



OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE  
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TRICARE  
MANAGEMENT ACTIVITY

MB&RS

CHANGE 78  
6010.54-M  
MAY 1, 2008

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:** AMA LICENSE AGREEMENT UPDATE

**PAGE CHANGE(S):** See pages 2 through 7.

**SUMMARY OF CHANGE(S):** This change updates the footnote for the AMA  
License Agreement for 2006 and future publications.

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

This change is made in conjunction with Aug 2002 TOM, Change No. 65, Aug 2002  
TRM, Change No. 77, and Aug 2002 TSM, Change No. 60.

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Acting Chief, Office of Medical Benefits  
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ATTACHMENT(S): 240 PAGE(S)  
DISTRIBUTION: 6010.54-M

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

**REMOVE PAGE(S)**

**INSERT PAGE(S)**

**CHAPTER 1**

Section 2.1, pages 3 and 4  
Section 15.1, page 1  
Section 16.1, page 1  
Section 17.1, pages 1 and 2

Section 2.1, pages 3 and 4  
Section 15.1, page 1  
Section 16.1, page 1  
Section 17.1, pages 1 and 2

**CHAPTER 2**

Section 1.1, page 1  
Section 1.2, page 1  
Section 2.1, pages 1 and 2  
Section 3.1, page 1  
Section 3.3, pages 1 and 2  
Section 4.1, page 1  
Section 6.1, pages 1, 2, and 5  
Section 6.2, page 1  
Section 8.1, page 1  
Section 9.1, page 1  
Section 10.1, page 1

Section 1.1, page 1  
Section 1.2, page 1  
Section 2.1, pages 1 and 2  
Section 3.1, page 1  
Section 3.3, pages 1 and 2  
Section 4.1, page 1  
Section 6.1, pages 1, 2, and 5  
Section 6.2, page 1  
Section 8.1, page 1  
Section 9.1, page 1  
Section 10.1, page 1

**CHAPTER 3**

Section 1.1, page 1  
Section 1.2, page 1

Section 1.1, page 1  
Section 1.2, page 1

**CHAPTER 4**

Section 2.1, page 3  
Section 2.1A, page 1  
Section 5.1, pages 1 and 2  
Section 5.2, pages 1 and 2  
Section 5.3, pages 1 and 2

Section 2.1, page 3  
Section 2.1A, page 1  
Section 5.1, pages 1 and 2  
Section 5.2, pages 1 and 2  
Section 5.3, pages 1 and 2

**REMOVE PAGE(S)**

**INSERT PAGE(S)**

**CHAPTER 4 (Continued)**

Section 5.4, pages 1 and 2  
Section 5.5, pages 1 and 2  
Section 5.6, pages 1 and 2  
Section 5.7, page 1  
Section 6.1, pages 1 and 2  
Section 6.2, pages 1 and 2  
Section 8.1, page 1  
Section 8.2, pages 1 and 2  
Section 9.1, pages 1 through 4  
Section 9.2, page 1  
Section 9.3, pages 1 and 2  
Section 9.4, pages 1 and 2  
Section 10.1, page 1  
Section 11.1, page 1  
Section 12.1, page 1  
Section 13.1, page 1  
Section 13.2, pages 1 and 2  
Section 14.1, pages 1 and 2  
Section 15.1, pages 1 through 3  
Section 16.1, page 1  
Section 17.1, pages 1 and 2  
Section 18.1, pages 1 and 2  
Section 18.2, pages 1 and 2  
Section 18.3, pages 1 and 2  
Section 18.4, page 1  
Section 19.1, page 1

Section 5.4, pages 1 and 2  
Section 5.5, pages 1 and 2  
Section 5.6, pages 1 and 2  
Section 5.7, page 1  
Section 6.1, pages 1 and 2  
Section 6.2, pages 1 and 2  
Section 8.1, page 1  
Section 8.2, pages 1 and 2  
Section 9.1, pages 1 through 4  
Section 9.2, page 1  
Section 9.3, pages 1 and 2  
Section 9.4, pages 1 and 2  
Section 10.1, page 1  
Section 11.1, page 1  
Section 12.1, page 1  
Section 13.1, page 1  
Section 13.2, pages 1 and 2  
Section 14.1, pages 1 and 2  
Section 15.1, pages 1 through 3  
Section 16.1, page 1  
Section 17.1, pages 1 and 2  
Section 18.1, pages 1 and 2  
Section 18.2, pages 1 and 2  
Section 18.3, pages 1 and 2  
Section 18.4, page 1  
Section 19.1, page 1

**REMOVE PAGE(S)**

**INSERT PAGE(S)**

**CHAPTER 4 (Continued)**

Section 20.1, pages 1 through 4  
Section 20.2, page 1  
Section 20.3, pages 1 and 2  
Section 21.1, pages 1 and 2  
Section 22.1, page 1  
Section 22.2, pages 1 and 2  
Section 23.1, pages 1 and 2  
Section 24.1, pages 1 and 2  
Section 24.2, pages 1, 2, and 5  
Section 24.4, pages 1 and 2  
Section 24.5, pages 1 and 2  
Section 24.6, pages 1 and 2  
Section 24.7, pages 1 through 5  
Section 24.8, pages 1 and 2

Section 20.1, pages 1 through 4  
Section 20.2, page 1  
Section 20.3, pages 1 and 2  
Section 21.1, pages 1 and 2  
Section 22.1, page 1  
Section 22.2, pages 1 and 2  
Section 23.1, pages 1 and 2  
Section 24.1, pages 1 and 2  
Section 24.2, pages 1, 2, and 5  
Section 24.4, pages 1 and 2  
Section 24.5, pages 1 and 2  
Section 24.6, pages 1 and 2  
Section 24.7, pages 1 through 5  
Section 24.8, pages 1 and 2

**CHAPTER 5**

Section 1.1, pages 1 through 5  
Section 2.1, pages 1 and 2  
Section 3.1, pages 1 through 4  
Section 4.1, pages 1 through 3

Section 1.1, pages 1 through 5  
Section 2.1, pages 1 and 2  
Section 3.1, pages 1 through 4  
Section 4.1, pages 1 through 3

**CHAPTER 6**

Section 1.1, pages 1 through 3  
Section 2.1, pages 1 and 2

Section 1.1, pages 1 through 3  
Section 2.1, pages 1 and 2

**CHAPTER 7**

Section 2.1, pages 1 through 4, 9, and 10  
Section 2.2, pages 1 through 6

Section 2.1, pages 1 through 4, 9, and 10  
Section 2.2, pages 1 through 6

**REMOVE PAGE(S)**

**INSERT PAGE(S)**

**CHAPTER 7 (Continued)**

Section 2.4, page 1  
Section 2.5, pages 1 through 4  
Section 2.6, page 1  
Section 2.7, pages 1 and 2  
Section 2.8, page 1  
Section 3.7, pages 3 and 4  
Section 3.10, pages 1 through 3  
Section 3.12, pages 1 and 2  
Section 3.13, pages 1 through 3  
Section 3.14, pages 1 and 2  
Section 3.15, page 1  
Section 3.16, pages 1 and 2  
Section 4.1, pages 1 and 2  
Section 4.2, page 1  
Section 5.1, page 1  
Section 6.1, pages 1 and 2  
Section 6.2, pages 1 and 2  
Section 6.3, page 1  
Section 7.1, pages 1 and 2  
Section 8.1, pages 1 and 2  
Section 8.2, pages 1 and 2  
Section 9.1, pages 1 and 2  
Section 10.1, pages 1 and 2  
Section 11.1, pages 1 and 2  
Section 12.1, page 1  
Section 13.1, page 1

Section 2.4, page 1  
Section 2.5, pages 1 through 4  
Section 2.6, page 1  
Section 2.7, pages 1 and 2  
Section 2.8, page 1  
Section 3.7, pages 3 and 4  
Section 3.10, pages 1 through 3  
Section 3.12, pages 1 and 2  
Section 3.13, pages 1 through 3  
Section 3.14, pages 1 and 2  
Section 3.15, page 1  
Section 3.16, pages 1 and 2  
Section 4.1, pages 1 and 2  
Section 4.2, page 1  
Section 5.1, page 1  
Section 6.1, pages 1 and 2  
Section 6.2, pages 1 and 2  
Section 6.3, page 1  
Section 7.1, pages 1 and 2  
Section 8.1, pages 1 and 2  
Section 8.2, pages 1 and 2  
Section 9.1, pages 1 and 2  
Section 10.1, pages 1 and 2  
Section 11.1, pages 1 and 2  
Section 12.1, page 1  
Section 13.1, page 1

**REMOVE PAGE(S)**

**INSERT PAGE(S)**

**CHAPTER 7 (Continued)**

Section 14.1, pages 1 and 2  
Section 15.1, page 1  
Section 15.2, page 1  
Section 16.1, page 1  
Section 16.2, page 1  
Section 16.3, pages 1 and 2  
Section 16.4, page 1  
Section 17.1, page 1  
Section 18.1, pages 1 through 3  
Section 18.2, pages 1 through 3  
Section 18.3, pages 1 and 2  
Section 18.4, page 1  
Section 18.5, page 1  
Section 19.1, pages 1 through 3  
Section 20.1, page 1  
Section 22.1, pages 1 through 4  
Section 23.1, pages 1 and 2

Section 14.1, pages 1 and 2  
Section 15.1, page 1  
Section 15.2, page 1  
Section 16.1, page 1  
Section 16.2, page 1  
Section 16.3, pages 1 and 2  
Section 16.4, page 1  
Section 17.1, page 1  
Section 18.1, pages 1 through 3  
Section 18.2, pages 1 through 3  
Section 18.3, pages 1 and 2  
Section 18.4, page 1  
Section 18.5, page 1  
Section 19.1, pages 1 through 3  
Section 20.1, page 1  
Section 22.1, pages 1 through 3  
Section 23.1, pages 1 and 2

**CHAPTER 8**

Section 2.3, pages 1 and 2  
Section 2.7, pages 1 and 2

Section 2.3, pages 1 and 2  
Section 2.7, pages 1 and 2

**CHAPTER 9**

Section 8.1, page 1  
Section 9.1, pages 1 and 2  
Section 10.1, pages 1 and 2  
Section 11.1, page 1  
Section 12.1, pages 1 through 3

Section 8.1, page 1  
Section 9.1, pages 1 and 2  
Section 10.1, pages 1 and 2  
Section 11.1, page 1  
Section 12.1, pages 1 and 2

**REMOVE PAGE(S)**

**INSERT PAGE(S)**

**CHAPTER 9 (Continued)**

Section 13.1, page 1

Section 15.1, pages 1 and 2

Section 13.1, page 1

Section 15.1, pages 1 and 2

**CHAPTER 12**

Section 4.2, pages 17 - 20, 29, and 30

Section 12.2, pages 3, 4, 9, and 10

Section 4.2, pages 17 - 20, 29, and 30

Section 12.2, pages 3, 4, 9, and 10



## TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

### CHAPTER 1, SECTION 2.1

#### UNPROVEN DRUGS, DEVICES, MEDICAL TREATMENTS, AND PROCEDURES

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

1. Adoptive immunotherapy using either tumor-infiltrating lymphocytes (TIL) or lymphokine-activated killer (LAK) cells, activated in vitro by recombinant or natural IL-2 or other lymphokines, for the treatment of cancer.

2. Adrenal tissue transplant to brain.

3. Autolymphocyte therapy (ALT).

4. Calcium EAP/calcium orotate and selenium (also known as Nieper therapy) - involves inpatient care and use of calcium compounds and other non-FDA approved drugs and special diets. Used for cancer, heart disease, diabetes, multiple sclerosis -- Not a proven treatment for any indication.

5. Services related to the candidiasis hypersensitivity syndrome, yeast syndrome, or gastrointestinal candidiasis are unproven (i.e., allergenic extracts of *Candida albicans* for immunotherapy and/or provocation/neutralization). Disseminated systemic candidiasis (ICD-9-CM 112.5) is a recognized diagnosis, and medically necessary treatment is covered.

6. Cellular therapy (HCPCS procedure code M0075).

7. Chelation therapy, except when using FDA-approved chelators for FDA-approved indications.

8. Diaphanography (Transillumination Light Scanning).

9. Dynamic Posturography (both static and computerized) (CPT<sup>1</sup> procedure code 92548).

10. Electric reflex salivary stimulation (Salitron® Electrostimulation System) in the treatment of xerostomia (dry mouth) secondary to Sjogren's syndrome (HCPCS procedure code E0755).

