 through 3. Added clarification about immunizations covered under the well-child benefit.

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13. Section 8.1, pages 1 and 2. Clarifies how services are handled after September 1, 2005, with ECHO implementation.
14. Section 18.1, page 3. Clarifies that services to address conditions resulting from occupational or educational deficits are excluded.
15. Section 18.2, page 3. Clarifies that services on the Individuals with Disabilities Education Act apply to the physical therapy policy.
16. Section 18.3, page 2. Clarifies that services on the Individuals with Disabilities Education Act apply to the occupational therapy policy.
17. Section 22.1, pages 2 through 4. Updated CPT and HCPCS codes and FY2007 facility fee.

CHAPTER 8

18. Table of Contents, page i. Added Sections 8.2, 16.1, and 17.1
19. Section 1.1, page 2. Ambulance Services - clarified exclusion for having the patient closer to home.
20. Section 5.1, pages 1 and 2. Removes the provision for coverage of off-label or non-FDA approved applications of devices.
21. Section 8.1, pages. Clarifies that providers must be "otherwise authorized" TRICARE providers.
22. Section 8.2, pages 1 and 2. Reissued from TRICARE Policy Manual 6010.47-M, March 2002 on therapeutic shoes.
23. Section 16.1, page 1. Reissued from TRICARE Policy Manual 6010.47-M, March 2002.
24. Section 17.1, pages 1 and 2. Reissued from TRICARE Policy Manual 6010.47-M, March 2002. Lymphedema.

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25. Section 13.1, pages 1. Adds HCPCS code T1013.

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26. Section 7.1, page 1. Changed ADFMs to ADSMs in paragraph II.A.

CHAPTER 11

27. Section 7.1, page. Clarified certification requirements for Organ Transplant Centers.

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28. Section 12.2, pages 32, 33 and 35. Added new DMIS-ID codes.

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MUSCULOSKELETAL SYSTEM

ISSUE DATE: August 26, 1985

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

I. CPT¹ PROCEDURE CODES

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

II. DESCRIPTION

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

III. POLICY

A. Services and supplies required in the diagnosis and treatment of illness or injury involving the musculoskeletal system are covered. FDA-approved surgically implanted devices are also covered.

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

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

IV. EXCLUSIONS

A. Percutaneous vertebroplasty (CPT¹ procedure codes 22520-**22525**) is unproven.

B. Percutaneous kyphoplasty (CPT¹ procedure codes 22523-22525) for the treatment of vertebral fractures is unproven.

C. Meniscal transplant (CPT¹ procedure code 29868) for meniscal injury is unproven.

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

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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 4, SECTION 6.1

MUSCULOSKELETAL SYSTEM

- E. Prolotherapy, joint sclerotherapy and ligamentous injections with sclerosing agents (HCPCS procedure code M0076) are unproven.
- F. Trigger point injection (CPT² procedure codes 20552, 20553) for migraine headaches.
- G. IDET (Intradiscal Electrothermal Therapy) for Chronic Discogenic Pain (CPT² procedure codes 0062T and 0063T) is unproven.
- H. Botox (chemodenervation) for migraine headaches is unproven.
- I. Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace, cervical; single interspace (CPT² procedure code 0090T) each additional interspace (CPT² procedure code 0092T) is unproven.
- J. Removal of total disc arthroplasty anterior approach cervical; single interspace (0093T) each additional interspace (CPT² procedure code 0095T). Also see [Chapter 4, Section 1.1](#).
- K. Artificial intervertebral disc replacement for degenerative disc disease **is unproven** (CPT² procedure codes 0090T - 0098T).
- L. Extracorporeal shock wave, high energy involving the lantar fascia (CPT² procedure code 28890) because this is for a complication of a noncovered procedure. Also see [Chapter 4, Section 1.1](#).

- END -

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ELECTRICAL STIMULATION OF BONE

ISSUE DATE: October 6, 1988

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

I. CPT¹ PROCEDURE CODES

20974 - 20975, 20670, 20680

II. HCPCS PROCEDURE CODES

E0747 - E0749, E0760

III. DESCRIPTION

Electrical stimulation to augment bone repair can be accomplished through one of the following methods:

A. A totally invasive method in which electrodes and power pack are surgically implanted within the extremity.

B. A semi-invasive method in which electrodes penetrate the fracture and the power pack is externally placed and the leads are connected to the inserted electrodes.

C. A totally noninvasive method in which the electrodes are placed over the cast surface and are connected to an external power pack.

IV. POLICY

A. Use of the invasive and semi-invasive types of devices are covered for nonunion of long bone fractures.

B. Use of the noninvasive type of device is covered for the following procedures:

1. Nonunion of long bone fractures.

2. Failed fusion.

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3. Congenital pseudo-arthrooses.

C. Use of the invasive or noninvasive type of device is covered as an adjunct to spinal fusions to increase the probability of fusion success for:

1. Patients at high risk for pseudo-arthritis, including those patients with:
 - a. One or more failed fusions;
 - b. Grade 2 or 3 spondylolisthesis;
 - c. Fusions at more than one level, or
2. Fusions performed on patients considered to be at high risk (i.e., smokers, obese, etc.).

D. Nonunion, for all types of devices. A nonunion is considered to be established when the fracture site shows no visibly progressive signs of healing.

E. When determined to be medically necessary, the electrical bone stimulator may be rented following the durable medical equipment reimbursement procedures outlined in [Chapter 8, Section 2.1](#).

F. When determined to be medically necessary, repairs, adjustments and accessories necessary for the effective functioning of the device, and removal and replacement of the covered device, as well as associated surgical costs are covered.

- END -

CARDIOVASCULAR SYSTEM

ISSUE DATE: August 26, 1985

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

I. CPT¹ PROCEDURE CODES

33010 - 33130, 33140, 33141, 33200 - 37183, 37195 - 37785, 92950 - 93272, 93303 - 93581, 93600 - 93745, 93770, 93797 - 93799

II. DESCRIPTION

The cardiovascular system involves the heart and blood vessels, by which blood is pumped and circulated through the body.

III. POLICY

A. Medically necessary services and supplies required in the diagnosis and treatment of illness or injury involving the cardiovascular system are covered.

B. Ventricular assist devices (VADs) (external and implantable) are covered if the device is FDA approved and used in accordance with FDA approved indications. VADs as destination therapy (CPT¹ 33979) are covered if they have received approval from the FDA for that purpose and are used according to the FDA-approved labeling instructions. Benefits are authorized when the procedure is performed at a TRICARE-certified heart transplantation center, a TRICARE-certified pediatric consortium heart transplantation center, or a Medicare facility which is approved for VAD implantation as destination therapy, for patients who meet all of the following conditions:

1. The patient has chronic end-stage heart failure (New York Heart Association Class IV end-stage left ventricular failure for at least 90 days with a life expectancy of less than 2 years).

2. The patient is not a candidate for heart transplantation.

3. The patient's Class IV heart failure symptoms have failed to respond to optimal medical management, including a dietary salt restriction, diuretics, digitalis, beta-blockers, and ACE inhibitors (if tolerated) for at least 60 of the last 90 days.

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4. The patient has left ventricular ejection fraction (LVEF) less than 25%.

5. The patient has demonstrated functional limitation with a peak oxygen consumption of less than 12 ml/kg/min; or the patient has a continued need for intravenous inotropic therapy owing to symptomatic hypotension, decreasing renal function, or worsening pulmonary congestion.

6. The patient has the appropriate body size (by device per FDA labeling) to support the VAD implantation.

C. Gamma and beta intracoronary radiotherapy (brachytherapy) is covered for the treatment of in-stent restenosis in native coronary arteries.

D. Transmyocardial revascularization (TMR) (CPT² procedures codes 33140 and 33141).

1. Coverage is available for patients with stable class III or IV angina which has been found refractory to standard medical therapy, including drug therapy at the maximum tolerated or maximum safe dosages. In addition, the angina symptoms must be caused by areas of the heart not amenable to surgical therapies such as percutaneous transluminal coronary angioplasty, stenting, coronary atherectomy or coronary bypass.

2. Coverage is limited to those uses of the laser used in performing the procedure which have been approved by the FDA for the purpose for which they are being used.

E. TMR as an adjunct to CABG is covered for patients with documented areas of the myocardium that are not amenable to surgical revascularization due to unsuitable anatomy.

F. FDA approved IDE clinical trials. See [Chapter 8, Section 5.1, paragraph D.](#) and [F.](#) for policy.

IV. EXCLUSIONS

A. Thermogram; cephalic (CPT² procedure code 93760); peripheral (CPT² procedure code 93762) are unproven.

B. Percutaneous Myocardial Laser Revascularization (PMR) is unproven.

C. Cardiomyoplasty (Cardiac Wrap) for treatment of heart failure is unproven.

D. Minimally Invasive Coronary Artery Bypass Graft (CABG) surgery to include Minimally Invasive Direct Coronary Artery Bypass (MIDCAB) and Port Access Coronary Artery Bypass (PACAB) are unproven.

E. Percutaneous Transluminal Angioplasty (PTA) in the treatment of obstructive lesions of the carotid, vertebral and cerebral arteries is unproven.

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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 4, SECTION 9.1

CARDIOVASCULAR SYSTEM

- F. Signal-Average Electrocardiography (CPT³ procedure code 93278) is unproven.
- G. Primary percutaneous transluminal mechanical thrombectomy (CPT³ procedure code 37184) with or without second and all subsequent vessel(s) with the same vascular family (CPT³ procedure code 37185) is unproven.
- H. Secondary percutaneous transluminal thrombectomy (CPT³ procedure code 37186) is unproven.
- I. Percutaneous transluminal mechanical thrombectomy vein(s) including intraprocedural pharmacological thrombolytic injections and fluroscopic guidance (CPT³ procedure code 37187) is unproven.
- J. Percutaneous transluminal mechanical thrombectomy, vein(s) including intraprocedural pharmacological thrombolytic injections and fluroscopic guidance, repeat treatment on subsequent day during course of thrombolytic therapy (CPT³ procedure code 37188) is unproven.

V. EFFECTIVE DATES

- A. March 1, 2001, for gamma and beta intracoronary radiotherapy (brachytherapy).
- B. January 1, 2002, for TMR.
- C. October 1, 2003, for ventricular assist devices as destination therapy.

- END -

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NERVOUS SYSTEM

ISSUE DATE: August 26, 1985

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

I. CPT¹ PROCEDURE CODES

61000 - **61626, 61680** - 61860, 61863 - 63048, 63055 - 64999, 95961, 95962, 95970 - 95975, 95978, 95979

II. DESCRIPTION

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

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

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

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

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

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

III. POLICY

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

B. Therapeutic embolization (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.
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 FDA approved vagus nerve stimulator as adjunctive therapy in reducing the frequency of seizures in adults and adolescents over 12 years of age, which are refractory to anti-epileptic medication is covered. Battery replacement is also covered.

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

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

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

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

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

IV. EXCLUSIONS

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

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

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

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

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

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

G. Dorsal root entry zone (DREZ) thermocoagulation or microcoagulation neurosurgical procedure is unproven.

H. Epidural steroid injections for thoracic pain are unproven.

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

J. Neuromuscular electrical stimulation for the treatment of denervated muscles is unproven.

K. Stereotactic cingulotomy is unproven.

L. Sacral nerve neurostimulator (CPT³ procedure codes 64561, 64581, 64585, 64590, and 64595). See [Chapter 4, Section 14.1](#) for coverage policy for the urinary system and the Sacral Nerve Root Stimulation (SNS).

M. Laminoplasty, cervical with decompression of the spinal cord, two or more vertebral segments with reconstruction of the posterior bony elements (CPT³ procedure codes 63050 and 63051).

N. Balloon angioplasty, intracranial, percutaneous (CPT³ procedure code 61630) is unproven. Effective January 1, 2006.

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CHAPTER 4, SECTION 20.1

NERVOUS SYSTEM

O. Transcatheter placement of intravascular stent(s) intracranial, (e.g., atherosclerotic stenosis) including angioplasty, if performed (CPT⁴ procedure code 61635) is unproven. Effective January 1, 2006.

P. Balloon dilation of intracranial vasospasm, initial vessel (CPT⁴ procedure code 61640) each additional vessel in same family (CPT⁴ procedure code 61641) or different vascular family (CPT⁴ procedure code 61642) is unproven. Effective January 1, 2006.

V. EFFECTIVE DATES

A. January 1, 1989, for PAVM.

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

C. July 14, 1997, for GDC.

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

E. June 1, 2004, for Magnetoencephalography.

- END -

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SMALL INTESTINE, COMBINED SMALL INTESTINE-LIVER, AND MULTIVISCERAL TRANSPLANTATION

ISSUE DATE: December 3, 1997

AUTHORITY: [32 CFR 199.4\(e\)\(5\)](#)

I. CPT¹ PROCEDURE CODES

44132, 44133, 44135, 44136

II. HCPCS PROCEDURE CODES

S2053, S2054, S2055

III. POLICY

A. Benefits are allowed for small intestine (SI), small intestine-liver (SI/L), and multivisceral transplantation.

NOTE: Multivisceral transplantation includes the en bloc graft of the stomach, pancreaticoduodenal complex, and small intestine. The liver is included for patients with irreversible liver disease. The kidney(s) is included for patients with renal failure.

1. A TRICARE Prime enrollee must have a referral from his/her Primary Care Manager (PCM) and an authorization from the contractor before obtaining transplant-related services. If network providers furnish transplant-related services without prior PCM referral and contractor authorization, penalties will be administered according to TRICARE network provider agreements. If Prime enrollees receive transplant-related services from non-network civilian providers without the required PCM referral and contractor authorization, Managed Care Support (MCS) contractors shall reimburse charges for the services on a Point of Service (POS) basis. Special cost-sharing requirements apply to POS claims.

2. For Standard and Extra patients residing in a MCS region, preauthorization authority is the responsibility of the MCS Medical Director or other designated utilization staff.

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B. SI, SI/L, and multivisceral transplantation are covered for pediatric and adult patients who meet the following criteria:

1. Are suffering from irreversible intestinal failure. Intestinal failure is defined as the loss of absorptive capacity of the small bowel secondary to severe, primary gastrointestinal disease or surgically-induced short bowel syndrome.

2. Have failed total parenteral nutrition (TPN). Indicators of failed TPN are liver failure, thrombosis, frequency of infection, and dehydration as demonstrated in the following clinical situations:

- a. Impending or overt liver failure due to TPN induced liver injury.
- b. Thrombosis of the major central venous channels, jugular, subclavian, and femoral veins.
- c. Frequent line infection and sepsis.
- d. Frequent episodes of severe dehydration despite intravenous fluid supplement in addition to TPN.

3. Pediatric patients have a parent or legal guardian who have a realistic understanding of the range of clinical outcomes that may be encountered for pediatric patients. Adult patients have a realistic understanding of the range of clinical outcomes that may be encountered.

4. Plans for long-term adherence to a disciplined medical regimen are feasible and realistic.

5. The transplant is performed at a TRICARE-certified SI transplantation center or TRICARE-certified pediatric consortium SI transplantation center or Medicare-certified SI transplantation center.

C. Services and supplies related to SI, SI/L, and multivisceral transplantation are covered for:

1. Evaluation of a potential candidate's suitability for SI, SI/L, and multivisceral transplantation whether or not the patient is ultimately accepted as a candidate for transplantation.

2. Pre- and post-transplantation inpatient hospital and outpatient services.

3. Surgical services and related pre- and postoperative services of the transplantation team.

4. Blood and blood products.

5. FDA approved immunosuppression drugs to include off-label uses when determined to be medically necessary for the treatment of the condition for which it is administered, according to accepted standards of medical practice.
6. Complications of the transplant procedure, including inpatient care, management of infection and rejection episodes.
7. Periodic evaluation and assessment of the successfully transplanted patient.
8. The donor acquisition team, including the costs of transportation to the location of the donor organ and transportation of the team and the donated organ to the location of the transplantation center.
9. The maintenance of the viability of the donor organ after all existing legal requirements for excision of the donor organ have been met.
10. Donor costs.
11. Hepatitis B and pneumococcal vaccines for patients undergoing transplantation.
12. DNA-HLA tissue typing in determining histocompatibility.
13. Transportation of the patient by air ambulance and the services of a certified life support attendant.

IV. POLICY CONSIDERATIONS

A. For beneficiaries who fail to obtain preauthorization for SI, SI/L, or multivisceral transplantation, TRICARE benefits may be extended if the services or supplies otherwise would qualify for benefits but for the failure to obtain preauthorization. If preauthorization is not received, the appropriate preauthorizing authority is responsible for reviewing the claims to determine whether the beneficiary's condition meets the clinical criteria for the SI, SI/L, or multivisceral transplantation benefit. Charges for transplant and transplant-related services provided to TRICARE Prime enrollees who failed to obtain PCM referral and contractor authorization will be reimbursed only under POS rules.

B. Benefits will only be allowed for transplants performed at a TRICARE-certified SI or Medicare-certified SI transplantation center. Benefits are also allowed for transplants performed at a pediatric facility that is TRICARE-certified as an SI transplantation center on the basis that the center belongs to a pediatric consortium program whose combined experience and survival data meet the TRICARE criteria for certification. The contractor is the certifying authority for transplant centers within its region. Refer to [Chapter 11, Section 7.1](#) for organ transplant center certification requirements.

C. Effective for admissions on or after October 1, 2001, SI, SI/L, and multivisceral transplantations shall be reimbursed under the assigned DRG based on the patient's diagnosis. Claims for admissions prior to October 1, 2001, shall be reimbursed based on billed charges.

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D. Claims for transportation of the donor organ and transplantation team shall be adjudicated on the basis of billed charges, but not to exceed the transport service's published schedule of charges, and cost-shared on an inpatient basis. Scheduled or chartered transportation may be cost-shared.

E. Charges made by the donor hospital will be cost-shared on an inpatient basis and must be fully itemized and billed by the transplantation center in the name of the TRICARE patient.

F. Acquisition and donor costs are not considered to be components of the services covered under the DRG and will be reimbursed based on billed charges. These costs must be billed separately on a standard UB-92 claim form in the name of the TRICARE patient.

G. When a properly preauthorized transplantation candidate is discharged less than 24 hours after admission because of extenuating circumstances, such as the available organ is found not suitable or other circumstances which prohibit the transplantation from being timely performed, all otherwise authorized services associated with the admission shall be cost-shared on an inpatient basis, since the expectation at admission was that the patient would remain more than 24 hours.

H. SI, SI/L, or multivisceral transplants performed on an emergency basis in an unauthorized SI facility may be cost shared only when the following conditions have been met:

1. The unauthorized center must consult with the nearest TRICARE-certified or Medicare-certified SI transplantation center regarding the transplantation case; and
2. It must be determined and documented by the transplant team physician(s) at the certified SI transplantation center that transfer of the patient (to the certified SI transplantation center) is not medically reasonable, even though transplantation is feasible and appropriate.

V. EXCLUSIONS

A. SI, SI/L, or multivisceral transplantation is excluded when any of the following contraindications exist:

1. Ability to ingest oral nutrition.
2. Serious, uncontrolled psychiatric illness that would hinder compliance with any stage of the transplant process.
3. Significant cardiopulmonary insufficiency.
4. History or presence of aggressive and/or incurable malignancy.
5. Persistent abdominal or systemic infection.
6. Severe autoimmune disease.

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7. Severe immunodeficiency disease.
8. Active alcohol or chemical dependency that interferes with compliance to strict treatment regimen.
9. Inability or unwillingness of the patient or legal guardian to give signed consent and to comply with regular follow-up requirements.

B. Also excluded are:

1. Expenses waived by the transplantation center (e.g., beneficiary/sponsor not financially liable).
2. Services and supplies not provided in accordance with applicable program criteria (i.e., part of a grant or research program; unproven procedure).
3. Administration of an unproven immunosuppressant drug that is not FDA approved or has not received approval as an appropriate "off-label" drug indication.
4. Pre- or post-transplantation nonmedical expenses (e.g., out-of-hospital living expenses, to include hotel, meals, privately owned vehicle for the beneficiary or family members).
5. Transportation of an organ donor.

VI. EFFECTIVE DATES

- A. January 1, 1996, for small intestine alone transplants for patients under the age of 16 and combined small intestine-liver transplants for pediatric and adult patients.
- B. February 1, 1998, for multivisceral transplants.
- C. October 4, 2000, for small intestine alone transplants for patients age 16 and older.

- END -

SIMULTANEOUS PANCREAS-KIDNEY, PANCREAS-AFTER-KIDNEY, AND PANCREAS-TRANSPLANT-ALONE

ISSUE DATE: February 5, 1996

AUTHORITY: [32 CFR 199.4\(e\)\(5\)](#)

I. CPT¹ PROCEDURE CODES

48550 - 48556

II. HCPCS PROCEDURE CODE

S2065

III. POLICY

A. Benefits are allowed for simultaneous pancreas-kidney transplantation (SPK), pancreas-after-kidney transplantation (PAK), and pancreas-transplantation-alone (PTA).

1. A TRICARE Prime enrollee must have a referral from his/her Primary Care Manager (PCM) and an authorization from the contractor before obtaining transplant-related services. If network providers furnish transplant-related services without prior PCM referral and contractor authorization, penalties will be administered according to TRICARE network provider agreements. If Prime enrollees receive transplant-related services from non-network civilian providers without the required PCM referral and contractor authorization. Managed Care Support (MCS) contractors shall reimburse charges for the services on a Point of Service basis. Special cost-sharing requirements apply to Point of Service claims.

2. For Standard and Extra patients residing in a Managed Care Support (MCS) region, preauthorization authority is the responsibility of the MCS Medical Director or other designated utilization staff.

B. Simultaneous pancreas-kidney transplantation (SPK) and pancreas-after-kidney transplantation (PAK) are covered when the transplantation is performed at a Medicare-approved renal transplantation center, for patients who:

1. Are suffering from concomitant, Type I Diabetes Mellitus that is resistant to exogenous therapy and end stage chronic renal disease; and

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2. Have exhausted more conservative medical and surgical treatments for Type I Diabetes Mellitus and renal disease.
3. Have a realistic understanding of the range of clinical outcomes that may be encountered.
4. Plans for long-term adherence to a disciplined medical regimen are feasible and realistic.