11. Eye movement desensitization and reprocessing therapy (EMDR) for treatment of psychiatric and behavioral disorders.

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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 1, SECTION 2.1

UNPROVEN DRUGS, DEVICES, MEDICAL TREATMENTS, AND PROCEDURES

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

## CATEGORY II CODES - PERFORMANCE MEASUREMENT

ISSUE DATE: October 15, 2003

AUTHORITY: [32 CFR 199.17\(j\)](#) and (p)(3)

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### I. CPT<sup>1</sup> PROCEDURE CODES

0001F, 0005F, 0012F, 0500F - 0503F, 0505F, 0507F, 1000F - 1008F, 1015F, 1018F, 1019F, 1022F, 1026F, 1030F, 1034F - 1036F, 1038F - 1040F, 2000F - 2004F, 2010F, 2014F, 2018F, 2022F - 2024F, 2026F, 2028F, 2030F, 2031F, 3000F, 3002F, 3006F, 3011F, 3014F, 3017F, 3020F, 3025F, 3027F, 3028F, 3035F, 3037F, 3040F, 3042F, 3046F - 3050F, 3061F, 3062F, 3066F, 3072F, 3076F - 3080F, 3082F - 3085F, 3088F - 3093F, 4000F - 4003F, 4006F, 4009F, 4011F, 4012F, 4014F - 4018F, 4025F, 4030F, 4033F, 4035F, 4037F, 4040F, 4045F, 4050F - 4056F, 4059F, 4060F, 4062F, 4064F - 4067F, 6005F

### II. DESCRIPTION

The CPT Category II codes are supplemental tracking codes that can be used for performance measurement.

### III. POLICY

A. Category II codes are to be used to collect data about the quality of care by coding certain services and/or test results that support performance measures and that have been agreed upon as contributing to good patient care. TRICARE has opted not to track Category II codes.

B. Category II codes are excluded under TRICARE.

IV. EFFECTIVE DATE            January 1, 2004.

- END -

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## CATEGORY III CODES

ISSUE DATE: March 6, 2002

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

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### I. CPT<sup>1</sup> PROCEDURE CODES

0003T, 0008T, 0016T - 0019T, 0021T, 0024T, 0026T - 0032T, 0041T - 0161T

### II. DESCRIPTION

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

### III. POLICY

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

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

### IV. EXCEPTIONS

A. Category III code 0024T may be covered under the Rare Disease Policy for children.

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

### V. EXCLUSION

Unlisted codes for category III codes. Effective January 1, 2002.

- END -

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

ISSUE DATE: November 6, 2007

AUTHORITY:

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### I. HCPCS "C" AND "S" CODES

C1000 - C9999; S0000 - S9999

### II. DESCRIPTION

A. HCPCS "C" codes include device categories, new technology procedures, and drugs, biologicals and radiopharmaceuticals that do not have other HCPCS assigned.

B. HCPCS "S" codes are temporary codes used by the private sector to report drugs, services, and supplies for which there are no national codes.

### III. POLICY

A. Upon implementation of TRICARE's Outpatient Prospective Payment System (OPPS), HCPCS "C" codes shall be paid according to OPPS guidelines as outlined in the TRICARE Reimbursement Manual (TRM), [Chapter 13](#). For hospital outpatient department (HOPD) services provided prior to the implementation of TRICARE's OPPS, and thereafter, for services by exempt OPPS hospitals, the contractor shall allow payment of HCPCS "C" codes consistent with current policy as stated in the TRM, [Chapter 1, Section 24, paragraph III.B](#).

B. Under TRICARE, "S" codes are not reimbursable except as follows:

1. S9122, S9123, and S9124 for the ECHO respite care benefit and the ECHO Home Health Care (EHHC) benefit; and

2. S0812, S1030, S1031, S1040, S2066, S2067, S2068, S2075, S2076, S2077, S2083, S2202, S2360, S2361, S2400, S2401, S2402, S2403, S2405, S2411, S3818, S3819, S3820, S3822, S3823, S8185, S8265, S8270, and S9430 for all beneficiaries; and

3. S5108 for direct Educational Interventions for Autism Spectrum Disorders (EIA) services provided to TRICARE beneficiaries and S5110 for training services provided to family members of beneficiaries receiving EIA services under the Department of Defense (DoD) Enhanced Access to Autism Services Demonstration. (See the TRICARE Operations Manual (TOM), [Chapter 20, Section 10](#)).

**TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002**  
CHAPTER 1, SECTION 17.1  
HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS) "C" AND  
"S" CODES

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C. Under TRICARE, HCPCS code S9999 is a recognized code for purposes of reporting sales tax but is not payable.

IV. EXCLUSIONS

HCPCS "C" codes are not allowed to be billed by independent professional providers.

- END -

## OFFICE VISITS

ISSUE DATE: April 19, 1983

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

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### I. CPT<sup>1</sup> PROCEDURE CODES

90801, 90802, 99201 - 99215

### II. POLICY

Office visits are covered when provided by an individual professional provider for the diagnosis or treatment of a specific illness or condition or set of symptoms.

### III. EXCLUSIONS

Office visits for the purpose of a routine physical examination, except as outlined under preventive care.

- END -

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## OFFICE VISITS WITH SURGERY

ISSUE DATE: March 1, 1996

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

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I. CPT<sup>1</sup> PROCEDURE CODE RANGE

99201 - 99215

II. DESCRIPTION

When surgery is performed at the time of the office visit.

III. POLICY

When a surgical procedure is performed at the time of an office visit, both the office visit and the surgical procedure are covered when modifier 25 is used as the basis for this situation (indicates that the patient's condition required a significant, separately identifiable Evaluation and Management (E/M) service above and beyond the usual preoperative and postoperative care associated with the procedure that was performed). If the modifier is not used, the charge for the office visit is to be denied.

- END -

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## HOME SERVICES

ISSUE DATE: March 3, 1992

AUTHORITY: [32 CFR 199.4\(c\)\(2\)\(iv\)](#) and [\(e\)\(12\)\(ii\)](#)

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### I. CPT<sup>1</sup> PROCEDURE CODES

Physician Code Range: 90801, 90802, 90804 - 90815, 90847, 90862, 99341 - 99350

Non-Physician Code Range: 90801, 90802, 90804 - 90815, 90847, 90862, 99341 - 99350, 99500 - 99507, 99511, 99512, 99600 - 99602

NOTE: TRICARE payment for non-physician services is limited to those authorized non-physician providers recognized in [32 CFR 199.6](#).

NOTE: Skilled nursing service (99341 - 99350) may be reported separately, using the modifier-25, if the patient's condition requires a significant separately identifiable E/M service, beyond the home health service(s)/procedure(s) (99500 - 99539).

### II. HCPCS PROCEDURES CODES

Non-Physician Code Range: G0151 - G0154, G0156

### III. DESCRIPTION

Visits provided by an individual professional provider for beneficiaries who are homebound.

### IV. POLICY

A. Home visits are covered when provided by an individual professional provider for the diagnosis or treatment of a covered condition for beneficiaries who are homebound or whose condition is such that home visits are indicated.

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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 2, SECTION 2.1

HOME SERVICES

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B. If the patient has been determined to be receiving custodial care, those home visits which are specifically related to the treatment of the custodial care conditions are covered only as follows:

1. When provided by a visiting nurse, such visits may be covered up to one hour per day for skilled nursing care.

2. When provided by a physician, may be covered up to 12 visits per calendar year (not to exceed one per month). Note that physician visits, regardless of the place of services, will be limited to this calendar year maximum when the treatment is of the custodial care condition. Physician visits for other than the custodial care condition are not limited to this calendar year maximum.

C. See the TRICARE Reimbursement Manual, [Chapter 8](#), reimbursement of Skilled Nursing Care.

D. This policy will remain in effect until the Home Health Agency Prospective Payment System is implemented.

V. EXCLUSIONS

A. Home visit, sleep studies (CPT<sup>2</sup> procedure code 95806).

B. Home visit, Day Life Activity (CPT<sup>2</sup> procedure code 99509).

C. Home visit, sing/m/fam/couns (CPT<sup>2</sup> procedure code 99510).

D. Home infusion for tocolytic therapy.

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## HOSPITAL CARE

ISSUE DATE: March 3, 1992

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

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### I. CPT<sup>1</sup> PROCEDURE CODES

99221 - 99233, 99238, 99239

### II. DESCRIPTION

A. An initial hospital visit includes the history, examination, and medical decision making.

B. Subsequent hospital care consists of visits subsequent to the initial visit. Such care consists of an interval history, examination, and medical decision-making.

### III. POLICY

Initial hospital care and subsequent hospital care is covered when provided by an individual professional provider for the covered hospitalization.

- END -

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## OUTPATIENT OBSERVATION STAYS

ISSUE DATE: July 8, 1998

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

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### I. CPT<sup>1</sup> PROCEDURE CODES

99217, 99218 - 99220, 99234 - 99236

### II. HCPCS CODES

Upon implementation of the Outpatient Prospective Payment System (OPPS): G0378, G0379

### III. DESCRIPTION

Outpatient observation stays are those services furnished by a hospital on a hospital's premises, including the use of a bed and periodic monitoring by a hospital's nursing or other staff, which are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital as an inpatient. Such services are provided when ordered by a physician or another individual authorized by State licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient tests.

### IV. POLICY

A. A person is considered a hospital inpatient if formally admitted as an inpatient with the expectation that he or she will remain at least overnight. When a hospital places a patient under observation, but has not formally admitted him or her as an inpatient, the patient initially is treated as an outpatient to determine the need for further treatment or for inpatient admission.

B. For observation stays prior to implementation of OPPS, the following provisions apply:

1. Cost-sharing of observation services, subsequent to ambulatory surgery reimbursement under the prospective ambulatory group payment, is covered if determined that placement on observation is medically necessary.

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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 2, SECTION 3.3

OUTPATIENT OBSERVATION STAYS

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2. Cost-sharing of outpatient observation services is covered following care provided in an emergency setting.
3. Cost-sharing at the observation level or outpatient level should be considered for inpatient denials when the services rendered are medically necessary, but provided at an inappropriate level of care.
4. Cost-sharing of outpatient mental health observation is covered.
5. Outpatient observation stays generally should not exceed 23 hours.
6. Up to 48 hours of outpatient observation services may be authorized by the Contractor when medical necessity has been clearly demonstrated. **If an observation stay is for more than 48 hours, the claim shall be processed as inpatient.**
7. Time spent in a recovery room following surgery should not be included in the 23 hour limit.
8. The time of admission to an observation bed is counted as the first hour of observation and is rounded to the nearest hour. The number of hours of observation should be indicated in the units field on the CMS 1450 UB-04 claim form. If the patient has more than 23 hours of observation show all hours of services provided in the units field.
9. Outpatient observation services are billed using the revenue code 0762 with the description listed as Observation Services. This code includes room and board services.

C. For observation stays on or after the implementation of OPSS, the following provisions apply:

1. Outpatient observation stays are separately payable when certain conditions are met for patients having diagnosis of chest pain, asthma, congestive heart failure or maternity (refer to the TRICARE Reimbursement Manual (TRM), [Chapter 13, Section 2, paragraph III.H](#) for those specific conditions that must be met in order to receive separate payment under the hospital Outpatient Prospective Payment System (OPSS)). The above conditions will only apply to observation stays reimbursed under the OPSS.
2. All other observation stays will be packaged under the primary procedure for payment. Hospitals are to report these observation charges under revenue code 0762 - "Observation Room", and HCPCS code G0378. The above packaging requirement is specific for observation stays reimbursed under the OPSS.
3. Outpatient observation stays generally should not exceed 24 hours.
4. For OPSS exempt hospitals, up to 48 hours of outpatient observation services may be authorized by the contractor when medical necessity has been clearly demonstrated. If an observation stay is for more than 48 hours, the claim shall be processed as inpatient.

D. A separate authorization for outpatient observation is not required.

## NURSING FACILITY VISITS

ISSUE DATE: March 3, 1992

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

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### I. CPT<sup>1</sup> PROCEDURE CODES

99304 - 99310, 99315, 93316, and 99318

Effective 1 January 2006, The American Medical Association Current Procedural Terminology (CPT) evaluation and management service codes (visit codes) were revised. The old 90000 series were replaced by a new CPT 90000 series. The new codes are valid for claims processing for claims submitted on or after January 1, 2006.

### II. DESCRIPTION

Nursing facilities (formerly called Skilled Nursing Facilities (SNFs), Intermediate Care Facilities (ICFs), or Long-term Care Facilities (LCFs)) are places of residence for people who require constant nursing care and have significant Activity of Daily Living deficiencies. Residents include the elderly and younger adults with physical disabilities. Adults 18 or older can stay in a skilled nursing facility to receive physical, occupational, and other rehabilitative therapies following an accident or illness.

### III. POLICY

Nursing facility visits are covered when provided by an authorized provider for the diagnosis or treatment of a specific illness or condition or set of symptoms.