C. Pancreas-transplantation-alone (PTA) is covered when performed at a Medicare approved renal transplantation center, for patients who:

1. Are suffering from Type I Diabetes Mellitus;
 - a. Patient with diabetes must be beta cell autoantibody positive; or
 - b. Patient must demonstrate insulinopenia defined as a fasting C-peptide level that is less than or equal to 110% of the lower limit of normal of the laboratory's measurement method. Fasting C-peptide levels will only be considered valid with a concurrently obtained fasting glucose less than or equal to 225 mg/Dl;
2. Patients must have a history of medically-uncontrollable labile (brittle) insulin-dependent diabetes mellitus with documented recurrent, severe, acutely life-threatening metabolic complications that require hospitalization. Aforementioned complications include frequent hypoglycemia unawareness or recurring severe ketoacidosis, or recurring severe hypoglycemic attacks;
3. Patients must have been optimally and intensively managed by an endocrinologist for at least 12 months with the most medically-recognized advanced insulin formulations and delivery systems;
4. Patients must have the emotional and mental capacity to understand the significant risks associated with surgery and to effectively manage the lifelong need for immunosuppression
5. Patients must otherwise be a suitable candidate for transplantation.

D. Services and supplies related to SPK, PAK, and PTA are covered for:

1. Evaluation of a potential candidate's suitability for SPK, PAK, and PTA whether or not the patient is ultimately accepted as a candidate for transplantation.
2. Pre- and post-transplantation inpatient hospital and outpatient services.
3. Surgical services and related pre- and postoperative services of the transplantation team.

4. The donor acquisition team, including the costs of transportation to the location of the donor organ and transportation of the team and the donated organ to the location of the transplantation center.
5. The maintenance of the viability of the donor organ after all existing legal requirements for excision of the donor organ have been met.
6. Donor costs.
7. Blood and blood products.
8. FDA approved immunosuppression drugs to include off-label uses when reliable evidence documents that the off-label use is safe, effective and in accordance with the national standards of practice in the medical community (proven). Mycophenolate Mofetil (Cellcept) and Tacrolimus (Prograf) for the prophylaxis of organ rejection in patients receiving SPK, PAK, and PTA are covered.
9. Complications of the transplantation procedure, including inpatient care, management of infection and rejection episodes.
10. Periodic evaluation and assessment of the successfully transplanted patient.
11. Hepatitis B and pneumococcal vaccines for patients undergoing transplantation.
12. DNA-HLA tissue typing in determining histocompatibility.
13. Transportation of the patient by air ambulance and the services of a certified life support attendant.

IV. POLICY CONSIDERATIONS

A. For beneficiaries who fail to obtain preauthorization for SPK, PAK, and PTA benefits may be extended if the services or supplies otherwise would qualify for benefits but for the failure to obtain preauthorization. If preauthorization is not received, the appropriate preauthorizing authority is responsible for reviewing the claims to determine whether the beneficiary's condition meets the clinical criteria for the SPK transplantation benefit. Charges for transplant and transplant-related services provided to TRICARE Prime enrollees who failed to obtain PCM referral and contractor authorization will be reimbursed only under Point of Service rules.

B. Benefits for SPK, PAK, or PTA transplantation will only be allowed for transplants performed at a Medicare-approved renal transplantation center.

C. Effective for admissions on or after October 1, 1999, SPK, PAK, and PTA transplantations shall be reimbursed under the assigned DRG. Claims for admissions prior to October 1, 1999, shall be reimbursed based on billed charges.

D. Claims for transportation of the donor organ and transplantation team shall be adjudicated on the basis of billed charges, but not to exceed the transport service's published

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schedule of charges, and cost-shared on an inpatient basis. Scheduled or chartered transportation may be cost-shared.

E. Charges made by the donor hospital will be cost-shared on an inpatient basis and must be fully itemized and billed by the transplantation center in the name of the TRICARE patient.

F. Acquisition and donor costs are not considered to be components of the services covered under the DRG and will be reimbursed based on billed charges. These costs must be billed separately on a standard UB-92 claim form in the name of the TRICARE patient.

G. When a properly preauthorized candidate is discharged less than 24 hours after admission because of extenuating circumstances, such as the available organ is found not suitable or other circumstances which prohibit the transplant from being timely performed, all otherwise authorized services associated with the admission shall be cost-shared on an inpatient basis, since the expectation at admission was that the patient would remain more than 24 hours.

H. SPKs, PAKs, or PTAs performed on an emergency basis in an unauthorized renal transplant facility may be cost-shared only when the following conditions have been met:

1. The unauthorized center must consult with the nearest Medicare-certified renal transplant center regarding the transplantation case; and

2. It must be determined and documented by the transplant team physician(s) at the Medicare-approved renal transplantation center that transfer of the patient (to a Medicare-approved renal transplantation center) is not medically reasonable, even though transplantation is feasible and appropriate.

V. EXCLUSIONS

A. SPKs, PAKs, and PTAs are excluded when any of the following contraindications exist:

1. Significant systemic or multisystemic disease (other than pancreatic-renal dysfunction) which limits the possibility of full recovery and may compromise the function of the newly transplanted organs.

2. Active alcohol or other substance abuse.

3. Malignancies metastasized to or extending beyond the margins of the kidney and/or pancreas.

4. Significant coronary artery disease.

B. The following are also excluded:

1. Expenses waived by the transplantation center (e.g., beneficiary/sponsor not financially liable).

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2. Services and supplies not provided in accordance with applicable program criteria (i.e., part of a grant or research program; unproven procedure).
3. Administration of an unproven immunosuppressant drug that is not FDA approved or has not received TRICARE approval as an appropriate "off-label" drug indication.
4. Pre- or post-transplantation nonmedical expenses (e.g., out-of-hospital living expenses, to include hotel, meals, privately owned vehicle for the beneficiary or family members).
5. Transportation of an organ donor.
6. Autologous islet cell transplantation (CPT² procedure code 48160) for the treatment of chronic pancreatitis. Allogeneic islet cell transplantation for the treatment of diabetes mellitus.

VI. EFFECTIVE DATES

- A. October 1, 1995, for SPK transplants.
- B. January 1, 1996, for PAK and PTA transplants.

- END -

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KIDNEY TRANSPLANTATION

ISSUE DATE: February 27, 1996

AUTHORITY: [32 CFR 199.4\(e\)\(5\)](#)

I. CPT¹ PROCEDURE CODE RANGE

50300 - 50380

II. POLICY

A. Cadaver and living donor kidney transplantation is covered when the transplant is performed at a Medicare-certified kidney transplantation center (pediatric consortia are not applicable for kidney transplantation at this time), for beneficiaries who:

1. Are suffering from concomitant, irreversible renal failure; and
2. Have exhausted more conservative medical and surgical treatment; and
3. Have plans for long-term adherence to a disciplined medical regimen that are feasible and realistic.

B. Benefits may be allowed for services and supplies during the Medicare waiting period for those beneficiaries who qualify for Medicare coverage as a result of end stage renal disease.

C. Services and supplies related to kidney transplantation are covered for:

1. Evaluation of potential candidate's suitability for kidney transplantation, whether or not the patient is ultimately accepted as a candidate for transplantation.
2. Pre- and post-transplant inpatient hospital and outpatient services.
3. Pre- and post-operative services of the transplant team.
4. The donor acquisition team, including the costs of transportation to the location of the donor organ and transportation of the team and the donated organ to the location of the transplantation center.

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5. The maintenance of the viability of the donor organ after all existing legal requirements for excision of the donor organ have been met.
6. Donor costs.
7. Blood and blood products.
8. FDA approved immunosuppression drugs to include off-label uses when reliable evidence documents that the off-label use is safe, effective and in accordance with nationally accepted standards of practice in the medical community (proven).
9. Complications of the transplant procedure, including inpatient care, management of infection and rejection episodes.
10. Periodic evaluation and assessment of the successfully transplanted patient.
11. Transportation of the patient by air ambulance and the services of a certified life support attendant.
12. DNA-HLA tissue typing determining histocompatibility.

III. POLICY CONSIDERATIONS

A. Kidney transplants are paid under the DRG.

B. For kidney transplants performed inside the Continental United States (CONUS), benefits will only be allowed for transplants performed at a Medicare approved kidney transplant center. Refer to [Chapter 11, Section 7.1](#) for organ transplant certification center requirements.

C. Acquisition and donor costs are not considered to be components of the services covered under the DRG. These costs must be billed separately on a standard UB-92 claim form in the name of the TRICARE patient.

D. The appropriate hospital standard kidney acquisition costs (live donor or cadaver) required for Medicare in every instance must be used as the acquisition cost for purposes of providing TRICARE benefits.

IV. EXCLUSIONS

Kidney transplantation is excluded as a benefit if any of the following contraindications exist:

A. Malignancies metastasized to or extending beyond the margins of the kidney.

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B. Significant systemic or multisystemic disease (because the presence of multi-organ involvement limits the possibility of full recovery and may compromise the function of the newly transplanted organs).

- END -

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 - 76083, 76086 - 76394, 76400, 76496 - 76499, 95965 - 95967

II. HCPCS PROCEDURE CODES

G0204 - G0207

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:

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.

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.

A Computerized Tomography (CT)/Computerized Axial Tomography (CAT) scan is

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interchangeably referred to as either a CT or CAT scan. This diagnostic test uses x-ray 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. Open MRI and Open MRI with contrast media are covered when medically necessary, appropriate, and the standard of care.

C. MRA is covered when medically necessary, appropriate and the standard of care. (CPT² procedure codes 70544-70549, 71555, 72159, 72198, 73225, 73725, and 74185.)

D. CT scans are covered when medically necessary, appropriate and the standard of care and all criteria stipulated in [32 CFR 199.4\(e\)](#) are met. (CPT² procedure codes 70450-70498, 71250-71275, 72125-72133, 72191-72194, 73200-73206, 73700-73706, 74150-74175, 75635, and 76355-76380.)

E. TRICARE considers three-dimensional (3D) rendering (CPT² procedure codes 76376 and 76377) medically necessary under certain circumstances ([see Chapter 5, Section 2.1](#)).

F. Helical (spiral) CT scans, with or without contrast enhancement, are covered when medically necessary, appropriate and the standard of care.

G. Chest x-rays (CPT² procedure codes 71010-71035) are covered.

H. Diagnostic mammography (CPT² procedure codes 76090-76092/HCPCS codes G0204-G0207) to further define breast abnormalities or other problems is covered.

I. Portable X-ray services are covered. The suppliers must meet the conditions of coverage of the Medicare program, set forth in the Medicare regulations, or the Medicaid program in that state in which the covered service is provided. In addition to the specific radiology services, reasonable transportation and set-up charges are covered and separately reimbursable.

J. Bone density studies (CPT² procedure codes 76070-76078) are covered for the following:

1. The diagnosis and monitoring of osteoporosis.

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2. The diagnosis and monitoring of osteopenia.

3. Patients must present with signs and symptoms of bone disease or be considered at high-risk for developing osteoporosis. High-risk factors which have been identified as the standard of care by the American College of Obstetricians and Gynecologists (ACOG) include:

a. Women who are estrogen-deficient and at clinical risk for osteoporosis.

Naturally or surgically post-menopausal women who have not been on **long-term** hormone replacement therapy (HRT). However, **current** use of HRT does not preclude estrogen deficiency.

b. Individuals who have vertebral abnormalities.

c. Individuals receiving long-term glucocorticoid (steroid) therapy.

d. Individuals with primary hyperparathyroidism.

e. Individuals with positive family history of osteoporosis.

f. Any other high-risk factor identified by ACOG as the standard of care.

V. EXCLUSIONS

A. Bone density studies for the routine screening of osteoporosis.

B. Ultrafast CT (electron beam computed tomography (HCPCS code S8092)) to predict asymptomatic heart disease is preventive.