- END -

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## EMERGENCY DEPARTMENT (ED) SERVICES

ISSUE DATE: March 3, 1992

AUTHORITY: [32 CFR 199.2\(b\)](#), [32 CFR 199.4\(b\)\(6\)](#) and [\(b\)\(7\)](#)

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### I. CPT<sup>1</sup> PROCEDURE CODE RANGE

99281 - 99285, 99288 (see EXCLUSIONS regarding 99288)

### II. BACKGROUND

The Advisory Commission on Consumer Protection and Quality in the Health Care Industry was appointed by President Clinton on March 26, 1997, to “advise the President on changes occurring in the health care system and recommend measures as may be necessary to promote and assure health care quality and value, and protect consumers and workers in the health care system.” As part of its work, the President asked the Commission to draft a “consumer bill of rights.”

In its report, the Commission stated that, “Consumers have the right to access emergency health care services when and where the need arises. Health plans should provide payment when a consumer presents to an emergency department with acute symptoms of sufficient severity—including severe pain—such that a ‘prudent layperson’ could reasonably expect the absence of medical attention to result in placing the consumer’s health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.” Emphasis is placed on the patient’s presenting symptoms rather than the final diagnosis.

In conjunction with the “prudent layperson” standard, TRICARE must also enforce the current provision that “appropriate medical care” required to provide “medically or psychologically necessary” services is to be furnished economically. That is, services are to be furnished in the least expensive level of care or medical environment adequate to provide the required medical care regardless of whether or not that level of care is covered by TRICARE. For care sought in an Emergency Department (ED), which was clearly a case of routine illness where the beneficiary’s medical condition never was, or never appeared to be, an emergency, the ED is the inappropriate “medical environment” to seek the care. A physician’s office, for example, would be a more adequate medical environment for non-emergency care. Non-emergent visits to the ED can be costly, contribute to overcrowded waiting rooms, divert resources away from other hospital-based care, and compromise the coordination and continuity of care.

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**TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002**

CHAPTER 2, SECTION 6.1

EMERGENCY DEPARTMENT (ED) SERVICES

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This policy encompasses the Commission's recommendations and the TRICARE provision that benefits be extended for care that is "medically and psychologically necessary" and "appropriate medical care".

III. DESCRIPTION

An emergency department is defined as an organized hospital-based facility for the provision of unscheduled episodic services to patients who present for immediate medical attention. The facility must be available 24 hours a day.

IV. POLICY

ED care to include professional and institutional charges is covered:

A. For medical, maternity or psychiatric emergencies that would lead a "prudent layperson," (someone with average knowledge of health and medicine), to believe that a serious medical condition existed or the absence of medical attention would result in a threat to his/her life, limb, or sight and requires immediate medical treatment or which manifest painful symptomatology requiring immediate palliative effort to relieve suffering. This includes situations where a beneficiary presents with severe pain.

B. For service and supplies, not otherwise excluded, that are ordered or administered in the ED to manage the care (e.g., tetanus toxoid injections, etc.).

V. POLICY CONSIDERATIONS

A. Medical emergency is the sudden and unexpected onset of a medical condition or the acute exacerbation of a chronic condition listed that is threatening to life, limb, or sight, and requires immediate medical treatment or manifests painful symptomatology requiring immediate palliative efforts to alleviate suffering.

B. Maternity emergency is a sudden unexpected medical complication which puts the mother, or fetus, at risk.

C. A psychiatric inpatient admission is an emergency when, based on a psychiatric evaluation performed by a physician (or other qualified mental health care professional with hospital admission authority), the patient is at immediate risk of serious harm to self or others as a result of mental disorder and requires immediate continuous skilled observation at the acute level of care.

D. Since claims are submitted with only the discharge diagnosis (not presenting symptoms), any ED claim about to be denied shall be suspended and developed prior to actual denial. Development shall determine whether the presenting symptoms meet the prudent layperson standard defined in policy above.

E. Pre-authorization is not required for ED services meeting the above POLICY.

F. An adverse determination of ED care claims is an appealable issue.

**TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002**

CHAPTER 2, SECTION 6.1

EMERGENCY DEPARTMENT (ED) SERVICES

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B. For CPT<sup>2</sup> procedure code 99288 no separate payment will be made as payment for this service is included in the payment for other services.

- END -

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## NEONATAL AND PEDIATRIC CRITICAL CARE SERVICES

ISSUE DATE: October 23, 2003

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

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I. CPT<sup>1</sup> PROCEDURE CODES

99293 - 99296, 99298, 99299

II. DESCRIPTION

Services provided by a physician directing the care of a critically ill neonate/infant.

III. POLICY

A. Neonatal and pediatric critical care services may be cost-shared.

B. Hospital-grade electric breast pumps may be covered for premature infants under certain circumstances (see [Chapter 8, Section 2.6](#)).

- END -

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## CONSULTATIONS

ISSUE DATE: March 3, 1992

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

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### I. CPT<sup>1</sup> PROCEDURE CODE RANGE

99241 - 99275

### II. DESCRIPTION

Advisory service(s) provided by an authorized provider requested by another authorized provider in the evaluation and management of a specific problem.

### III. POLICY

Consultations performed by an individual professional provider at the request of the patient's attending provider are covered.

### IV. EXCLUSIONS

- A. Telephone consultations and telephone toll charges are not covered.
- B. Staff consultations required by the policies of a hospital or other institution.

- END -

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## PATIENT TRANSPORT

ISSUE DATE: March 11, 2002

AUTHORITY: [32 CFR 199.4\(a\)\(1\)\(i\)](#)

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### I. CPT<sup>1</sup> PROCEDURE CODES

99289, 99290

### II. DESCRIPTION

Patient transport refers to physician attendance and direct face-to-face care by a physician during the interfacility transport of a critically ill or injured patient. Face-to-face care begins when the physician assumes the primary responsibility of the patient at the referring hospital/facility and ends when the receiving hospital/facility accepts responsibility for the patient's care.

### III. POLICY

Procedure(s) or service(s) performed/directed by the physician before and during transport of a critically ill or injured patient is a covered benefit.

- END -

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## PHYSICIAN STANDBY CHARGES

ISSUE DATE: February 14, 1984

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

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### I. CPT<sup>1</sup> PROCEDURE CODES

99026, 99027, 99360

### II. DESCRIPTION

A physician standby charge is a charge made by an individual provider to cover the expenses involved in maintaining a ready or available status in the event the services the provider has to offer may be required.

### III. POLICY

Separate reimbursement for physician's standby charges may not be considered for coverage since no service is actually rendered during a standby situation. Standby services are considered part of the routine institutional services and, as such, should be included in the institutional charge.

- END -

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## ANESTHESIA

ISSUE DATE:

AUTHORITY: 32 CFR 199.4(b)(2)(viii), (c)(2)(vii), (c)(3)(viii), and (g)(15)

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### I. CPT<sup>1</sup> PROCEDURE CODES

00100 - 01999, 99100, 99116, 99135, 99140

### II. POLICY

- A. Anesthesia services and supplies are covered.
- B. See [Chapter 3, Section 1.2](#) for conscious sedation.

See the TRICARE Reimbursement Manual, [Chapter 1, Section 9](#) for information on reimbursement of anesthesia.

### III. EXCLUSIONS

- A. Hypnotherapy.
- B. A separate benefit is not payable for anesthesia administered by the attending physician (surgeon or obstetrician) or dentist, or by the surgical, obstetrical or dental assistant. This exclusion does not apply to cases involving administration of local or regional anesthesia such as local anesthesia administered by a surgeon in the surgeon's office, by an obstetrician in a delivery room, or by an orthopedic surgeon in an operating room.

- END -

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CHAPTER 3  
SECTION 1.2

## MODERATE (CONSCIOUS) SEDATION

ISSUE DATE:

AUTHORITY: 32 CFR 199.4(b)(2)(v), (b)(3)(iii), (b)(5)(v), (d)(3)(vi), (e)(11)(i), (e)(11)(ii), (e)(11)(iii), (g)(15)

I. CPT<sup>1</sup> PROCEDURE CODES

99143 - 99145, 99148 - 99150

## II. DESCRIPTION

Moderate (conscious) sedation is a drug induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation.

## III. POLICY

A. Conscious sedation is bundled into many procedures. Conscious sedation is not covered separately when provided by the same physician as it is considered an integral part of the primary procedure.

B. If a physician performs a procedure that does not bundle conscious sedation and the same physician also performs moderate sedation, it is appropriate to separately bill CPT<sup>1</sup> procedure codes 99143 - 99145.

C. If a second physician performs conscious sedation (other than the professional performing the diagnostic or therapeutic service) it is appropriate to separately bill CPT<sup>1</sup> procedure codes 99248 - 99150, if the site is in a facility setting.

- END -

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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 4, SECTION 2.1

COSMETIC, RECONSTRUCTIVE AND PLASTIC SURGERY - GENERAL GUIDELINES

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- J. Rhinoplasties (except when performed to restore function).
- K. Chemical peeling (exfoliation) for the following:
  - 1. Treatment or removal of facial wrinkles, and
  - 2. Treatment of acne or of acne scars.
- L. Revision of scars resulting from surgery and/or a disease process, except disfiguring and extensive scars resulting from neoplastic surgery.
- M. Dermabrasion of the face (except when performed as part of surgery to restore body form following accidental injury or revision of disfiguring and extensive scars resulting from neoplastic surgery).
- N. Removal of tattoos.
- O. Hair transplants.
- P. Electrolysis.
- Q. Penile implant procedure for psychological impotency, transsexualism, or other such conditions as gender dysphoria.
- R. Insertion of prosthetic testicles for transsexualism, or such other conditions as gender dysphoria.
- S. Liposuction for body contouring.
- T. Rhytidectomy (CPT<sup>1</sup> procedure codes 15824 - 15826, 15828, and 15829) except for treatment of significant burns or other significant major facial trauma.
- U. When it is determined that a cosmetic, reconstructive and/or plastic surgery procedure does not qualify for benefits, all related services and supplies are excluded, including any institutional costs.

- END -

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## GENERAL SURGERY

ISSUE DATE: March 11, 2002

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

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### I. CPT<sup>1</sup> PROCEDURE CODES

10021, 10022

### II. DESCRIPTION

This new subsection was added to conform to the CPT Manual, which relocated procedure codes that were located in the Pathology and Laboratory section of the CPT Manual.

### III. POLICY

Fine needle aspiration, with or without imaging guidance, is covered.

NOTE: For fine needle aspiration, use CPT<sup>1</sup> procedure code 10021. For image guided breast biopsy, see CPT<sup>1</sup> procedure codes 19102, 19103, 10022.

- END -

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## INTEGUMENTARY SYSTEM

ISSUE DATE: August 26, 1985

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

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### I. CPT<sup>1</sup> PROCEDURE CODES

10021, 10022, 10040 - 11977, 11981 - 11983, 12001 - 15366, 15570 - 15776, 15840 - 15845, 15851 - 19499, 97601, and 97602

### II. DESCRIPTION

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

### III. POLICY

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

B. Topical Treatment of Skin Ulcers Caused by Venous Insufficiency. Topical application of Alpigraf by a physician for the treatment of skin ulcers caused by venous insufficiency is a covered benefit. Effective May 26, 1998.

C. Topical Treatment of Diabetic Foot Ulcers. Application of tissue cultured skin grafts for diabetic foot ulcers is a covered benefit. Effective May 8, 2000.

D. Topical Treatment of Diabetic Foot Ulcers. Application of Becaplermine Gel (Regranex) is a covered treatment of lower extremity diabetic neuropathic foot ulcers that extend into the subcutaneous tissue or beyond. Effective December 16, 1997.

### IV. EXCLUSIONS

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

B. Services performed for cosmetic purposes.

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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 4, SECTION 5.1

INTEGUMENTARY SYSTEM

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C. Subcutaneous hormone (estradiol and/or testosterone) pellet implantation (CPT<sup>2</sup> procedure code 11980) is unproven. Estradiol pellets are not FDA approved for general use in humans.

D. Endoscopic thoracic sympathectomy when performed for the treatment of hyperhidrosis.

E. Xenograft skin for temporary wound closure, trunk, arms, legs, (CPT<sup>2</sup> procedure codes 15400 and 15401) is unproven.

F. Xenograft skin for temporary wound closure, face, scalp, eyelids, mouth, neck ears, orbits, genitalia, hands, feet and/or multiple digits (CPT<sup>2</sup> procedure codes 15420 and 15421) is unproven.

G. Acellular xenograft implant (CPT<sup>2</sup> procedure codes 15430 and 15431) is unproven.

- END -

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## POSTMASTECTOMY RECONSTRUCTIVE BREAST SURGERY

ISSUE DATE: October 7, 1982

AUTHORITY: [32 CFR 199.4\(e\)\(8\)\(i\)\(D\)](#)

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### I. CPT<sup>1</sup> PROCEDURE CODES

19160 - 19240, 19340 - 19499 (For post-mastectomy reconstruction surgery)  
19316, 19318, 19324 - 19325 (For contralateral symmetry surgery)

### II. DESCRIPTION

Breast reconstruction consists of both mound reconstruction, nipple-areola reconstruction and areolar/nipple tattooing.

### III. POLICY

A. Payment may be made for post-mastectomy reconstruction of the breast following a covered mastectomy.

B. Payment may be made for contralateral symmetry surgery (i.e., reduction mammoplasty, augmentation mammoplasty, or mastopexy performed on the other breast to bring it into symmetry with the post-mastectomy reconstructed breast).

NOTE: Services related to the reduction of the contralateral breast in post-mastectomy reconstructive breast surgery are not subject to the regulatory exclusion for mammoplasties performed primarily for reasons of cosmesis.

C. Treatment of complications following reconstruction (including implant removal) regardless of when the reconstruction was performed, and complications that may result following symmetry surgery, removal and reinsertion of implants are covered.

D. External surgical garments (specifically designed as an integral part of an external prosthesis) are considered medical supply items and are covered in lieu of reconstructive breast surgery.

NOTE: Benefits are subject to two initial mastectomy bras and two replacement mastectomy bras per calendar year.

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**TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002**

CHAPTER 4, SECTION 5.2

POSTMASTECTOMY RECONSTRUCTIVE BREAST SURGERY

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E. Breast prosthesis is limited to the first initial device per missing body part. Requests for replacements are subject to medical review to determine reason for replacement.

F. U.S. Food and Drug Administration (FDA) approved implant material and customized external breast prostheses are covered.

G. Breast Magnetic Resonance Imaging (MRI) to detect implant rupture is covered. The implantation of the breast implants must have been covered by TRICARE.

- END -

## PROPHYLACTIC MASTECTOMY, PROPHYLACTIC OOPHORECTOMY, AND PROPHYLACTIC HYSTERECTOMY

ISSUE DATE: October 25, 1993

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

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### I. CPT<sup>1</sup> PROCEDURE CODES

19300 - 19307, 58150 - 58294, 58541 - 58554, 58661, 58940 - 58956

### II. DESCRIPTION

A. Prophylactic mastectomy is an extirpative procedure (usually simple or total mastectomy) which removes all breast tissue which would be otherwise subject to breast carcinoma. Carefully selected indications have been developed for prophylactic mastectomy and are included in this policy.

B. Prophylactic oophorectomy is removal of the ovaries before development of cancerous cells. Carefully selected indications have been developed for prophylactic oophorectomy and are included in this policy.

C. Prophylactic hysterectomy is removal of the uterus before development of cancerous cells. Carefully selected indications have been developed for prophylactic hysterectomy and are included in this policy.

### III. POLICY

A. Bilateral prophylactic mastectomies are covered for patients at increased risk of developing breast carcinoma who have one or more of the following:

1. Atypical hyperplasia of lobular or ductal origin confirmed on biopsy; or
2. A negative or positive Breast Cancer (BRCA) genetic test and family history of breast cancer in a first-degree relative (especially a mother or sister) who is premenopausal and has bilateral breast cancer (Family Cancer Syndrome); or
3. Fibronodular, dense breasts which are mammographically and/or clinically difficult to evaluate and the patient presents with either of the above (or both) clinical presentations.

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B. Unilateral prophylactic mastectomies are covered when the contralateral breast has been diagnosed with cancer for patients with:

1. Diffuse microcalcifications in the remaining breast, especially when ductal in-situ carcinoma has been diagnosed in the contralateral breast; or
2. Lobular carcinoma in-situ; or
3. Large breast and/or ptotic, dense or disproportionately-sized breast that are difficult to evaluate mammographically and clinically; or
4. In whom observational surveillance is elected for lobular carcinoma in-situ and the patient develops either invasive lobular or ductal carcinoma; or
5. A negative or positive BRCA genetic test and family history of breast cancer in a first-degree relative (especially a mother or sister) who is premenopausal and has bilateral breast cancer (Family Cancer Syndrome).

C. Prophylactic oophorectomy is covered when there is a positive BRCA genetic test and:

1. There is a first degree family history of ovarian cancer (e.g., parent, child, sibling); or
2. There is a 2+2nd degree relative history of ovarian cancer (two or more second degree relatives).

D. **Prophylactic hysterectomy is covered:**

1. **For women with a positive BRCA genetic test who are about to undergo or are undergoing tamoxifen therapy.**
2. **For women who have been diagnosed with Hereditary Nonpolypoid Colorectal Cancer (HNPCC) or are found to be carriers of HNPCC-associated mutations.**

E. Benefits will only be allowed for subcutaneous mastectomies performed as an alternative treatment for benign breast diseases if the individual is not at high risk of breast cancer.

#### IV. EXCLUSION

Subcutaneous mastectomy, a procedure that is not extirpative, fails to remove all breast tissue. Therefore, subcutaneous mastectomy is not effective as prophylactic assurance against breast cancer in high risk indications, nor is subcutaneous mastectomy a cancer treatment. Therefore, benefits will not be allowed for subcutaneous mastectomy in the prevention of breast carcinoma. (From October 25, 1993, through the implementation date of this policy, subcutaneous mastectomy was listed as a covered benefit.) Claims processed during this time should not be recouped.

## REDUCTION MAMMOPLASTY FOR MACROMASTIA

ISSUE DATE: October 22, 1985  
AUTHORITY: 32 CFR 199.4(c)(2) and (e)(8)

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### I. CPT<sup>1</sup> PROCEDURE CODE

19318

### II. DESCRIPTION

A. Reduction mammoplasty is the surgical excision of a substantial portion of the breast, including the skin and the underlying glandular tissue, until a clinically normal size is obtained. Because breasts are paired organs and macromastia usually affects both sides, bilateral surgery is performed. When there is significant one-sided hypertrophy, a unilateral breast reduction is performed. Reduction mammoplasty is usually prompted by physical necessity due to the signs and symptoms of macromastia, and is, therefore, reconstructive in nature.

B. Female breast hypertrophy, macromastia, is the development of abnormally large breasts. This condition can cause significant clinical manifestations when the excessive breast weight adversely affect the supporting structures of the shoulders, neck, and trunk. Macromastia is distinguished from large, normal breast by the presence of persistent, painful symptoms and physical signs.

NOTE: Specific weight guidelines for breast-tissue resection or reduction in bra-cup size are not valid since they are poorly correlated with relief of the symptoms of macromastia. There are wide variations in the range of normal individual height, body weight and associated breast sizes; the amount of breast tissue that must be removed to relieve symptoms therefore varies with the height and weight of each patient (e.g., a small-statured person will need proportionally less breast tissue removed to alleviate signs and symptoms of macromastia than a larger person).

### III. POLICY

A. Reduction mammoplasty is covered for medically indicated signs and symptoms of macromastia.

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**TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002**

CHAPTER 4, SECTION 5.4

REDUCTION MAMMOPLASTY FOR MACROMASTIA

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NOTE: Medically indicated symptoms may include postural backache, upper back and neck pain, and ulnar paresthesia. Appropriate physical findings are "true" hypertrophy, and shoulder grooving and intertrigo. Mixed symptoms may include breast pain and inability to lose weight in the breast. Signs may include poor posture and the inability to participate in normal physical activities. These may be functionally significant in some individuals.

- B. Photo-documentation may be requested as part of a coverage determination.

IV. EXCLUSIONS

- A. Reduction mammoplasties to treat fibrocystic disease of the breast.
- B. Reduction mammoplasty performed solely for cosmetic purposes.
- C. Mastopexy surgery (resuspending breast) and breast ptosis (drooping breast).

- END -

## SILICONE OR SALINE BREAST IMPLANT REMOVAL

ISSUE DATE: June 30, 1993

AUTHORITY: 32 CFR 199.4(a)(1), (e)(8)(iv), and (e)(9)

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### I. CPT<sup>1</sup> PROCEDURE CODES

19328, 19330

### II. DESCRIPTION

The removal of silicone or saline mammary implant material.

### III. POLICY

A. Removal of silicone or saline breast implants is covered if the initial silicone or saline breast implantation was or would have been a covered benefit.

B. Signs or symptoms of complications must be present and documented. Current medical literature supports removal of silicone or saline breast implants for the following indications:

1. Signs and symptoms that may signal implant rupture; and
2. Capsular contracture.

C. If the initial silicone or saline breast implant surgery was for an indication not covered or coverable by TRICARE, implant removal may be covered only if it is necessary treatment of a complication which represents a separate medical condition.

D. Breast Magnetic Resonance Imaging (MRI) to detect implant rupture is covered. The implantation of the breast implants must have been covered by TRICARE.

### IV. EXCLUSIONS

A. Removal of silicone or saline breast implants for the presence of autoimmune or connective tissue disorders.

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**TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002**

CHAPTER 4, SECTION 5.5

SILICONE OR SALINE BREAST IMPLANT REMOVAL

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B. In the case of implants not originally covered or coverable, implant damage, hardening, leakage, and autoimmune disorder do not qualify as separate medical conditions. They are considered unfortunate sequelae resulting from the initial non-covered surgery, and, therefore, are excluded.

- END -

## BREAST RECONSTRUCTION AS A RESULT OF A CONGENITAL ANOMALY

ISSUE DATE: April 16, 1986

AUTHORITY: [32 CFR 199.4\(c\)\(2\)](#) and [\(e\)\(8\)](#)

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### I. CPT<sup>1</sup> PROCEDURE CODES

19361-19369, 19499

### II. DESCRIPTION

A congenital anomaly is a significant deviation from the normal form, existing at, and usually before, birth. It also refers to certain malformations or diseases which may be either hereditary or due to some influence occurring during gestation.

### III. POLICY

A. Breast reconstructive surgery, to include surgery performed to establish symmetry, is covered to correct breast deformities related to a verified congenital anomaly. The following are examples of congenital anomalies that require breast reconstruction:

1. Amastia (absence of the breast); athelia (absence of nipple); polymastia (supernumerary breasts); polythelia (supernumerary nipples); tubular breast deformity.
2. Congenital hypoplasia of one breast and gigantomastia of the contralateral breast with ptosis.
3. Paucity of breast tissue due to chest wall deformities.

NOTE: The intent of the law is to allow coverage for reconstructive surgery to correct a congenital anomaly. A congenital anomaly may be present at birth, but only manifest later; e.g., at puberty. In these cases, documentation (i.e., photographs and physical examination, etc.) to verify the anomaly may be required.

B. Augmentation and/or reduction of the collateral breast to correct congenital asymmetry when related to a congenital anomaly is covered.

C. Breast Magnetic Resonance Imaging (MRI) to detect implant rupture is covered. The implantation of the breast implants must have been covered by TRICARE.

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**TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002**  
CHAPTER 4, SECTION 5.6  
BREAST RECONSTRUCTION AS A RESULT OF A CONGENITAL ANOMALY

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IV. EXCLUSION

Reconstructive breast surgery for incomplete or underdevelopment of breast not related to a verified congenital anomaly may not be cost-shared.

- END -

## GYNECOMASTIA

ISSUE DATE: May 18, 1994

AUTHORITY: [32 CFR 199.4](#)

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### I. CPT<sup>1</sup> PROCEDURE CODES

19318, 19140, 19182

### II. DESCRIPTION

A. Pathological gynecomastia (ICD-9-CM 611.1) is an abnormal enlargement of the male mammary glands. Some causes of pathological gynecomastia are testicular or pituitary tumors, some syndromes of male hypogonadism, cirrhosis of the liver, administration of estrogens for prostatic carcinoma, and therapy with steroidal compounds.

B. Physiological (pubertal) gynecomastia occurs in teenage boys, usually between the ages of 13-15. In more than 90% of these boys, the condition resolves within a year. Gynecomastia persisting beyond one (1) year is severe and is usually associated with pain in the breast from distension (ICD-9-CM 611.71) and fibrous tissue stroma.

### III. POLICY

Benefits may be cost-shared for medically necessary medical, diagnostic, and surgical treatment.

NOTE: Coverage criteria for surgical interventions may include, but is not limited to: severe gynecomastia (enlargement has not resolved after one year); fibrous tissue stroma exists; or breast pain.

### IV. EXCLUSION

Surgical treatment performed purely for psychological reasons.

- END -

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## MUSCULOSKELETAL SYSTEM

ISSUE DATE: August 26, 1985

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

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### I. CPT<sup>1</sup> PROCEDURE CODES

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

### II. HCPCS CODES

S2360, S2361

### III. DESCRIPTION

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

### IV. POLICY

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

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

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

D. Percutaneous vertebroplasty (CPT<sup>1</sup> procedure codes 22520-22522, S2360, S2361) and balloon kyphoplasty (CPT<sup>1</sup> procedure codes 22523-22525) are covered for the treatment of painful osteolytic lesions and osteoporotic compression fractures refractory to conservative medical treatment.