C. MRIs (CPT³ procedure codes 76093 and 76094) to screen for breast cancer, **for diagnosis of suspicious lesions to avoid biopsy, to evaluate response to neoadjuvant chemotherapy.**

D. 3D rendering (CPT³ procedure codes 76376 and 76377) for monitoring coronary artery stenosis activity in patients with angiographically confirmed CAD is unproven.

E. 3D rendering (CPT³ procedure codes 76376 and 76377) for evaluating graft patency in individuals who have undergone revascularization procedures is unproven.

F. 3D rendering (CPT³ procedure codes 76376 and 76377) for use as a screening test for CAD in healthy individuals or in asymptomatic patients who have one or more traditional risk factors for CAD is unproven.

G. Computed tomography angiography (CPT³ procedure codes 76376 and 76377) for acute ischemic stroke is unproven.

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H. Computed tomography angiography (CPT⁴ procedure codes 76376 and 76377) for intracerebral aneurysm and subarachnoid hemorrhage is unproven.

I. Computed tomography, heart, without contrast, including image post processing and quantitative evaluation of coronary calcium (CPT⁴ procedure code 0144T) is unproven.

J. Computed tomography, heart, without contrast material followed by contrast, material(s) and further sections, including cardiac gating and 3D image post processing; cardiac structure and morphology (CPT⁴ procedure code 0145T) is unproven.

K. Computed tomographic angiography of coronary arteries (including native and anomalous coronary arteries, coronary bypass grafts) without quantitative evaluation of coronary calcium (CPT⁴ procedure code 0146T). Computed tomographic angiography of coronary arteries (including native and anomalous coronary arteries, coronary bypass grafts) with quantitative evaluative of coronary calcium (CPT⁴ procedure code 0147T) is unproven.

L. Cardiac structure and morphology and computed tomographic angiography of coronary arteries (including native and anomalous coronary arteries, coronary bypass grafts) without quantitative evaluation of coronary calcium (CPT⁴ procedure code 0148T). Cardiac structure and morphology and computed tomographic angiography of coronary arteries (including native and anomalous coronary arteries, coronary bypass grafts) with quantitative evaluative of coronary calcium (CPT⁴ procedure code 0149T) is unproven.

M. Cardiac structure and morphology in congenital heart disease (CPT⁴ procedure code 0150T). Computed tomography, heart, without contrast material followed by contrast material(s) and further sections, including cardiac gating and 3D image post processing, function evaluation (left and right ventricular function, ejection fraction and segmental wall (CPT⁴ procedure code 0152T)) is unproven.

VI. EFFECTIVE DATE

A. The effective date for MRIs with contrast media is dependent on the FDA approval of the contrast media and a determination by the contractor of whether the labeled or unlabeled use of the contrast media is medically necessary and a proven indication.

B. **March 31, 2006, for breast MRI.**

- END -

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(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.

NOTE: Pre-exposure prophylaxis for persons with a high risk of exposure to rabies is not covered.

(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.

(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 tuberculosis 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 3 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 6 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); 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 homepage (<http://www.cdc.gov>) for a current schedule of CDC recommended vaccines. The effective date of coverage for the Human Papilloma Virus (HPV) vaccine is October 13, 2006.

(b) Coverage is extended 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).

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

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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. Physical examination annually for males age 13-39 with history of cryptorchidism, orchipexy, or testicular atrophy.

b. Skin Cancer. Physical skin examination 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. Tuberculosis screening. Screening annually, regardless of age, all individuals at high risk for tuberculosis (as defined by CDC) using Mantoux tests.

b. Rubella antibodies. Females, once during age 12-18, unless documented history of adequate rubella vaccination with at least one dose of rubella vaccine on or after the first birthday.

3. Cardiovascular Disease.

a. Cholesterol. Non-fasting total blood cholesterol at least once every five years, beginning 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.

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 mammographies 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 CPT ¹ CODE
SCREENING EXAMINATIONS:		
COMPREHENSIVE HEALTH PROMOTION AND 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.	99382-99386, 99392-99396

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CLINICAL PREVENTIVE SERVICES - TRICARE PRIME

SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT CPT ¹ 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 5 through 11 that are required in connection with school enrollment. The effective date for coverage of school enrollment physicals is October 30, 2000.	99201-99205*, 99211-99214*, 99383 and 99393
	NOTE: 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 5 through 11 (CPT ¹ procedure codes 99383 and 99393).	
Breast Cancer:	Physical Examination: For women under age 40, physicians may elect to perform clinical breast examination for those who are at high risk, especially those whose first-degree relatives have had breast cancer diagnosed before menopause. For women age 40 and older, annual clinical examinations should be performed.	See appropriate level evaluation and management codes.
	Mammography: Annual screening mammograms for women over age 39; For high risk women (family history of breast cancer in a first degree relative), baseline mammogram age 35, then annually.	76083, 76092 HCPCS codes G0202, G0204, G0206
Cancer of Female Reproductive Organs:	Physical Examination: Pelvic examination should be performed in conjunction with Pap smear testing for cervical neoplasms and premalignant lesions.	See appropriate level evaluation and management codes.
	Papanicolaou 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.	88141-88155, 88164-88167, 88174, 88175, 99201-99215, or 99301-99313.
Testicular Cancer:	Physical 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.

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CLINICAL PREVENTIVE SERVICES - TRICARE PRIME

SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT CPT ¹ CODE
Cardiovascular Diseases:	Cholesterol: Non-fasting total blood cholesterol: At least once every five years, beginning age 18.	80061
	Blood pressure screening: For children: annually between 3 and 6 years of age, and every 2 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.	76999
	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.
	Vision Care: Pediatric vision screening at birth and approximately 6 months of age to include determination of vision on visual acuity, ocular alignment and red reflex, along with external examination of ocular abnormalities. Comprehensive eye examination once every 2 years for all TRICARE Prime enrollees age 3 and older. Diabetic patients, at any age, should have comprehensive eye examinations at least yearly.	92002, 92004, 92012, 92014, 92015, 99172, and 99173.
	NOTE: Comprehensive 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 comprehensive eye examinations since PCMs are incapable of providing comprehensive eye examinations; i.e., a prime beneficiary will be allowed to set up his or her own appointment for a comprehensive eye examination with either an optometrist and/or ophthalmologist.	

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CLINICAL PREVENTIVE SERVICES - TRICARE PRIME

SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT CPT ¹ CODE
Other (Continued):	Hearing screening: For children: all high risk neonates (as defined by the Joint Committee on Infant Hearing) audiology screening before leaving the hospital. If not tested at birth, high-risk children should be screened before three months of age. Evaluate hearing of all children as part of routine examinations and refer those with possible hearing impairment as appropriate.	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 6 years. Screening by blood lead level determination for all children at high risk for lead exposure per CDC guidelines.	83655
COUNSELING SERVICES:		
These are expected components of good clinical practice that are integrated into the appropriate office visit at no additional charge.	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.
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 (MMWR)</i> . Refer to the CDC's home page (http://www.cdc.gov) for current schedule of CDC recommended vaccines. The effective date of coverage for the Human Papilloma Virus (HPV) vaccine is October 13, 2006.	

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- END -

FAMILY PLANNING

ISSUE DATE: August 26, 1985

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

I. POLICY

The family planning procedures listed below may be cost-shared:

- A. Surgical insertion, removal, and replacement of intrauterine devices.
- B. Measurement for, and purchase of, contraceptive diaphragms, including remeasurement and replacement.
- C. Prescription contraceptives and prescription contraceptives used as emergency contraceptives. This includes the Preven Emergency Contraceptive Kit approved by the **Food and Drug Administration (FDA)** on September 2, 1998. This kit contains special doses of regular birth control pills and a pregnancy test that is self-administered before taking the pills. The pregnancy test is considered an integral part of the kit and the total kit is a TRICARE benefit.

NOTE: Implantable prescription contraceptives are covered if FDA approved and used for the labeled indication.

- D. Male and female surgical sterilization.

II. EXCLUSIONS

- A. Prophylactics (condoms).
- B. Spermicidal foams, jellies, and sprays not requiring a prescription.
- C. Services and supplies related to noncoital reproductive technologies, including but not limited to artificial insemination (including cost related to donors and semen banks), in-vitro fertilization and gamete intrafallopian transfer (GIFT).
- D. Male and female reversal of a surgical sterilization procedure.
- E. For routine screening **Papanicolaou (pap)** smear tests, routine gynecologic examinations, and related laboratory testing, see the Preventive Services policy.

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CHAPTER 7, SECTION 2.3

FAMILY PLANNING

F. The family planning benefit does not include screening **pap** smear tests, routine gynecologic examinations, including related laboratory testing. However, family planning benefits may be allowed during an office visit for a screening **pap** test.

- 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, 81000 - 81015, 81099, 83655, 84030, 84035, 85014, 85018, 86580, 86585, 90465 - 90468, 90471 - 90474, 90476 - 90748, 92002, 92004, 92012, 92014, 92015, 92551, 92585 - 92588, 99172, 99173, 99381 - 99383, 99391 - 99393, 99431, 99433, 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, certified nurse practitioner, or certified physician assistant. Well-child services are considered preventive and are subject to the same cost sharing/copayment and authorization requirements prescribed under the TRICARE Prime and Standard Clinical Preventive Services benefits.

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 "Preventive Care" benefit (see [Chapter 7, Section 2.1](#) and [Chapter 12, Section 2.2](#)).

C. Immunizations are covered for age appropriate dose of vaccines **that have been** recommended and adopted by **the** Advisory Committee on Immunization Practices (ACIP)

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and accepted by the Director of the Centers for Disease Control and Prevention (CDC) and the Secretary of Health and Human Services (HHS) and published in a CDC *Morbidity and Mortality Weekly Report* (MMWR). Refer to the CDC's home page (<http://www.cdc.gov>) for access to the MMWRs and a current schedule of CDC recommended vaccines.

Immunizations required by dependents of active duty military personnel who are traveling outside the United States as a result of an active duty member's duty assignment, and such travel is being performed under orders issued by a Uniformed Service, are covered.

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

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

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

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

1. History and physical examination and mental health assessment.
2. Developmental and behavioral appraisal.
 - a. Height and weight should be measured regularly throughout infancy and childhood.
 - b. Head circumference should be measured for children through 24 months of age.
 - c. Sensory screening: vision, hearing (by history).

(1) Eye and vision screening by primary care provider during routine examination at birth, and approximately **six** months of age. Comprehensive eye examination once every **two** years beginning at age **three**. The **two** comprehensive eye examinations offered between the ages of **three** and **six** should include screening for amblyopia and strabismus.

(2) All high risk neonates (as defined by the Joint Committee on Infant Hearing) should undergo audiology screening before leaving the hospital. If not tested at birth, high-risk children should be screened before three months of age. Evaluate hearing of

all children as part of routine examinations and refer those with possible hearing impairments as appropriate.

NOTE: Newborn hearing screening within the first 3 months of life and preferably before hospital discharge, using Evoked Otoacoustic Emission (EOE) and/or Auditory Brainstem Response (ABR) testing.

- d. Dental screenings.
- e. Discussion with parents, anticipatory guidance.

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

1. Immunizations are covered for age appropriate dose of vaccines that have been recommended and adopted by the ACIP and accepted by the Director of the CDC and the Secretary of HHS and published in a CDC MMWR. 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.

2. Heredity and metabolic screening:

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

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

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

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

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

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

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

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

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

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CHAPTER 7, SECTION 2.5

WELL-CHILD CARE

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

H. Well-child services are considered preventive and are subject to the same cost-sharing/copayment and authorization requirements as prescribed under TRICARE preventive services (refer to [Chapter 7, Section 2.1](#) and [Chapter 12, Section 2.2](#)).