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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 4, SECTION 6.1

MUSCULOSKELETAL SYSTEM

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V. EXCLUSIONS

- A. Meniscal transplant (CPT<sup>2</sup> procedure code 29868) for meniscal injury is unproven.
- B. Ligament replacement with absorbable copolymer carbon fiber scaffold is unproven.
- C. Prolotherapy, joint sclerotherapy and ligamentous injections with sclerosing agents (HCPCS procedure code M0076) are unproven.
- D. Trigger point injection (CPT<sup>2</sup> procedure codes 20552, 20553) for migraine headaches.
- E. IDET (Intradiscal Electrothermal Therapy) for Chronic Discogenic Pain (CPT<sup>2</sup> procedure codes 0062T and 0063T) is unproven.
- F. Botox (chemodenervation) for migraine headaches is unproven.
- G. Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace, cervical; single interspace (CPT<sup>2</sup> procedure code 0090T) each additional interspace (CPT<sup>2</sup> procedure code 0092T) is unproven.
- H. Removal of total disc arthroplasty anterior approach cervical; single interspace (0093T) each additional interspace (CPT<sup>2</sup> procedure code 0095T). Also see [Chapter 4, Section 1.1](#).
- I. Artificial intervertebral disc replacement for degenerative disc disease is unproven (CPT<sup>2</sup> procedure codes 0090T - 0098T).
- J. Extracorporeal shock wave, high energy involving the plantar fascia (CPT<sup>2</sup> procedure code 28890).
- K. X STOP Interspinous Process Decompression System for the treatment of neurogenic intermittent claudication secondary to lumbar spinal stenosis is unproven.
- L. Hip core decompression is unproven.

VI. EFFECTIVE DATE

March 1, 2007, for percutaneous vertebroplasty and balloon kyphoplasty.

- END -

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## ELECTRICAL STIMULATION OF BONE

ISSUE DATE: October 6, 1988

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

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### I. CPT<sup>1</sup> 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.

3. Congenital pseudo-arthrooses.

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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 4, SECTION 6.2  
ELECTRICAL STIMULATION OF BONE

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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-arthrosis, 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 -

## RESPIRATORY SYSTEM

ISSUE DATE: August 26, 1985

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

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### I. CPT<sup>1</sup> PROCEDURE CODES

30000 - 32488, 32491, 32500 - 32999, 96570, 96571

### II. DESCRIPTION

The respiratory system is comprised of the tubular and cavernous organs and structures by means of which pulmonary ventilation and gas exchange between ambient air and the blood are brought about.

### III. POLICY

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

B. Resection of pneumatoceles is a covered procedure.

C. Lung Volume Reduction Surgery (LVRS) is a covered procedure, see [Chapter 4, Section 8.2](#).

### IV. EXCLUSIONS

A. Endoscopic thoracic sympathectomy for the treatment of hyperhidrosis is excluded.

B. Pillar palatal implant system for the treatment of Obstructive Sleep Apnea (OSA) is unproven.

- END -

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## LUNG VOLUME REDUCTION SURGERY (LVRS)

ISSUE DATE: March 3, 2005

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

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### I. CPT<sup>1</sup> PROCEDURE CODE

32491

### II. HCPCS PROCEDURE CODES

G0302, G0303, G0304, G0305

### III. DESCRIPTION

Lung volume reduction surgery (LVRS), also referred to as reduction pneumoplasty, lung shaving or lung contouring, is a palliative surgical procedure for late-stage emphysema. Surgeons remove a large volume (approximately 20% to 30%) of tissue from one or both lungs simultaneously or sequentially. This reduces the volume of the chest cavity occupied by the lungs, enabling the patient to ventilate the remaining lung tissue more effectively. The surgery can be performed either by video-assisted thorascopic surgery (VATS) or by open incision (median sternotomy), and the lung volume can be reduced, using a stapler.

### IV. POLICY

A. LVRS is covered for patients with severe upper lobe predominant emphysema or severe non-upper lobe emphysema with low exercise capacity. Patients must meet the following selection criteria:

1. History and physical exam consistent with emphysema; and
2. Patient has not smoked for 4 or more months; and
3. For patients with cardiac ejection fraction less than 45%, there is no history of congestive heart failure or myocardial infarction within six months of consideration for surgery; and

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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 4, SECTION 8.2

LUNG VOLUME REDUCTION SURGERY (LVRS)

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4. The patient has all of the following on pre-operative workup:
  - a. Forced expiratory volume (FEV<sub>1</sub>) (maximum of pre- and post-bronchodilator values) less than or equal to 45% of predicted and, if age 70 or older, FEV<sub>1</sub> 15% of predicted or more; and
  - b. Post-bronchodilator total lung capacity (TLC) greater than or equal to 100% of predicted value and residual volume (RV) greater than or equal to 150% of predicted value; and
  - c. Resting partial pressure of oxygen (PaO<sub>2</sub>) 44 mm Hg or greater; and
  - d. Resting partial pressure of carbon dioxide (PaCO<sub>2</sub>) less than or equal to 60 mm Hg on room air; and
  - e. CT scan evidence of bilateral emphysema; and
  - f. Plasma cotinine less than or equal to 13.7 ng/ml (if not using nicotine products) or carboxyhemoglobin less than or equal to 2.5% (if using nicotine products); and
  - g. Six-minute walk test greater than 140 meters.
- B. LVRS is limited to bilateral excision of a damaged lung with stapling performed via median sternotomy or video-assisted thorascopic surgery.
- C. LVRS is not covered if the patient has either of the following contraindication:
  1. Post-bronchodilator FEV<sub>1</sub> is 20% or less than its predicted value and patient has either:
    - a. A homogenous distribution of emphysema on CT scan; or
    - b. A carbon monoxide diffusion capacity (DL<sub>CO</sub>) is 20% or less than its predicted value.
  2. Patients with predominantly non-upper lobe emphysema and a high maximal workload.
    - a. A high maximal workload is defined as a maximal workload (on cycle ergometry with an increment of 5 or 10 W per minute after three minutes of pedaling with the ergometer set at 0 W and the person breathing 30% oxygen) above the sex-specific 40th percentile (25 W for women, 40 W for men).
    - b. Predominantly non-upper lobe predominance of emphysema is defined to exclude disease on CT that is judged by the radiologist as affecting primarily the upper lobes of the lung, and to include disease that is judged to be predominantly lower lobe, diffuse, or predominantly affecting the superior segments of the lower lobes.

## CARDIOVASCULAR SYSTEM

ISSUE DATE: August 26, 1985

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

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### I. CPT<sup>1</sup> 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 (CPT<sup>1</sup> 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) (CPT<sup>2</sup> 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 Coronary Artery Bypass Graft (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.

G. Endovenous radiofrequency ablation/obliteration (CPT<sup>2</sup> procedure codes 36475 and 36476) for the treatment of saphenous venous reflux with symptomatic varicose veins is covered when:

1. One of the following indications is present:

a. Persistent symptoms interfering with activities of daily living in spite of conservative/non-surgical management. Symptoms include aching, cramping, burning, itching and/or swelling during activity or after prolonged standing.

b. Significant recurrent attacks of superficial phlebitis.

c. Hemorrhage from a ruptured varix.

d. Ulceration from venous stasis where incompetent varices are a contributing factor.

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e. Symptomatic incompetence of the great or small saphenous veins (symptoms as in [paragraph III.G.1.a.](#)).

2. A trial of conservative, non-operative treatment has failed. This would include mild exercise, avoidance of prolonged immobility, periodic elevation of legs, and compressive stockings.

3. The patient's anatomy is amenable to endovenous ablation.

H. Ambulatory Blood Pressure Monitoring (ABPM) is only covered for beneficiaries with suspected white coat hypertension and is NOT covered for any other uses. The information obtained by ABPM is necessary in order to determine the appropriate medical management of the beneficiary. Suspected white coat hypertension is considered to exist when the following is documented:

1. There is no evidence of end-organ damage;

2. Office blood pressure greater than 140/90 mm Hg on at least three separate clinic/office visits with two separate measurements made at each visit; and

3. At least two blood pressure measurements taken outside the office which are less than 140/90 mm Hg.

#### IV. EXCLUSIONS

A. Thermogram; cephalic (CPT<sup>3</sup> procedure code 93760); peripheral (CPT<sup>3</sup> 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 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.

F. Signal-Average Electrocardiography (CPT<sup>3</sup> procedure code 93278) is unproven.

G. Primary percutaneous transluminal mechanical thrombectomy (CPT<sup>3</sup> procedure code 37184) with or without second and all subsequent vessel(s) with the same vascular family (CPT<sup>3</sup> procedure code 37185) is unproven.

H. Secondary percutaneous transluminal thrombectomy (CPT<sup>3</sup> procedure code 37186) is unproven.

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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 4, SECTION 9.1

CARDIOVASCULAR SYSTEM

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I. l. Percutaneous transluminal mechanical thrombectomy vein(s) including intraprocedural pharmacological thrombolytic injections and fluroscopic guidance (CPT<sup>4</sup> 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 (CPT<sup>4</sup> procedure code 37188) is unproven.

K. Pulmonary vein antrum isolation/ablation for treatment of atrial fibrillation 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.

D. December 1, 2003, for endovenous radiofrequency ablation/obliteration.

E. January 1, 2005, for ABPM.

- END -

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## PHOTOPHERESIS

ISSUE DATE: June 30, 1993

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

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### I. CPT<sup>1</sup> PROCEDURE CODE

36522

### II. DESCRIPTION

Photopheresis is a type of plasmapheresis during which white blood cells and some plasma is exposed to ultraviolet (UV) light before being returned to the patient.

### III. POLICY

Photopheresis is covered for the following:

- A. The treatment of skin manifestations of cutaneous T-cell lymphoma (CTCL) in persons who have not been responsive to other forms of treatment.
- B. The prevention of rejection in cardiac transplantation.
- C. For other indications when reliable evidence supports that photopheresis is safe, effective and comparable or superior to standard care (proven).

- END -

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## INTRACORONARY STENTS

ISSUE DATE: July 8, 1998

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

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### I. CPT<sup>1</sup> PROCEDURE CODES

92980, 92981

### II. HCPCS PROCEDURE CODES

G0290, G0291

### III. DESCRIPTION

Intracoronary stenting consists of coils or tubes that are positioned within the coronary vessel to provide support or “scaffolding” to the internal vessel architecture. Most stents are metallic coils or tubes and balloon expandable or self-expanding.

### IV. POLICY

A. Coronary artery stenting may be cost-shared for the following indications as an adjunct to percutaneous transluminal coronary angioplasty:

1. To reduce the incident of restenosis; and
2. For acute or threatened vessel closure following balloon angioplasty.

B. Coronary artery stents are covered for treatment of saphenous vein narrowing with previous coronary angioplasty bypass grafting.

C. Intracoronary stents must have FDA approval based on its specific intention.

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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 4, SECTION 9.3

INTRACORONARY STENTS

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V. EFFECTIVE DATES

- A. November 1, 1996, for intracoronary stents.
- B. April 24, 2003, for drug eluting stents.

- END -

## THERAPEUTIC APHERESIS

ISSUE DATE: December 29, 1982

AUTHORITY: [32 CFR 199.4\(d\)\(1\)](#)

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### I. CPT<sup>1</sup> PROCEDURE CODES

36520, 36521

### II. DESCRIPTION

Any procedure in which blood is withdrawn from a donor, a portion (plasma, leukocytes, platelets, etc.) is separated and retained, and the remainder is retransfused into the donor.

### III. POLICY

Therapeutic apheresis is covered when medically necessary and the standard of medical practice. Outlined below are some examples of conditions for which therapeutic apheresis is indicated. 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).

- A. Myasthenia gravis during a life-threatening crisis;
- B. Goodpasture's Syndrome.
- C. Life-threatening immune complex rheumatoid vasculitis.
- D. Multiple myeloma (symptomatic monoclonal gammopathy).
- E. Waldenstrom's macroglobulinemia.
- F. Hypergammaglobulinemia purpura.
- G. Cryoglobulinemia.
- H. Thrombotic thrombocytopenic purpura.
- I. Guillain-Barre syndrome.

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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 4, SECTION 9.4

THERAPEUTIC APHERESIS

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J. Membranous and proliferative nephritis (glomerulonephritis).

K. Chronic myelogenous leukemia.

L. Chronic inflammatory demyelinating polyneuropathy.

M. Familial hypercholesterolemia. The device must be FDA approved and used only in accordance with FDA labeling.

N. Leukapheresis in the treatment of leukemia.

O. Hemolytic uremic syndrome (HUS).

P. Hyperviscosity syndromes.

Q. Homozygous familial hypercholesterolemia.

R. Post-transfusion purpura.

S. Refsum's disease.

IV. EXCLUSION

Therapeutic apheresis for the treatment of desmoplastic small, round-cell tumor is unproven.

- END -

## TRANSJUGULAR INTRAHEPATIC PORTOSYSTEMIC SHUNT (TIPS)

ISSUE DATE: May 7, 1999

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

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### I. CPT<sup>1</sup> PROCEDURE CODES

37140 - 37181, 37205, 49425

### II. DESCRIPTION

Transjugular intrahepatic portosystemic shunt (TIPS) is an invasive radiological procedure performed percutaneously through the jugular vein and involves the creation of an intrahepatic shunt between the hepatic vein and portal vein.

### III. POLICY

A. TIPS is 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. Therapy of acute or recurrent esophageal variceal bleeding which is not controlled by or is unresponsive to standard treatment such as endoscopic therapy, pharmacological therapy or surgical shunt.

2. Patients with irreversible hepatic disease who are candidates for liver transplantation and require control of esophageal variceal bleeding.

3. For the treatment of patients with refractory ascites.

### IV. EFFECTIVE DATES

A. September 29, 1995, for acute or recurrent esophageal varical bleeding.

B. June 8, 2000, for refractory ascites.

- END -

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## HEMIC AND LYMPHATIC SYSTEMS

ISSUE DATE: August 26, 1985

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

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### I. CPT<sup>1</sup> PROCEDURE CODES

37765, 37766, 38100 - 38200, 38220, 38221, 38300 - 38999

### II. DESCRIPTION

The lymphatic system involves the lymphatic vessels and lymphoid tissue, considered collectively. Hemic refers to the blood.

### III. POLICY

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

- END -

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## MEDIASTINUM AND DIAPHRAGM

ISSUE DATE: August 26, 1985

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

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### I. CPT<sup>1</sup> PROCEDURE CODE RANGE

39000 - 39599

### II. DESCRIPTION

The mediastinum involves the mass of tissues and organs separating the two lungs, between the sternum in front and the vertebral column behind, and from the thoracic inlet above to the diaphragm below. It contains the heart and its large vessels, the trachea, esophagus, thymus, lymph nodes, and other structures and tissues. The diaphragm involves the musculomembranous partition separating the abdominal and thoracic cavities, and serves as a major inspiratory muscle.

### III. POLICY

Services and supplies required in the diagnosis and treatment of illness or injury involving either the mediastinum or diaphragm are covered.

- END -

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## DIGESTIVE SYSTEM

ISSUE DATE: August 26, 1985

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

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### I. CPT<sup>1</sup> PROCEDURE CODES

40490 - 40831, 40899 - 43644, 43651 - 43761, 43800, 43810, 43820, 43842, 43846 43848, 43880, 43999, 44005 - 47362, 47371, 47379, 47381, 47399 - 49999, 91123, 96570, 96571

### II. DESCRIPTION

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

### III. POLICY

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

### IV. EXCLUSIONS

- A. Vestibuloplasty except for adjunctive care (CPT<sup>1</sup> procedure code range 40840-40845).
- B. Percutaneous interstitial thermal ablation in the treatment of hepatic cancer is unproven.
- C. For bariatric procedures, see [Section 13.2](#).

- END -

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## SURGERY FOR MORBID OBESITY

ISSUE DATE: November 9, 1982

AUTHORITY: [32 CFR 199.4\(e\)\(15\)](#)

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### I. CPT<sup>1</sup> PROCEDURE CODES

43644, 43770 - 43774, 43842, 43846, 43848, 43886 - 43888, S2083

### II. DESCRIPTION

Morbid obesity means the body weight is 100 pounds over ideal weight for height and bone structure, according to the most current Metropolitan Life Table, and such weight is in association with severe medical conditions known to have higher mortality rates in association with morbid obesity; or, the body weight is 200% or more of ideal weight for height and bone structure.

### III. POLICY

A. Gastric bypass, gastric stapling or gastroplasty, to include vertical banded gastroplasty is covered when one of the following conditions is met:

1. The patient is 100 pounds over the ideal weight for height and bone structure and has one of these associated medical conditions: diabetes mellitus, hypertension, cholecystitis, narcolepsy, Pickwickian syndrome (and other severe respiratory diseases), hypothalamic disorders and severe arthritis of the weight-bearing joints.

2. The patient is 200% or more of the ideal weight for height and bone structure. An associated medical condition is not required for this category.

3. The patient has had an intestinal bypass or other surgery for obesity and, because of complications, requires a second surgery (a takedown).

B. In determining the ideal body weight for morbid obesity using the Metropolitan Life Table, contractors must apply 100 pounds (or 200%) to both the lower and higher end of the weight range. Payment will be allowed when beneficiaries meet all requirements for morbid obesity surgery including the ideal weight within the newly determined range.

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IV. EXCLUSIONS

- A. Nonsurgical treatment of obesity, morbid obesity, dietary control or weight reduction.
- B. Biliopancreatic bypass (jejunioileal bypass, Scopinaro procedure) for treatment of morbid obesity is unproven (CPT<sup>2</sup> procedure code 43645, 43845, 43847, or 43633).
- C. Gastric bubble or balloon for treatment of morbid obesity is unproven.
- D. Gastric wrapping/open gastric banding (CPT<sup>2</sup> procedure code 43843) for treatment of morbid obesity is unproven.
- E. Unlisted CPT<sup>2</sup> procedure codes 43659 (laparoscopy procedure, stomach); 43999 (open procedure, stomach); and 49329 (laparoscopy procedure, abdomen, peritoneum, and omentum) for gastric bypass procedures.

V. EFFECTIVE DATES

- A. Laparoscopic surgical procedure for gastric bypass and gastric stapling (gastroplasty), including vertical banded gastroplasty are covered, effective December 2, 2004.
- B. Laparoscopic adjustable gastric banding is covered, effective February 1, 2007.

- END -

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## URINARY SYSTEM

ISSUE DATE: August 26, 1985

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

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### I. CPT<sup>1</sup> PROCEDURE CODES

50010 - 53899, 64561, 64581, 64585, 64590, 64595

### II. DESCRIPTION

The urinary system involves those organs concerned in the production and excretion of urine.

### III. POLICY

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

B. Benefits may be considered for the implantation of similar FDA approved devices. The Sacral Nerve Root Stimulation (SNS) has received FDA approval. Services and supplies related to the implantation of the SNS may be covered for individuals with urge incontinence, nonobstructive urinary retention, or symptoms of urgency-frequency syndrome that is not due to a neurologic condition, who have failed previous conservative treatments, and who have had a successful peripheral nerve evaluation test.

C. The use of a bedwetting alarm for the treatment of primary nocturnal enuresis may be considered for cost sharing when prescribed by a physician and after physical or organic causes for nocturnal enuresis have been ruled out.

D. Collagen implantation of the urethra and/or bladder neck may be covered for patients not amenable to other forms of urinary incontinence treatment.

E. Cryoablation for renal cell carcinoma (CPT<sup>1</sup> procedure codes 50250 and 50542) may be considered for coverage under the Rare Disease policy ([Chapter 1, Section 3.1](#)) on a case-by-case basis. Effective June 1, 2006.

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IV. EXCLUSIONS

A. Peri-urethral Teflon injection is unproven.

B. Silastic gel implant.

C. Acrylic prosthesis (Berry prosthesis).

D. Bladder stimulators, direct or indirect, such as spinal cord, rectal and vaginal electrical stimulators, or bladder wall stimulators. Payment for any related service or supply, including inpatient hospitalization primarily for surgical implementation of a bladder stimulator.

E. Transurethral balloon dilation of the prostate (CPT<sup>2</sup> procedure code 52510) is unproven.

F. Laparoscopic radiofrequency ablation (CPT<sup>2</sup> procedure code 50542) and percutaneous radiofrequency ablation (CPT<sup>2</sup> procedure code 50592) for renal masses/tumors are unproven.

V. EFFECTIVE DATE

Transurethral Needle Ablation (TUNA) of the prostate is proven (CPT<sup>2</sup> procedure code 53852). Effective June 1, 2004.

- END -

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## MALE GENITAL SYSTEM

ISSUE DATE: August 26, 1985

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

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### I. CPT<sup>1</sup> PROCEDURE CODES

54000 - 55300, 55450 - 55866, 55873 - 55899, 55970

### II. DESCRIPTION

The male genital system includes the male organs of reproduction.

### III. POLICY

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

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

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

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

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

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

1. Penile Implant

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

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

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

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

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

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

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

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

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

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

IV. EXCLUSIONS

- A. Penile implants and related services when performed for psychological impotence, transsexualism, or such other conditions as gender dysphoria.
- B. Testicular prosthesis and related services when performed for transsexualism or such other conditions as gender dysphoria.
- C. Therapy for sexual dysfunctions or inadequacies (see [Chapter 7, Section 1.1.](#)).
- D. Arterial revascularization for distal lesions and venous leakage when treatment is for organic impotency.
- E. Intersex surgery, except when performed to correct sex gender confusion/ambiguous genitalia, which is documented to have been present at birth (CPT<sup>2</sup> procedure code 55970).
- F. Reversal of surgical sterilization (CPT<sup>2</sup> procedure code 55400).
- G. Cryosurgery for prostate metastases M or N is unproven.
- H. Electroejaculation (CPT<sup>2</sup> procedure code 55870).

- END -

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## INTERSEX SURGERY

ISSUE DATE: August 26, 1985

AUTHORITY: [32 CFR 199.4\(e\)\(7\)](#) and [\(g\)\(29\)](#)

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### I. CPT<sup>1</sup> PROCEDURE CODE RANGE

55970 - 55980

### II. DESCRIPTION

Intersex involves an individual who shows intermingling, in varying degrees, of the characteristics of each sex, including physical form, reproductive organs, and sexual behavior.

### III. POLICY

Surgery performed to correct sex gender confusion (i.e., ambiguous genitalia) which has been documented to be present at birth is a covered benefit.

### IV. EXCLUSION

All services and supplies directly and indirectly related to intersex surgery for other than ambiguous genitalia documented to be present at birth, are excluded from cost-sharing.

- END -

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## FEMALE GENITAL SYSTEM

ISSUE DATE: August 26, 1985

AUTHORITY: 32 CFR 199.4(c)(2), (c)(3), (e)(3), and (g)(34)

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### I. CPT<sup>1</sup> PROCEDURE CODES

11975 - 11977, 55980, 56405 - 58301, 58340, 58345, 58346, 58350, 58353, 58356, 58400 - 58671, 58679, 58700 - 58740, 58800 - 58960, 58999, 59001

### II. DESCRIPTION

The female genital system includes the female organs of reproduction.

### III. POLICY

A. Services and supplies required in the diagnosis and treatment of illness or injury involving the female genital system are covered. Infertility testing and treatment, including correction of the physical cause of infertility, are covered under this provision. This does not include artificial insemination, which is excluded from coverage.

B. Uterine suspension; parametrial fixation as treatment for uterine prolapse may be cost-shared only to retain the uterus for biologic purposes.

C. Intersex surgery (CPT<sup>1</sup> procedure code 55980) is limited to surgery performed to correct sex gender confusion/ambiguous genitalia which is documented to have been present at birth.

NOTE: For policy on prophylactic mastectomy, prophylactic oophorectomy, and prophylactic hysterectomy, see [Chapter 4, Section 5.3](#).

### IV. POLICY CONSIDERATION

Benefits are payable for Uterine Artery Embolization (UAE), as an alternative treatment (CPT<sup>1</sup> procedure code 37210) to hysterectomy or myomectomy, for those individuals with confirmed, symptomatic uterine fibroids who are premenopausal and who do not wish to preserve their childbearing potential.

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V. EXCLUSIONS

- A. Prophylactics (condoms).
- B. Over-the-counter spermicidal products.
- C. Reversal of a surgical sterilization procedure (CPT<sup>2</sup> procedure codes 58672, 58673, 58750-58770).
- D. Artificial insemination, including any costs related to donors and semen banks (CPT<sup>2</sup> procedure codes 58321-58323).
- E. In-Vitro Fertilization (IVF), Gamete Intrafallopian Transfer (GIFT) and all other non-coital reproductive procedures, including all services and supplies related to, or provided in conjunction with, those technologies (CPT<sup>2</sup> procedure codes 58970-58976).
- F. Hysterectomy (CPT<sup>2</sup> procedure codes 58150-58285, 58550, 59525) performed solely for purposes of sterilization in the absence of pathology.
- G. Subtotal hysterectomy performed exclusively to preserve sexual function and/or to prevent postoperative complications (e.g., urinary incontinence; vaginal prolapse).
- H. Cervicography (CPT<sup>2</sup> category III procedure code 0003T) is unproven.
- I. Uterine Artery Embolization (UAE) for individuals with specific contraindications, including such conditions as pelvic malignancy and pelvic inflammatory disease, and premenopausal patients who wish to preserve their childbearing potential.