- END -

SPECIAL OTORHINOLARYNGOLOGIC SERVICES

ISSUE DATE: April 19, 1983

AUTHORITY: 32 CFR 199.4(c)(3)(iv), (g)(45), (g)(47), and 32 CFR 199.5(c)

I. CPT¹ PROCEDURE CODES

92502 - 92512, 92516, 92520, 92526, 92551 - 92597, 92601 - 92617, 92626, 92627, 92630, 92633, 92700

II. DESCRIPTION

Otolaryngology is that branch of medicine concerned with the screening, diagnosis and management of medical and surgical disorders of the ear, the upper respiratory and upper alimentary systems and related structures and the head and neck.

Audiology is the discipline involved in the prevention, identification and the evaluation of hearing disorders, the selection and evaluation of hearing aids, and the re-habilitation of individuals with hearing impairment. Audiological services, including function tests, performed to provide medical diagnosis and treatment of the auditory system.

III. POLICY

A. Otorhinolaryngology services, including audiological services are covered for the diagnosis and treatment of a covered medical condition.

B. For services prior to September 1, 2005, hearing aid services and supplies may be cost-shared only for active duty beneficiaries through the basic program.

C. For services on or after September 1, 2005, hearing aid services and supplies may be cost-shared only for active duty family members (ADFMs) with a profound hearing loss through the TRICARE Basic Program. See Chapter 7, Section 8.2.

D. Diagnostic analysis of cochlear implant with programming is covered for patients under seven years of age (CPT¹ procedure codes 92601, 92602), and age seven years or older with programming (CPT¹ procedure codes 92603, 92604). See Chapter 4, Section 22.2.

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CHAPTER 7, SECTION 8.1

SPECIAL OTORHINOLARYNGOLOGIC SERVICES

E. Evaluation for prescription of non-speech-generating augmentative and alternative communication device, including programming and modification, may be cost-shared only for eligible beneficiaries through the **Extended Care Health Option (ECHO)** on the basis of a speech disability or of multiple disabilities, one of which involves a speech disability (CPT² procedure codes 92605 - 92609).

- END -

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III. EXCLUSIONS

A. Community and work integration training, such as listed in CPT¹ procedure code 97537 is excluded.

B. Vocational rehabilitation. Educational services intended to provide a beneficiary with the knowledge and skills required for the performance of a specific occupation, vocation, or job.

C. Coma stimulation. Activities of external stimulation intended to arouse a beneficiary from a coma.

D. Programs. Standard bundles of services (programs) as an all-inclusive priced unit or services.

NOTE: Services rendered during such a program encounter must be itemized and each reviewed to determine if rendered by an authorized individual professional provider, if it is a covered benefit, and whether it is medically necessary and appropriate.

E. A systematic, goal-oriented rehabilitation treatment program originally designed to improve cognitive functions and functional abilities to increase levels of self-management and independence following neurological damage to the central nervous system.

F. Cognitive rehabilitation services that are prescribed specifically and uniquely to teach compensatory methods to accomplish tasks which rely upon cognitive processes are unproven.

G. The use of a MIRE device for treatment of diabetic peripheral neuropathy is unproven.

H. Services provided to address disorders or conditions (e.g., speech, language, or communication) resulting from occupational or educational deficits.

- END -

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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 7, SECTION 18.2

PHYSICAL MEDICINE/THERAPY

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. Vertebral axial decompression (VAX-D) for relieving low back pain associated with herniated disc or degenerative disc disease of the lumbar vertebrae is 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 of 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.

- END -

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 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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CHAPTER 7, SECTION 18.3

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 of 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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TELEMEDICINE/TELEHEALTH

ISSUE DATE: **April 17, 2003**

AUTHORITY: **32 CFR 199.4** and **32 CFR 199.14**

I. DESCRIPTION

Telemedicine or telehealth is the use of communication technology to furnish medical information and services. Generally, two different kinds of technology are in use in telemedicine. One technology is a two-way interactive video. This technology is used, for example, when a consultation involving the patient and a specialist is necessary. The videoconferencing equipment or an interactive telecommunication system at two locations permits a “real-time” or “live” service or consultation to take place.

The other technology, called “store and forward,” is used to transfer video images from one location to another. A camera or similar device records (stores) an image(s) that is then sent (forwarded) via telecommunications media to another location for later viewing. The sending of x-rays, computed tomography scans, or magnetic resonance images are common store-and forward applications. The original image may be recorded and/or forwarded in digital or analog format and may include video “clips” such as ultrasound examinations, where the series of images that are sent may show full motion when reviewed at the receiving location.

NOTE: “Interactive telecommunication systems” is defined as multimedia communications equipment that includes, at a minimum, audio-video equipment permitting two-way, real time service or consultation involving the patient and practitioner as appropriate to the medical needs of the patient. Telephones, facsimile machines, and electronic mail systems do not meet the definition of interactive telecommunications systems. Services or advice rendered by telephone are specifically excluded from TRICARE coverage as provided in **32 CFR 199.4(g)(52)**.

II. POLICY

A. Coverage for Telehealth.

1. Requirements, criteria, and limitations applicable to medical and psychological services shall also apply to services involving telehealth.

2. Authorized providers rendering telehealth services are required to be practicing within the scope and jurisdiction of their license or certification.

TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 7, SECTION 22.1

TELEMEDICINE/TELEHEALTH

3. Scope of Coverage. The use of interactive audio/video technology may substitute for a face-to-face, "hands on" encounter for consultation, office visits, individual psychotherapy, psychiatric diagnostic interview examination, and pharmacologic management when appropriate and medically necessary. These services and corresponding Current Procedure Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes are listed below:

- Consultations (CPT¹ procedure codes 99241 - 99275) (Effective August 1, 2003 - December 31, 2005)
- Consultations (CPT¹ procedure codes 99241 - 99255) (Effective January 1, 2006)
- Office or other outpatient visits (CPT¹ procedure codes 99201 - 99215)
- Individual psychotherapy (CPT¹ procedure codes 90804 - 90809)
- Psychiatric diagnostic interview examination (CPT¹ procedure code 90801)
- Pharmacologic management (CPT¹ procedure code 90862)
- End Stage Renal Diseases related services (HCPCS codes G0308, G0309, G0311, G0312, G0314, G0315, G0317, and G0318) (Effective January 1, 2005)
- Individual Medical Nutrition Therapy (HCPCS codes G0270, CPT¹ procedure codes 97802 and 97803) (Effective January 1, 2006)

4. Conditions of Payment.

a. Technology. For TRICARE payment to occur, interactive audio and video telecommunications must be used, permitting real-time communication between the distant site physician or practitioner and the TRICARE beneficiary. As a condition of payment, the patient must be present and participating in the telehealth visit.

NOTE: A telehealth service originating from a patient's home is not covered.

b. Telepresenters. A medical professional is not required to present the beneficiary to physician or practitioner at the distant site unless medically necessary. The decision of medical necessity will be made by the physician or practitioner located at the distant site.

5. "Store and Forward" Technology. TRICARE allows payment for those telemedicine applications (such as teleradiology or telepathology) in which, under conventional health care delivery, the medical service does not require face-to-face "hands-on" contact between patient and physician. For example, TRICARE permits coverage of teleradiology, which is the most widely used and reimbursed form of telemedicine, as well as physician interpretation of electrocardiogram and electroencephalogram readings that are transmitted electronically.

B. Reimbursement For Telehealth

1. Payment for Physician/Practitioner at the Distant Site. The term "distant site" means the site where the physician or practitioner, providing the professional service, is located at the time the service is provided via a telecommunication system. The payment

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amount for the professional service provided via a telecommunication system by the physician or practitioner at the distant site is equal to the CHAMPUS Maximum Allowable Charge (CMAC) for the service provided. Payment for an office visit, consultation, individual psychotherapy or pharmacologic management via a telecommunications system should be made at the same amount as when these services are furnished without the use of a telecommunications system. For TRICARE payment to occur, the service must be within a practitioner's scope of practice under State law. The beneficiary is responsible for any applicable copay or cost sharing.

2. Payment for Originating Site Facility. The term originating site means the location of an eligible TRICARE beneficiary at the time the service being furnished via a telecommunications system occurs. For covered telehealth services delivered via a telecommunications system, the payment for the originating site facility fee will be the lesser of the originating site fee or the actual charge. The facility fee for the originating site is provided in [Figure 7-22.1-1](#). It will be updated annually by the Medicare Economic Index. Beginning with the 2006 update, the originating site facility fee (Q3014) annual updates will be included in the annual updates of the CMAC file and TRICARE contractors will implement these updates in accordance with the annual CMAC updates. Outpatient cost-share rules will apply to this fee.

3. For reporting telehealth services, contractors will use CPT or HCPCS codes with a GT modifier for distant site and Q3014 for originating site to distinguish telehealth services.

III. EFFECTIVE DATE August 1, 2003.

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FIGURE 7-22.1-1 TELEHEALTH ORIGINATING SITE FACILITY FEE

PERIOD	MEI INCREASE	FACILITY FEE
10/01/2001 - 12/31/2002	N/A	\$20.00
01/01/2003 - 12/31/2003	3.0%	\$20.60
01/01/2004 - 12/31/2004	2.9%	\$21.20
01/01/2005 - 02/28/2006	3.1%	\$21.86
2006	2.8%	\$22.47
2007	2.1%	\$22.94

NOTE: Beginning with the 2006 update, the telehealth originating site facility fee (Q3014) annual updates will be included in the annual updates of the CMAC file and TRICARE contractors will implement these updates in accordance with the annual CMAC updates. See [paragraph II.B.2.](#)

- END -

OTHER SERVICES

SECTION	SUBJECT
1.1	Ambulance Service
2.1	Durable Medical Equipment: Basic Program
2.2	Infantile Apnea Cardiorespiratory Monitor
2.3	Implantable Infusion Pump
2.4	Cold Therapy Devices For Home Use
2.5	Home Prothrombin Time (PT) International Normalized Ratio (INR) Monitor
2.6	Breast Pumps
3.1	Orthotics
4.1	Prosthetic Devices And Supplies
5.1	Medical Devices
5.2	Neuromuscular Electrical Stimulation (NMES) Devices
6.1	Medical Supplies And Dressings (Consumables)
7.1	Nutritional Therapy
7.2	Liquid Protein Diets
8.1	Diabetes Outpatient Self-Management Training Services
8.2	Therapeutic Shoes For Diabetics
9.1	Pharmacy Benefits Program
10.1	Oxygen And Oxygen Supplies
11.1	Podiatry
12.1	Wigs Or Hairpiece
13.1	Adjunctive Dental Care
13.2	Dental Anesthesia And Institutional Benefit
14.1	Physician-Assisted Suicide
15.1	Custodial Care Transitional Policy (CCTP)
16.1	Mucus Clearance Devices
17.1	Lymphedema

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, MTF, or VA 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.

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

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AMBULANCE SERVICE

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.

- END -

MEDICAL DEVICES

ISSUE DATE: December 18, 1992

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

I. DESCRIPTION

A. Section 201(h) of the Food, Drug and Cosmetic Act defines medical devices as an instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar or related article, including a component part, or accessory which is:

1. Recognized in the official National Formulary, or the United States Pharmacopoeia, or any supplement to them,
2. Intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation, treatment, or prevention of disease, in man or other animals, or
3. Intended to affect the structure of any function of the body of man or other animals, and which does not achieve any of its primary intended purposes through chemical action within or on the body of man or other animals and which is not dependent upon being metabolized for the achievement of any of its primary intended purposes.