- END -

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## MATERNITY CARE

ISSUE DATE: August 26, 1985

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

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### I. CPT<sup>1</sup> PROCEDURE CODES

59000 - 59899, 82105, 82106, 82731, 84702

### II. DESCRIPTION

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

### III. POLICY

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

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

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

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

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

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

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

IV. EXCLUSIONS

A. Services and supplies related to noncoital reproductive procedures.

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

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

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

E. Salivary estriol test for preterm labor is unproven (CPT<sup>2</sup> procedure code 82677).

- END -

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## ANTEPARTUM SERVICES

ISSUE DATE: March 3, 1992

AUTHORITY: 32 CFR 199.4(e)(3)(ii), (e)(16), and (g)(36)

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### I. CPT<sup>1</sup> PROCEDURE CODES

59000 - 59051, 59070, 59072, 59074, 59076

### II. DESCRIPTION

Antepartum services include amniocentesis, (transabdominal needle aspiration of amniotic fluid), chordocentesis (percutaneous puncture of the umbilical vein to obtain fetal blood sample), chorionic villus sampling (transabdominal or transcervical aspiration of the villus tissue), fetal stress tests, and electronic fetal monitoring. These services are performed to detect genetic abnormalities, hemolytic disease and metabolic disorders, assess fetal age, pulmonary maturity and health, and determine fetal stress.

### III. POLICY

A. Amniocentesis, chordocentesis, and chorionic villus sampling are covered when:

1. Performed to assess fetal lung maturity for preterm labor or delivery because of life-endangering fetal and/or maternal conditions.
2. Performed to assess the degree of fetal involvement in hemolytic disease.
3. Performed for genetic testing when:
  - a. The mother is 35 years old or older, or will be 35 by delivery; or
  - b. The mother or father has had a previous child born with a congenital abnormality; or
  - c. The mother or father has a family history of congenital abnormalities; or
  - d. The mother contracted rubella during the first trimester of pregnancy; or

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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 4, SECTION 18.2

ANTEPARTUM SERVICES

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- e. There is a history of three or more spontaneous abortions in the current marriage or in previous mating of either spouse; or
  - f. The fetus is at an increased risk for a hereditary error of metabolism detectable in vitro; or
  - g. The fetus is at an increased risk for neural tube defect (family history or elevated maternal serum alpha-fetoprotein level); or
  - h. There is a history of sex-linked conditions (i.e., Duchenne muscular dystrophy, hemophilia, x-linked mental retardation, etc.).
- B. Electronic fetal monitoring, supervision, and interpretation, to determine at-risk fetal distress and to avoid intrapartum fetal brain damage and loss is covered.

IV. EXCLUSIONS

Antepartum services are excluded when:

- A. Performed to establish paternity of a child.
- B. Performed to determine the sex of an unborn child.
- C. Performed as routine or demand genetic testing.
- D. Isoimmunization to the ABO blood antigens.

- END -

## ABORTIONS

ISSUE DATE: April 19, 1983

AUTHORITY: 32 CFR 199.2(b) and 32 CFR 199.4(e)(2)

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### I. CPT<sup>1</sup> PROCEDURE CODE RANGE

59812 - 59857

### II. DESCRIPTION

Abortion means the intentional termination of a pregnancy by artificial means done for a purpose other than that of producing a live birth. An elective abortion means the intentional termination of pregnancy by artificial means done for a purpose other than that of producing a live birth.

### III. POLICY

A. By law, elective abortions may not be cost-shared. Abortions may be cost-shared only when the life of the mother would be endangered if the fetus were carried to term. Covered abortion services are limited to medical services and supplies. Physician certification attesting that the abortion was performed because the mother's life would have been endangered if the fetus were carried to term is required.

B. Services and supplies related to spontaneous, missed or threatened abortions and abortions related to ectopic pregnancies may be cost-shared.

### IV. EXCLUSIONS

A. Services and supplies related to a noncovered abortion.

B. Abortion counseling, referral, preparation and follow-up for a non-covered abortion.

C. Abortions for fetal abnormality (e.g., anencephalic) or for psychological reasons (i.e., threatened suicide).

D. Selective reduction of multi-fetal gestations, except when the life of the mother would be endangered if the multi-fetal gestation was carried to term.

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**TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002**

CHAPTER 4, SECTION 18.3

ABORTIONS

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V. EFFECTIVE DATES

A. June 5, 1981, for beneficiaries of the Department of Health and Human Services (includes the Coast Guard, Commissioned Corps of the Public Health Service and the National Oceanic and Atmospheric Administration).

B. December 29, 1981, for beneficiaries of the Department of Defense (includes Army, Navy, Air Force and Marine Corps).

- END -

## CESAREAN SECTIONS

ISSUE DATE: July 27, 1993

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

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### I. CPT<sup>1</sup> PROCEDURE CODE RANGE

59510 - 59515

### II. POLICY

Services and supplies related to medically necessary cesarean sections may be cost-shared. Cost-sharing for services and supplies related elective cesarean sections, that is, those done at the request or convenience of the beneficiary, is limited to what would have been provided for vaginal delivery. The beneficiary is responsible for any amount that exceeds the amount of coverage when an elective cesarean section is performed.

- END -

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## ENDOCRINE SYSTEM

ISSUE DATE: August 26, 1985

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

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### I. CPT<sup>1</sup> PROCEDURE CODES

60000 - 60699

### II. DESCRIPTION

A. The endocrine system consists of glands and other structures that elaborate internal secretions (hormones) which are released directly into the circulatory system and which influence metabolism and other body processes.

B. Organs having endocrine function include the pituitary, thyroid, parathyroid, and adrenal glands, the pineal body, the gonads, the pancreas, and the paraganglia.

### III. POLICY

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

### IV. EXCLUSION

Carotid body resection (CPT<sup>1</sup> procedure codes 60600 and 60605) when done solely to relieve the symptoms of pulmonary dyspnea, including chronic obstructive pulmonary disease, is unproven.

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## NERVOUS SYSTEM

ISSUE DATE: August 26, 1985

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

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### I. CPT<sup>1</sup> 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 reduce the likelihood of rupture and hemorrhagic stroke. By applying a low voltage direct

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current to a stainless steel wire at the base of the coil, the platinum coil is detached. This applied current not only detaches the coil but also promotes electrothrombosis within the aneurysm.

III. POLICY

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

B. Therapeutic embolization (CPT<sup>2</sup> 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 (CPT<sup>3</sup> 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 (CPT<sup>3</sup> procedure codes 63050 and 63051).

N. Balloon angioplasty, intracranial, percutaneous (CPT<sup>3</sup> procedure code 61630) is unproven. Effective January 1, 2006.

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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 4, SECTION 20.1

NERVOUS SYSTEM

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O. Transcatheter placement of intravascular stent(s) intracranial, (e.g., atherosclerotic stenosis) including angioplasty, if performed (CPT<sup>4</sup> procedure code 61635) is unproven. Effective January 1, 2006.

P. Balloon dilation of intracranial vasospasm, initial vessel (CPT<sup>4</sup> procedure code 61640) each additional vessel in same family (CPT<sup>4</sup> procedure code 61641) or different vascular family (CPT<sup>4</sup> 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.

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## STEREOTACTIC RADIOFREQUENCY PALLIDOTOMY WITH MICROELECTRODE MAPPING FOR TREATMENT OF PARKINSON'S DISEASE

ISSUE DATE: July 8, 1998

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

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### I. CPT<sup>1</sup> PROCEDURE CODE

61720

### II. DESCRIPTION

Pallidotomy (a new procedure) is a neurosurgical procedure involving a surgical lesion of the globus pallidus, which lies in the basal ganglia portion of the brain, with the aim of controlling one or more of the major symptoms of parkinsonism, including tremor, rigidity, and hypokinesia, in those patients who have not responded adequately to medical treatment.

### III. POLICY

Pallidotomy for Parkinson's disease may be cost-shared when the patient has a diagnosis of idiopathic Parkinson's disease.

### IV. EXCLUSIONS

A. Patients exhibiting signs of early dementia.

B. Elderly patients with very advanced disease, autonomic symptoms, severe speech impairment.

C. Patients with "Parkinson's Plus" syndrome which mimic true Parkinson's disease, e.g., postural instability, freezing, poor speech volume and swallowing difficulties.

V. EFFECTIVE DATE            November 1, 1996.

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## STEREOTACTIC RADIOFREQUENCY THALAMOTOMY

ISSUE DATE: July 8, 1998

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

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### I. CPT<sup>1</sup> PROCEDURE CODE

61720

### II. DESCRIPTION

Thalamotomy with microelectrode mapping is a neurosurgical procedure involving precision placement of a destructive lesion in the thalamus for relief of Parkinsonian resting tremor, intention tremor or dystonia.

### III. POLICY

A. Benefits are covered for unilateral thalamotomy with microelectrode mapping for destructive lesion in the globus pallidus to treat disabling tremor from either Parkinson's disease, intention tremor or dystonia when patients are no longer receptive to other treatments.

B. Indications for a thalamotomy are as follows:

1. Intention tremor:
  - a. Multiple sclerosis
  - b. Post-traumatic
  - c. Familial (Essential)
  - d. Post cerebrovascular accident (stroke)
2. Dystonia of arm or leg (also known as focal dystonias)
3. Dystonia musculorum deformans
4. Post-traumatic dystonia

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5. Parkinsonism resting tremor

C. Contraindications for a thalamotomy are as follows:

1. Dementia, memory or thought disturbance
2. Poorly controlled high blood pressure
3. Gait disturbance
4. Significant speech problems

IV. EXCLUSIONS

A. Muscle resection for Parkinsonian tremor, intention tremor, or dystonia is unproven.

B. Rhizotomy for Parkinsonian tremor, intention tremor, or dystonia is unproven.

C. Selective peripheral denervation for Parkinsonian tremor, intention tremor, or dystonia is unproven.

D. Fetal tissue transplantation (embryonic mesencephalic transplantation) for Parkinsonian tremor, intention tremor, or dystonia is unproven.

V. EFFECTIVE DATE            October 1, 1995.

- END -

## EYE AND OCULAR ADNEXA

ISSUE DATE: August 26, 1985

AUTHORITY: [32 CFR 199.4\(c\)\(2\)](#), [\(c\)\(3\)](#) and [\(g\)\(46\)](#)

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### I. CPT<sup>1</sup> PROCEDURE CODES

65091 - 65755, 65772 - 68899, 77600 - 77615

### II. DESCRIPTION

The eye is the organ of vision and the ocular adnexa are the appendages or adjunct parts; i.e., eyelids, lacrimal apparatus.

### III. POLICY

A. Services and supplies required in the diagnosis and treatment of illness or injury involving the eye or ocular adnexa are covered.

B. Phototherapeutic Keratectomy (PTK) is covered for corneal dystrophies.

C. Strabismus. Surgical procedures and eye examinations to correct, treat, or diagnose strabismus are covered.

D. Corneal transplants. A corneal transplant (keratoplasty) is a covered surgical procedure. Relaxing keratotomy to relieve astigmatism following a corneal transplant is covered.

E. Transpupillary thermotherapy (laser hyperthermia, CPT<sup>1</sup> procedure codes 77600 - 77615), with chemotherapy, is covered for the treatment of retinoblastoma. See also [Chapter 5, Section 5.1](#).

### IV. EXCLUSIONS

A. Refractive corneal surgery except as noted in [paragraph III.D](#). (CPT<sup>1</sup> procedure codes 65760, 65765, 65767, 65770, 65771).

B. Eyeglasses, and contact lenses except as noted in [Chapter 7, Section 6.2](#).

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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 4, SECTION 21.1

EYE AND OCULAR ADNEXA

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C. Orthokeratology.

D. Orthoptics, also known as visual training, vision therapy, eye exercises, eye therapy, is excluded by [32 CFR 199.4\(g\)\(46\)](#) (CPT<sup>2</sup> procedure code 92065).

E. Epikeratophakia for treatment of aphakia and myopia is unproven.

- END -

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## AUDITORY SYSTEM

ISSUE DATE: August 26, 1985

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

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### I. CPT<sup>1</sup> PROCEDURE CODE RANGE

69000 - 69990, 92620, 92621, and 92625

### II. DESCRIPTION

The auditory system pertains to the sense of hearing.

### III. POLICY

Services and supplies required for the diagnosis and treatment of illness or injury involving the auditory system are covered.