B. Devices which meet this definition are regulated by the Food and Drug Administration (FDA) and are subject to premarketing and postmarketing regulatory controls. (For further information see the FDA's web site: <http://www.fda.gov>.)

II. POLICY

A. Medical devices may be covered when medically necessary, appropriate, the standard of care, and not otherwise excluded.

B. Medical devices must be FDA approved. Not all FDA-approved devices are covered. Coverage of a medical device is subject to all other requirements of the law, rules, and policy governing TRICARE. If the device is used for a noncovered or excluded indication, benefits may not be allowed. For example, tinnitus masker is an FDA-approved device; however, TRICARE considers this device unproven and, therefore, not a benefit.

C. A humanitarian use device approved for marketing through a Humanitarian Device Exemption application may be covered. Coverage of any such device is subject to all other requirements of the law, rules, and policy governing TRICARE.

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MEDICAL DEVICES

D. TRICARE will consider for coverage a device with an FDA-approved Investigational Device Exemption (IDE) categorized by the FDA as non-experimental/investigational (FDA Category B) for beneficiaries participating in FDA-approved clinical trials. Coverage of any such Category B device is dependent on its meeting all other requirements of the law, rules, and policy governing TRICARE and upon the beneficiary involved meeting FDA-approved IDE study protocols.

E. Devices with a FDA-approved IDE categorized by the FDA as non-experimental/investigational (FDA Category B), which was the subject of an FDA approved clinical trial(s), may be considered for coverage once it receives FDA approval for commercial marketing. Coverage is dependent on the device meeting the FDA requirements/conditions of approval and all other requirements governing TRICARE.

III. EXCLUSIONS

A. Experimental/Investigational (Category A) IDEs.

B. Off-label **uses of devices**.

IV. EFFECTIVE DATE

A. Device used for an FDA-approved application - Effective date is the date of the FDA approval.

B. Category B IDEs - Effective date is the date the device is classified as a Category B device by the FDA.

- END -

CHAPTER 8
SECTION 8.1

DIABETES OUTPATIENT SELF-MANAGEMENT TRAINING SERVICES

ISSUE DATE:

AUTHORITY: [32 CFR 199.4](#)

I. HCPCS PROCEDURE CODES

G0108 - Diabetes outpatient self-management training services, individual session per 30 minutes of training.

G0109 - Diabetes outpatient self-management training services, group session, per individual, per 30 minutes of training.

II. DESCRIPTION

A diabetes outpatient self-management and training service is a program that educates beneficiaries in the successful self-management of diabetes. The training program includes all three of the following criteria: education about self-monitoring of blood glucose, diet, and exercise; an insulin treatment plan developed specifically for the patient who is insulin-dependent; and motivates patients to use the skills for self-management.

III. POLICY

A. Outpatient diabetes self-management and training programs are covered when the services are provided by:

1. An otherwise authorized individual professional provider who also meets the National Standards for Diabetes Self-Management Education programs recognized by the American Diabetes Association (ADA); or

2. An otherwise authorized TRICARE provider who is Medicare certified to provide diabetes outpatient self-management training services.

B. The following medical conditions, as well as any other medical condition in which diabetes self management training is medically necessary, would be eligible for coverage for training services.

1. New onset diabetes.

2. Poor glycemic control as evidenced by a glycosylated hemoglobin (HbA1C) or 9.5 or more in the 90 days before attending the training.

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DIABETES OUTPATIENT SELF-MANAGEMENT TRAINING SERVICES

3. A change in the treatment regimen from no diabetes medications to any diabetes medication, or from oral diabetes medication to insulin.

4. High risk for complications based on poor glycemic control; documented episodes of severe hypoglycemia or acute severe hypoglycemia occurring in the past year during which the beneficiary needed third party assistance for either emergency room visits or hospitalization.

5. High risk based on at least one of the following documented complications:

a. Lack of feeling in the foot or other foot complications such as foot ulcer or amputation.

b. Pre-proliferative or proliferative retinopathy or prior laser treatment of the eye.

c. Kidney complications related to diabetes, such as macroalbuminuria or elevated creatinine.

C. Benefits are cost-shared only for services related to the beneficiary. Therefore, we would encourage caregivers to attend the training with the beneficiary.

D. Providers should bill for their professional services using HCPCS code G0108 and G0109. When billing for these codes the provider must provide a copy of his/her "Certificate of Recognition" from the American Diabetes Association. Pricing of these Level II HCPCS codes will be under the allowable charge methodology per the TRICARE Reimbursement Manual. Once sufficient data is collected, the contractors, as part of the CMAC annual update, will be provided pricing information for these codes.

IV. EFFECTIVE DATE **July 1, 1998.**

- END -

THERAPEUTIC SHOES FOR DIABETICS

ISSUE DATE: February 27, 1996

AUTHORITY: [32 CFR 199.2](#) and [32 CFR 199.4](#)

I. HCPCS PROCEDURE CODES

A5500 - A5513

II. POLICY

Coverage of extra-depth shoes with inserts or custom molded shoes with inserts for individuals with diabetes.

III. COVERAGE LIMITATION

A. For each individual, coverage of the footwear and inserts is limited to one of the following within one calendar year:

1. One pair of custom molded shoes (including inserts provided with such shoes) and two pairs of multidensity inserts, or

2. One pair of extra-depth shoes (not including inserts provided with such shoes) and three pairs of multidensity inserts.

3. Modification of custom-molded or extra-depth shoes may be substituted for one pair of inserts, other than the initial pair of inserts. The most common modifications available are:

- a. Rigid rocker bottoms
- b. Roller bottoms
- c. Metatarsal bars
- d. Wedges
- e. Offset heels

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THERAPEUTIC SHOES FOR DIABETICS

- B. The physician who is managing the beneficiary's systemic diabetic condition must:
1. Document that the patient has diabetes
 2. Document that the patient has one or more of the following conditions:
 - a. Previous amputation of the foot or part of the foot
 - b. History of previous foot ulceration
 - c. Pre-ulcerative callus formation, or peripheral neuropathy with a history of callus formation, foot deformity, or poor circulation; and
 - d. Certify that the patient is being treated under a comprehensive plan of care for his diabetes and needs therapeutic shoes.

IV. EFFECTIVE DATE May 1, 1993.

- END -

MUCUS CLEARANCE DEVICES

ISSUE DATE: June 5, 1995

AUTHORITY: [32 CFR 199.4](#)

I. HCPCS PROCEDURE CODES

A7025, A7026, E0480, E0482 - E0484, S8185

II. DESCRIPTION

A. Mucus clearance devices are designed to clear mucus secretions from the lungs of patients with mucociliary clearance impairment.

B. Some mucus clearance devices resemble a combination of a smoker's pipe and a referee's whistle. It consists of a hardened plastic mouthpiece at one end, a plastic perforated cover at the opposite end, and a valve on the inside created by a high-density stainless steel ball resting in a plastic circular cone.

C. Other bronchial drainage systems include an air oscillator and an inflatable vest and uses high-frequency chest wall oscillations, which also clear mucus from the airway wall. This type of system is a mechanical form of chest physiotherapy (CPT) used as an alternative to conventional CPT in patients with cystic fibrosis.

III. POLICY

A. Reimbursement of the mucus clearance device includes Cystic Fibrosis (CF), Chronic Obstructive Pulmonary Disease (COPD) (which encompasses both chronic bronchitis and emphysema), and other mucus producing lung diseases.

B. The mucus clearance device used must be Food and Drug Administration (FDA) approved. Coverage can only begin effective the date of FDA approval.

- END -

LYMPHEDEMA

ISSUE DATE: September 12, 1986

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

I. HCPCS PROCEDURE CODES

Level II Codes E0650-E0673

II. DESCRIPTION

Lymphedema refers to edema from accumulation of lymph secondary to obstruction to its flow.

III. POLICY

A. Lymphovenous anastomosis by open surgical correction is a covered benefit.

B. Lymphedema pumps, both segmental and non-segmental, are authorized durable medical equipment for both institutional and home use.

IV. POLICY CONSIDERATIONS

A physician's prescription is required for all claims for the segmental type pumps with or without a calibrated pressure gradient.

V. EXCEPTIONS

Lymphovenous anastomosis by use of a special needle for insertion of lymphatic vessels directly into the veins is not a covered benefit.

- END -

OTHER ECHO BENEFITS

ISSUE DATE: July 3, 1997

AUTHORITY: 32 CFR 199.5(c)(8)

I. CPT¹ PROCEDURE CODE

99199

II. HCPCS PROCEDURE CODE

T1013

III. POLICY

A. Assistive services. Subject to all applicable requirements, TRICARE may cost-share the services of a qualified interpreter or translator for **Extended Care Health Option (ECHO)** beneficiaries who are deaf and/or mute, readers for ECHO beneficiaries who are blind, and personal assistants for ECHO beneficiaries with other types of qualifying conditions, when such services are necessary to the rendering or delivery of an authorized ECHO service or item.

B. Equipment adaptation. Subject to all applicable requirements, TRICARE may cost-share such services and structural modification to the equipment as necessary to make the equipment serviceable for a particular disability.

C. Equipment maintenance. Reasonable repairs and maintenance for that portion of the useful life of beneficiary owned equipment that was cost-shared through the ECHO (or its predecessor, the PFPWD) and is concurrent with the beneficiary's ECHO eligibility may be cost-shared as an ECHO benefit subject to all applicable requirements.

IV. EXCLUSION

Services available under the TRICARE Basic Program are not eligible to be cost-shared under the ECHO.

V. EFFECTIVE DATE September 1, 2005.

- END -

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TRANSITIONAL SURVIVOR STATUS AND SURVIVOR STATUS

ISSUE DATE: September 28, 2006

AUTHORITY: [32 CFR 199.3](#), Public Law 109-163

I. DESCRIPTION

A. Eligible surviving family members whose sponsor died while on active duty for a period of more than 30 days may continue their TRICARE eligibility and their status is reflected as either Transitional Survivor or Survivor.

B. Transitional Survivor and Survivor are terms used to reflect the status of certain otherwise eligible TRICARE beneficiaries. The status determines the appropriate payment rate and benefit level used in claims processing. Transitional Survivor status reflects active duty family member (ADFM) payment rates and provisions. Survivor status reflects retiree payment rates.

C. TRICARE Eligibility rules have priority over the rules that apply to those in Transitional Survivor or Survivor status.

II. BACKGROUND

A. Family members of **active duty service members (ADSMs)** who died while on active duty have always been eligible for TRICARE; however, their payment rates/cost-sharing provisions have changed over time. Initially, their cost-sharing provisions were at the retiree payment rate for all care received.

B. Section 707(c) of the National Defense Authorization Act for Fiscal Year 1995 (NDAA FY 1995), Public Law 103-337 provided for two changes.

1. For dependents of active duty members who died while on active duty between January 1, 1993 and October 1, 1993, only care for pre-existing conditions was cost-shared at the active duty dependent payment rate.

2. Effective October 1, 1993, active duty dependent payment rate was limited to a one-year period.

C. Section 704 of the Floyd D. Spence NDAA FY 2001 created a three year period, beginning with the date of death, for health care to be cost shared at the active duty dependent payment rate. After three years, survivors remained eligible for TRICARE, but at the retiree payment rate. This provision was effective October 30, 2000.

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TRANSITIONAL SURVIVOR STATUS AND SURVIVOR STATUS

III. POLICY

A. Effective with respect to deaths occurring on or after October 7, 2001, Section 715 of the NDAA FY 2006, Public Law 109-163, extended the time frame that certain eligible dependents (children and unmarried persons) remain in Transitional Survivor status. See [paragraph III.B.](#)

B. Time Frames for Transitional Survivor Status.

1. Spouse. Transitional Survivor status is retained for three years from the date of death of the sponsor. After three years, the surviving spouse converts to Survivor status and TRICARE benefits may continue at retiree payment rates and rules.

2. Children and Unmarried Persons (those defined in 10 U.S.C. 1072(2)(D) or (I)) whose sponsor died on or after October 7, 2001. Transitional survivor status ends at age 21 or 23 if enrolled in a full-time course of study in a secondary school or in a full-time course of study in an institution of higher education (subject to the eligibility limitations as described in the NOTE below).

3. Incapacitated Children and Incapacitated Unmarried Persons (those defined in 10 U.S.C. 1072(2)(D) or (I)) whose sponsor died on or after October 7, 2001. Transitional Survivor status (subject to the eligibility limitations as described in the NOTE below) is the greater of:

- a. Three years from the sponsor's date of death, **OR**
- b. The date on which such dependent attains 21 years of age, **OR**
- c. The date on which the dependent attains 23 years of age if enrolled in a full-time course of study in a secondary school or in a full-time course of study in an institution of higher education.

NOTE: A status of Transitional Survivor or Survivor status does not impact eligibility rules. Loss of eligibility as a result of any condition which routinely results in loss of TRICARE eligibility such as reaching age limits, marriage, remarriage, etc. also results in loss of Transitional Survivor/Survivor status. Individuals are considered to be eligible for TRICARE if they are shown as eligible on the Defense Enrollment Eligibility Reporting System (DEERS). The DEERS record will indicate the dates of eligibility and the status.

C. Actions necessary due to Section 715 of the NDAA FY 2006.

1. Status Conversion. Dependent children whose sponsor's death occurred on or after October 7, 2001, and who, upon implementation of this policy are:

- a. In Transitional Survivor status shall remain in Transitional Survivor status in accordance with time frames found in [paragraph III.B.](#) above. The Transitional Survivor's Health Care Plan (e.g., Prime, Standard, etc.) shall continue until such time it is changed by the beneficiary.

CERTIFICATION OF ORGAN TRANSPLANT CENTERS

ISSUE DATE: June 20, 1988

AUTHORITY: 32 CFR 199.6(b)(4)(ii) and (b)(4)(iii)

I. POLICY

A. Certifying Authority. The TRICARE contractor is the certifying authority for applications for status as a TRICARE-authorized institutional provider for liver, heart, combined heart-kidney, combination liver-kidney, lung, heart-lung, and small intestine within its region. Medicare is the approving authority for kidney transplant centers.

B. General Certification Requirements. To obtain TRICARE certification as an organ transplant center, the center must have:

1. An active solid organ transplantation program.
2. Participation in a donor organ procurement program and network.
3. An interdisciplinary body to determine the suitability of candidates for transplantation on an equitable basis.
4. An anesthesia team that is available at all time.
5. A nursing service team trained in the hemodynamic support of the patient and in managing immunosuppressed patients.
6. Pathology and immunology resources that are available for studying and reporting the pathological responses to transplantation.
7. Evidence that the center safeguards the rights and privacy of patients.
8. Continual compliance with state transplantation laws and regulations, if any.
9. Legal counsel familiar with transplantation laws and regulations.

C. The continued compliance of a certified transplantation center must be verified by the contractor no less than every 24 months.

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CERTIFICATION OF ORGAN TRANSPLANT CENTERS

D. Reporting Requirements. The transplant center must report to the TRICARE certifying authority any decrease in actuarial survival rates below the actuarial survival rate established by TRICARE for initial facility certification.

E. Liver Transplantation Centers. TRICARE shall provide coverage for liver transplantation procedures performed only by experienced transplant surgeons at centers complying with the provisions outlined in [paragraph I.B.](#) and the following criteria or status as a TRICARE-certified liver transplantation center may be granted based upon Medicare certification as a liver transplant center.

1. The transplant center must:

a. Have staff board eligible or board certified physicians and other experts in the fields of hepatology, pediatrics, infectious disease, nephrology with dialysis capability, pulmonary medicine with respiratory therapy support, pathology, immunology, and anesthesiology to complement a qualified transplantation team.

b. Have a transplant surgeon who is specifically trained for liver grafting and who can assemble and train a team to function successfully whenever a donor liver is available.

c. Have at least a 50% one year actuarial survival rate for 10 cases as calculated using the Kaplan-Meier product limit method. A 50% one-year actuarial survival rate for all subsequent liver transplantations must be maintained for continued TRICARE approval.

F. Heart Transplantation Centers. TRICARE shall provide coverage for heart transplantation procedures performed only by experienced transplant surgeons at centers complying with provisions outlined in [paragraph I.B.](#) and the following criteria or status as a TRICARE-certified heart transplantation center may be granted based upon Medicare certification as a heart transplantation center.

1. The transplant center must:

a. Have experts in the fields of cardiology, cardiovascular surgery, anesthesiology, immunology, infectious disease, nursing, social services, and organ procurement to complement the transplant team.

b. Have an active cardiovascular medical and surgical program as evidenced by a minimum of 500 cardiac catheterizations and coronary arteriograms and 250 open heart procedures per year.

c. Have an established heart transplantation program with documented evidence of 12 or more heart transplants in each of the three consecutive preceding 12-month periods prior to the date of application (a total of 36 or more heart transplantation procedures).

d. Demonstrate actuarial survival rates of 73% for one year and 65% for two years for patients who have had heart transplants since January 1, 1982 at that facility. The Kaplan-Meier product limit method shall be used to calculate actuarial survival.

2. TRICARE approval will lapse if either the number of heart transplants falls below **eight** in 12 months or if the one-year actuarial survival rate falls below 60% for a consecutive 24-month period.

G. Lung Transplantation. TRICARE shall provide coverage for lung transplantation procedures performed only by experienced transplant surgeons at centers complying with the provisions outlined in [paragraph I.B.](#) and the following criteria or status as a TRICARE-certified lung transplantation center may be granted based upon Medicare certification as a lung transplantation center.

1. The center must have:

a. Experts in the fields of cardiology, cardiovascular surgery, pulmonary disease, anesthesiology, immunology, infectious disease, nursing, social services, and organ procurement to complement the transplant team.

b. Performed lung (single and/or double) transplantation in at least 10 patients within the 12 months prior to application and in at least an additional 10 patients prior thereto.

c. Demonstrated Kaplan-Meier actuarial survival rates of no less than 65% at one-year post-transplantation for patients who have undergone lung transplantation at the center since January 1, 1987.

H. Heart-Lung and Lung Transplantation. TRICARE shall provide coverage for heart-lung transplantation procedures performed only by experienced transplant surgeons at centers complying with the provisions outlined in [paragraph I.B.](#) and meeting either the heart or lung transplantation criteria or performed in a Medicare-certified heart, lung or heart-lung transplant center.

I. Small Intestine (SI), Combined Small Intestine-Liver (SI/L), and Multivisceral Transplantation.

1. TRICARE shall provide coverage for SI, SI/L, and multivisceral transplantation procedures performed only by experienced transplant surgeons at centers complying with the provisions outlined in [paragraph I.B.](#) and meeting the following criterion or status as a TRICARE-certified transplant center may be granted based upon Medicare certification as a small intestine transplant center:

2. Perform 10 SI, SI/L, or multivisceral transplants with a documented Kaplan-Meier actuarial survival rate of no less than 65% at one-year.

J. Simultaneous Pancreas-Kidney (SPK), Pancreas-Transplant-Alone (PTA), and Pancreas-After-Kidney (PAK) Transplantation. TRICARE shall provide coverage for **SPK** transplantation, **PTA**, and **PAK transplantation** procedures performed only by experienced transplant surgeons at Medicare-approved renal transplant centers.

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CERTIFICATION OF ORGAN TRANSPLANT CENTERS

K. Combined Liver-Kidney Transplantation (CLKT). If the facility is certified as a TRICARE (or Medicare) certified liver transplant center, the facility may be considered to be a certified center to perform **CLKTs**.

L. Kidney Transplantation. Kidney transplants must be performed at a Medicare-approved transplant center.

M. Combined Heart-Kidney Transplantation (CHKT). **CHKTs** must be performed at a center certified by TRICARE or Medicare for heart transplantation and Medicare-approved for renal transplantation.

N. Organ Transplant Consortia. TRICARE shall approve individual pediatric organ transplant centers which meet the General Certification Requirements outlined in [paragraph B.](#), and would otherwise qualify as a TRICARE-certified transplantation center by using the combined experience and survival date of a consortium of which a single transplant team rotates among member hospitals for purposes of meeting the certification requirements outlined in [paragraphs E.](#) through [M.](#), for heart, heart-lung, **lung**, liver, liver-kidney, heart-kidney, small intestine, small intestine-liver, **and** multivisceral when:

1. The consortium hospitals are under common control or have a formal affiliation arrangement with each other under the auspices of an organization such as a university or a legally-constituted medical research institute;

2. The consortium hospitals share resources by using the same personnel or services in their transplant programs. The individual physician members of the transplant team practice in all of the hospitals;

3. The same organ procurement organization, immunology, and tissue typing services are used by all the hospitals; and

4. The hospital submits its individual and combined experience and survival data to the TRICARE authorizing authority; and

5. If one of the hospitals is a pediatric transplant program, in addition to the requirements previously listed the following apply:

a. Although pediatric surgeons and pathologists are not required to practice the adult hospital and vice versa, it can be documented that they otherwise function as members of the transplant team.

b. The facility must have other solid organ transplant program(s) that meet TRICARE criteria for certification based on actuarial survival rates and experience.

c. The surgeon responsible for the transplant is commonly involved in the type of surgery (i.e., related to hepatology, cardiology and pulmonary medicine) with children of the age and size in whom the transplant is being performed; and

d. If the program involves heart transplant, the facility must have an active pediatric cardiovascular medical and surgical program with a minimum of 150 cardiac

catheterizations performed per year on patients in the pediatric range. A surgical case load of 200 operations per year should be performed in combined adult and pediatric programs: of these, at least 100 operations per year (three of four should use extracorporeal circulation) should be on pediatric patients. In programs serving only a pediatric population, at least 100 cardiac procedures (three of four should use extracorporeal circulation) should be performed per year.

○ Calculation of Survival Rates for Transplantation. Each facility seeking TRICARE certification as a transplantation center must calculate survival rates using the Kaplan-Meier (product-limit) technique utilizing the definitions and rules below. Each applicant facility must identify its Kaplan-Meier actuarial survival percentage at one year. Each applicant facility must also submit calculations to support the reported survival percentage.

1. Each applicant facility will report all transplantation experience from its inception at the facility.

2. TRICARE recognizes the team experience gained in retransplantation. Therefore, retransplantation experience must be reported and calculated in the same manner as first transplantation experience.

3. All experience and survival rates must be reported as of a point in time that is no more than 90 days prior to the submission of the application for TRICARE certification. That date is referred to as the fiducial date.

4. Calculations assume survival only to (and censoring on) the date of last ascertained survival.

5. Patients who are not thought to be dead are considered "lost to follow-up" if they were:

a. Operated more than 120 days before the fiducial date, but have no ascertained survival within 60 days of the fiducial date; or

b. Operated from 61 to 120 days before the fiducial date, but ascertained survival is less than 60 days from date of transplant; or

c. Operated within 60 days of the fiducial date, but not ascertained to have survived as of the fiducial date.

6. Survival must be calculated with the assumption that each patient in the "lost to follow-up" category died on or one day after the date of last ascertained survival.

7. Clearly defined and well justified secondary or alternate treatment of "lost to follow-up" may also be submitted, but primary attention will be given to the results using definitions and procedures specified above.

8. These specified definitions and procedures use a simpler format but are identical to those published by CMS (Federal Register, Volume 52, Number 85; April 6, 1987; pages 10947-8).

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CHAPTER 11, SECTION 7.1

CERTIFICATION OF ORGAN TRANSPLANT CENTERS

9. Facilities seeking certification for lung and/or heart-lung transplantation must report all lung and heart-lung transplantation experience. When facility experience is reported and the actuarial survival is calculated, lung and heart-lung transplantation experience must be combined to arrive at a single one-year survival percentage.

P. Revocation of Provider Status. In the event a transplant center's certified provider status is revoked, the certifying authority shall provide a copy of the initial determination terminating the provider to:

1. The transplant center affected.
2. The Regional Director of the TRICARE region.
3. The TRICARE Management Activity-Aurora (TMA-A), Program Integrity Branch.

Q. Patient Selection. The patient must meet the requirements criteria for the applicable transplant as outlined in each individual transplant policy.

II. EXCLUSIONS

Facility certification is not required for transplants other than those listed in [paragraph I.A.](#)

III. EFFECTIVE DATE

For those centers meeting the certification requirements, approval is effective on the date the application is signed by the applicant or the date the contractor determines that the facility met TRICARE certification requirements.

- END -

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FIGURE 12-12.2-14 TGRO DMIS-ID BY REGION

TRICARE EUROPE			TRICARE EUROPE		
DMIS -ID	COUNTRY	FACILITY CITY	DMIS -ID	COUNTRY	FACILITY CITY
6720	Austria	Vienna	6721	Belarus	Minsk
6720	Belgium	Klein-Brogel	6721	Bosnia	Sarajevo
6720	Denmark	Copenhagen	6721	Bulgaria	Sofia
6720	France	Istress	6721	Croatia	Zagreb
6720	France	Paris	6721	Cyprus	Nicosia
6720	Germany	Berlin	6721	Czech Republic	Brno
6720	Germany	Bonn	6721	Czech Republic	Prague
6720	Germany	Bremerhaven	6721	Estonia	Tallinn
6720	Germany	Flensburg	6721	Finland	Helsinki
6720	Germany	Garmisch-Partenkirchen	6721	Georgia	Tbilisi
6720	Germany	Kalkar	6721	Greece	Athens
6720	Germany	Muenster	6721	Greece	Larissa
6720	Germany	Munich	6721	Hungary	Budapest
6720	Germany	Pfullendorf	6721	Israel	Jerusalem
6720	Germany	Ulm	6721	Israel	Tel Aviv
6720	Ireland	Dublin	6721	Latvia	Riga
6720	Italy	Ghedi	6721	Lithuania	Vilnius
6720	Italy	Latina	6721	Macedonia	Skopje
6720	Italy	Milan	6721	Moldova	Chisinau
6720	Italy	Poggio Renatico	6721	Poland	Warsaw
6720	Italy	Rome	6721	Romania	Bucharest
6720	Italy	Solbiate	6721	Russia	Moscow
6720	Italy	Taranto	6721	Russia	St Petersburg
6720	Luxembourg	Luxembourg	6721	Russia	Vladivostok
6720	Malta	Valletta	6721	Serbia-Montenegro	Belgrade
6720	Norway	Oslo	6721	Slovakia	Bratislava
6720	Norway	Stavanger	6721	Slovenia	Ljubljana
6720	Portugal	Lisbon	6721	Turkey	Ankara
6720	Spain	Madrid	6721	Turkey	Istanbul
6720	Spain	Moron	6721	Turkey	Izmir
6720	Spain	Valencia	6721	Ukraine	Kiev
6720	Sweden	Stockholm	6722	Algeria	Algiers
6720	Switzerland	Bern	6722	Chad	N'Djamena
6720	Switzerland	Chambessy	6722	Ivory Coast	Abidijan
6720	Switzerland	Geneva	6722	Ghana	Accra
6720	Netherlands	Rotterdam	6722	Guinea	Conakry
6720	Netherlands	The Hague	6722	Liberia	Monrovia
6720	Netherlands	Vokel	6722	Mali	Bamako
6720	United Kingdom	Cheltenham	6722	Morocco	Rabat
6720	United Kingdom	Digby	6722	Nigeria	Lagos
6720	United Kingdom	Portsmouth	6722	Niger	Niamey
6720	United Kingdom	Yeovilton	6722	Senegal	Dakar
6721	Albania	Tirana	6722	Togo	Lome'
6721	Armenia	Yerevan	6722	Tunisia	Tunis
6721	Azerbaijan	Baku	6723	Angola	Luanda
			6723	Botswana	Gaborone

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FIGURE 12-12.2-14 TGRO DMIS-ID BY REGION (CONTINUED)

TRICARE EUROPE		
DMIS -ID	COUNTRY	FACILITY CITY
6723	Burundi	Bujumbura
6723	Cameroon	Yaounde
6723	Congo	Kinshasa
6723	Gabon	Libreville
6723	Mozambique	Maputo
6723	Namibia	Windhoek
6723	Rwanda	Kigali
6723	South Africa	Cape Town
6723	South Africa	Johannesburg
6723	South Africa	Pretoria
6723	Tanzania	Dar Es Salaam
6723	Uganda	Kampala
6723	Zambia	Lusaka
6723	Zimbabwe	Harare
6724	Djibouti	Djibouti
6724	Egypt	Cairo
6724	Egypt	Ismail
6724	Egypt	Maadi
6724	Egypt	Namru
6724	Egypt	New Maadi
6724	Eritrea	Asmara
6724	Ethiopia	Addis Adaba
6724	Jordan	Amman
6724	Kazakhstan	Almaty
6724	Kenya	Nairobi
6724	Kuwait	Kuwait City (Al Kuwayt)
6724	Kyrgyzstan	Bishkek
6724	Lebanon	Beirut
6724	Oman	Muscat
6724	Pakistan	Islamabad
6724	Pakistan	Karachi
6724	Qatar	Doha
6724	Saudi Arabia	Dhahran
6724	Saudi Arabia	Al Kharj
6724	Saudi Arabia	Hofuf
6724	Saudi Arabia	Jubail
6724	Saudi Arabia	Khamis
6724	Saudi Arabia	Tabuk
6724	Saudi Arabia	Taif
6724	Saudi Arabia	Jeddah
6724	Saudi Arabia	Riyadh
6724	Syria	Damascus
6724	Tajikistan	Dushanbe
6724	Turkmenistan	Ashgabat
6724	United Arab Emirates	Abu Dhabi

TRICARE EUROPE		
DMIS -ID	COUNTRY	FACILITY CITY
6724	United Arab Emirates	Dubai
6724	Uzbekistan	Tashkent
6724	Yemen	Sanaa
6724	Seychelles	Victoria
6894	Europe	TGRO Outreach

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FIGURES

FIGURE 12-12.2-14 TGRO DMIS-ID BY REGION (CONTINUED)

TRICARE PACIFIC		TRICARE LATIN AMERICA, CANADA, & CARIBBEAN BASIN	
DMIS-ID	COUNTRY	DMIS-ID	COUNTRY
0983	American Samoa	0970	Antigua
0983	Australia	0972	Argentina
0983	Bangladesh	0970	Aruba
0983	Burma/Myanmar	0970	Bahamas AUTECH
0983	Cambodia	0970	Bahamas
0983	China	0970	Barbados
0983	Fiji	0971	Belize
0983	India	0972	Bolivia
0983	Indonesia	0972	Brazil
0983	Laos	0972	Chile
0983	Madagascar	0972	Colombia
0983	Malaysia	0971	Costa Rica
0983	Mongolia	0971	Costa Rica
0983	Nepal	0972	Colombia
0983	New Zealand	0970	Dominica
0983	Northern Mariana Islands	0970	Dominican Republic
0983	Palau	0972	Ecuador
0983	Philippines	0971	El Salvador
0983	Singapore	0971	Guatemala
0983	Sri Lanka	0972	Guyana
0983	Taiwan	0970	Haiti
0983	Thailand	0971	Honduras
0983	Vietnam	0971	Honduras Embassy
6895	TGRO Outreach - Pacific	0970	Jamaica
		0971	Mexico
		0970	Netherlands Antilles
		0971	Nicaragua
		0971	Panama
		0972	Paraguay
		0972	Peru
		0972	Suriname
		0970	Trinidad & Tobago
		0972	Uruguay
		0975	U.S. Virgin Islands
		0972	Venezuela
		6895	TGRO Outreach - Latin America

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FIGURE 12-12.2-15 REMOTE NON-TGRO SITE DMIS-IDS

TRICARE EUROPE		
DMIS -ID	COUNTRY	FACILITY CITY
6897	Afghanistan	
6897	Greece	Araxos
6897	Belgium	
6897	Germany	Buechel
6897	Czech Republic	
6897	Denmark	
6897	Turkey	Eskishir
6897	Italy	Florence
6897	France	
6897	Germany	Freiburg
6897	Germany	
6897	Belgium	Glons
6897	Spain	Granada
6897	United Kingdom	Guernsey
6897	Germany	Hamburg
6897	Hungary	
6897	Iran	
6897	Iraq	
6897	Ireland	
6897	Italy	
6897	Denmark	Karup Denmark
6897	Kenya	Kisumu
6897	Greenland	Nwk
6897	United Kingdom	Oakhanger
6897	Poland	
6897	Kosovo	Belgrade (Pristina)
6897	United Kingdom	RAF Fylingdales
6897	Romania	
6897	Saudi Arabia	
6897	Scotland	
6897	Somalia	
6897	Spain	
6897	United Kingdom	St Helena
6897	Sudan	
6897	Sweden	
6897	Netherlands	Vriezenveen
6897	Libya	Tripoli
6897	Turkey	
6897	United Kingdom	Westisup
6897	Russia	Yekaterinburg
6897	United Kingdom	Gibraltar
6897	Pakistan	Peshawar

TRICARE PACIFIC	
DMIS-ID	COUNTRY
0961	Japan
6898	Other Pacific Non-TGRO (serving Diego Garcia, Kwajalein, Jonston Island)

TRICARE LATIN AMERICA/CANADA	
DMIS-ID	COUNTRY
0969	Canada
0953	Remote Puerto Rico

FIGURE 12-12.2-17 ATTESTATION

ATTESTATION

I _____ certify that I personally provided the services listed on the attached TRICARE claim I signed and dated

_____ **(Date Signed)** to _____ **(Patient's Name)** _____, a TRICARE Beneficiary. I further certify that the amount billed for these services is the amount I routinely charge the general public, Governmental, and other health plans and health insurers for these services.

I understand that TRICARE beneficiaries are required, by law, to pay their cost-share and deductible and that I will collect the required cost-share and deductible from the beneficiary listed on the claim or another individual or entity on behalf of the beneficiary. I further understand that by accepting the TRICARE payment, I am accepting the TRICARE determined allowable charge plus the beneficiary's cost-share and deductible as payment in full and that I will not bill or collect any amounts in excess of the TRICARE allowable charge. This does not prohibit me from billing for any non-covered services.

Provider's Signature

Date

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