### IV. EXCLUSIONS

Benefits are not payable for a pulse generator system for the tympanic treatment of inner ear endolymphatic fluid (HCPCS code E2120).

- END -

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## COCHLEAR IMPLANTATION

ISSUE DATE: March 2, 1988

AUTHORITY: 32 CFR 199.4(c)(2), (c)(3), (d)(3), and 32 CFR 199.5(c)(2)

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### I. CPT<sup>1</sup> PROCEDURE CODES

69930, 92510, 92601 - 92604

### II. DESCRIPTION

A cochlear implant device is an electronic instrument, part of which is implanted surgically to stimulate auditory nerve fibers, and part of which is worn or carried by the individual to capture and amplify sound. Cochlear implant devices are available in single channel and multi-channel models. The purpose of implanting the device is to provide an awareness and identification of sounds and to facilitate communication for persons who are profoundly hearing impaired.

### III. POLICY

A. Cochlear implantation using FDA-approved cochlear implants and when used according to approved indications is a covered benefit.

B. For those individuals who have a single channel device and do not have open set discrimination, extending cochlear implant candidacy to second ear is covered.

C. Replacement of the cochlear implant external speech processor device is covered.

### IV. EXCLUSIONS

A. Cochlear implantation is contraindicated when preoperative radiographic evidence indicates an underdeveloped internal auditory canal, the absence of cochlear development or a physical condition which precludes placement of the electrode array or receiver-stimulator (e.g., cochlear ossification that prevents electrode insertion).

B. Cochlear implantation is contraindicated when there is a middle ear infection, the cochlear lumen is structurally unsuited to implantation, or there is a lesion in the auditory nerve or acoustic area of the central nervous system.

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**TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002**

CHAPTER 4, SECTION 22.2

COCHLEAR IMPLANTATION

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C. Cochlear implantation may not be cost-shared when there is a contraindication to surgery and implantation, such as poor anesthetic risk, severe mental retardation, severe psychiatric disorders, and organic brain syndrome.

- END -

## HIGH DOSE CHEMOTHERAPY AND STEM CELL TRANSPLANTATION

ISSUE DATE: November 1, 1983

AUTHORITY: [32 CFR 199.4\(e\)\(5\)](#) and [\(g\)\(15\)](#)

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### I. CPT<sup>1</sup> PROCEDURE CODES

38230 - 38241, 88240, 88241

### II. DESCRIPTION

A. High dose chemotherapy (HDC) is defined as the use of cytotoxic therapeutic agents (that are otherwise approved by the FDA for general use in humans) in dosages and/or frequencies of dosage that exceed the FDA labelling for the agent. HDC is generally considered when conventional regimens of chemotherapeutic agents have failed to arrest disease progression. One of the major adverse effects of HDC is that of bone marrow suppression, itself a potentially lethal process.

B. Stem cell "transplantation" or "rescue" is defined as a technique for collecting stem cells from a donor (either from the bone marrow or from the bloodstream), preparing and storing the collected stem cells, then reinfusing the prepared stem cells into the bloodstream of a patient in the treatment of oncologic, hematologic or lymphoproliferative disease with curative potential. The goal of stem cell "transplantation" or "rescue" is to reverse the bone marrow suppression caused by either HDC or by a primary bone marrow disease process (e.g., aplastic anemia).

There are five general types of stem cell "transplantation" or "rescue":

1. Autologous bone marrow transplant (ABMT), where the patient is both donor and recipient of stem cells harvested from the bone marrow.
2. Autologous peripheral stem cell transplantation (PSCT), where the patient is both donor and recipient of stem cells harvested from the bloodstream using the apheresis process.
3. Allogeneic bone marrow transplantation (BMT), where stem cells from a histocompatible donor (other than the patient) are harvested from the bone marrow, then later infused into the bloodstream of the patient. With BMT, the patient may have either a

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related or unrelated donor who has the same or closely matched human leukocyte antigen (HLA) typing necessary for successful transplantation.

4. Allogeneic peripheral stem cell transplantation, where stem cells are harvested from the bloodstream of a histocompatible donor (other than the patient) then later infused into the bloodstream of the patient.

5. Umbilical cord blood stem cell transplantation (UCBT), where stem cells are harvested from the umbilical cord and placenta, then later infused into the bloodstream of the patient.

### III. POLICY

A. Benefits are allowed for HDC with ABMT or **Autologous PSCT, Allogeneic Bone Marrow or Allogeneic Peripheral Stem Cell Transplantation, with or without HDC, and Allogeneic Umbilical Cord Blood Transplantation, with or without HDC.**

1. 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 TRICARE network provider agreements. If Prime enrollees receive transplant-related services from non-network civilian reporters without the required PCM referral and contractor authorization, Managed Care Support (MCS) contractors shall reimburse charges for the services on a Point of Services 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. HDC with ABMT or **Autologous PSCT** is covered in the treatment of the following malignancies. 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. Non-Hodgkin's lymphoma, follicular, intermediate, or high-grade; when:

- a. Conventional dose chemotherapy has failed; or
- b. The patient has relapsed following a course of radiation therapy; or
- c. The patient is in first complete remission with risk factors for relapse.

NOTE: For purposes of coverage, mantle cell lymphomas will be considered as intermediate grade, non-Hodgkin's lymphomas.

2. Hodgkin's disease when:

- a. Conventional dose chemotherapy has failed; or

## HEART-LUNG AND LUNG TRANSPLANTATION

ISSUE DATE: October 27, 1995

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

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### I. CPT<sup>1</sup> PROCEDURE CODES

32850 - 32854, 33930 - 33935

### II. DRGs

495 for lung transplant.

### III. POLICY

A. Heart-lung and single and double lung transplantation requires preauthorization.

B. Living donor lobar lung transplantation requires preauthorization.

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.

C. The designated preauthorizing authority shall only use the criteria contained in this policy when preauthorizing lung and heart-lung transplantations.

D. The designated preauthorizing authority may also preauthorize advanced life support for air ambulance and a certified advanced life support attendant for a heart-lung or lung transplantation patient who has received preauthorization.

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E. **Affirmative Patient Selection Criteria.** Benefits are allowed for single and double lung and living donor lobar lung transplantation when the transplant is performed at a TRICARE or Medicare-certified lung transplant center or TRICARE-certified pediatric consortium lung transplant center. Benefits are allowed for heart-lung transplantation when the transplant is performed at a TRICARE or Medicare-certified heart, lung, or heart-lung transplant center or TRICARE-certified pediatric consortium heart, lung or heart-lung transplantation center. The beneficiaries must meet the following criteria:

1. Have irreversible, progressively disabling, end-stage pulmonary or cardiopulmonary disease.
2. Have tried or considered all other medical and surgical therapies that might have been expected to yield both short and long-term survival comparable to that of transplantation.
3. Have a realistic understanding of the range of clinical outcomes that may be encountered.
4. Demonstrate plans for a long-term adherence to a disciplined medical regimen are feasible and realistic.

F. In addition to meeting the above patient selection criteria, the following adverse factors must be absent or minimized:

1. Acutely ill patients (i.e., with serious exacerbation of chronic end-stage disease or with nonchronic end-stage disease) or those who currently require mechanical ventilation for more than a very brief period (because there is difficulty in adequate assessment, a propensity for infection and likelihood for poor results).
2. Significant systemic or multi-system disease (because the presence of multi-organ involvement limits the possibility of full recovery and may compromise the function of the newly transplanted organ(s)).
3. Extrapulmonary site of infection (because of the probability of recrudescence once immunosuppression is instituted).
4. Hepatic dysfunction, even secondary to right ventricular failure, such as bilirubin exceeding 2.5 mg/ml (because of hepatotoxicity of many post-transplant medications and complications due to coagulopathies, hepatic encephalopathy, infection, poor wound healing, and increased postoperative mortality).
5. Renal dysfunction, such as preoperative serum creatinine greater than 1.5 mg/dl or a 24-hour creatinine clearance less than 50 ml/min, except that with severe pulmonary hypertension creatinine clearance as low as 35 ml/min may be acceptable if intrinsic renal disease is excluded. (Cyclosporine is nephrotoxic).
6. Systemic hypertension that requires multidrug therapy for even moderate control (for example, multidrugs to bring diastolic pressure below 105 mm Hg), either at

## HEART TRANSPLANTATION

ISSUE DATE: December 11, 1986

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

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### I. CPT<sup>1</sup> PROCEDURE CODES

33940 - 33945, 33975 - 33980

### II. POLICY

#### A. Benefits are allowed for heart transplantation.

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. Benefits are allowed for heart transplantation when the transplant is performed at a TRICARE or Medicare-certified heart transplant center or TRICARE-certified pediatric consortium heart transplantation center, for beneficiaries who:

1. Have an end-stage cardiac disease who have exhausted alternative medical and surgical treatments; and
2. Have a very poor prognosis as a result of poor cardiac functional status; and
3. For whom plans for long-term adherence to a disciplined medical regimen are feasible.

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C. In addition to meeting the above patient selection criteria, the following adverse factors must be absent or minimized:

1. Advancing age (because of diminished capacity to withstand postoperative complications). The selection of any patients for transplantation beyond age 50 must be done with particular care to ensure an adequately young physiologic age and the absence or insignificance of coexisting disease.

2. Severe pulmonary hypertension (because of the limited work capacity of the typical donor right ventricle). A pulmonary vascular resistance above 5 Wood units or pulmonary artery systolic pressure over 65 mm Hg is considered to be severe pulmonary hypertension.

3. Renal or hepatic dysfunction not explained by the underlying heart failure and not deemed reversible (because of the nephrotoxicity and hepatotoxicity of cyclosporin).

4. Acute severe hemodynamic compromise at the time of transplantation if accompanied by compromise or failure of a vital end-organ (because of a substantially less favorable prognosis for survival than for the average transplant recipient).

5. Symptomatic peripheral or cerebrovascular disease (because of accelerated progression in some patients after cardiac transplantation and chronic corticosteroid treatment).

6. Chronic obstructive pulmonary disease or chronic bronchitis (because of poor postoperative course and likelihood of exacerbation of infection with immunosuppression).

7. Active systemic infection (because of the likelihood of exacerbation with initiation of immunosuppression).

8. Recent and unresolved pulmonary infarction or pulmonary roentgenographic evidence of infection or of abnormalities of unclear etiology (because of the likelihood that this represents pulmonary infection).

9. Systemic hypertension, either at transplantation or prior to development of end-stage cardiac disease, that requires multi-drug therapy for even moderate control (multi-drugs to bring diastolic pressure below 105 mm Hg). Other systemic disease considered likely to limit or preclude survival and rehabilitation after transplantation.

10. Cachexia, even in the absence of major end-organ failure (because of the significantly less favorable survival of such patients).

11. The need for or prior transplantation of a second organ such as lung, liver, kidney, or marrow (because this represents the coexistence of significant disease).

12. A history of a behavior pattern or psychiatric illness considered likely to interfere significantly with compliance with a disciplined medical regimen (because a lifelong medical regimen is necessary, requiring multiple drugs several times a day, with serious consequences in the event of their interruption or excessive consumption).

H. Heart transplantations performed on an emergency basis in an unauthorized heart transplant facility may be cost shared only when the following conditions have been met:

1. The unauthorized center must consult with the nearest TRICARE or Medicare-approved center regarding the transplantation case; and

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

#### IV. EXCLUSIONS

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

B. Services and supplies not provided in accordance with applicable program criteria (i.e., part of a grant or research program; unproven procedure).

C. Administration of an unproven immunosuppressant drug that is not FDA approved or has not received approval as an appropriate "off-label" drug indication.

D. Pre- or post-transplant nonmedical expenses (e.g., out-of-hospital living expenses, to include hotel, meals, privately owned vehicle for the beneficiary or family members).

E. Transportation of an organ donor.

F. Prolonged extracorporeal circulation for cardiopulmonary insufficiency (CPT<sup>2</sup> procedure codes 33960 and 33961).

G. Artificial hearts.

#### V. EFFECTIVE DATES

A. November 7, 1986, for heart transplants.

B. The date of FDA approval for ventricular assist devices.

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

ISSUE DATE: December 3, 1997

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

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### I. CPT<sup>1</sup> PROCEDURE CODES

44132, 44133, 44135, 44136

### II. 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.

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.

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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.

## LIVER TRANSPLANTATION

ISSUE DATE: September 3, 1986

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

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### I. CPT<sup>1</sup> PROCEDURE CODES

47133 - 47136, 47140 - 47142

### II. POLICY

A. Benefits are allowed for liver and living donor liver transplantations (LDLT).

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 health care services from non-network civilian providers without the required PCM referral and contractor authorization, 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 an MCS region, preauthorization is the responsibility of the MCS Medical Director or other designated utilization staff.

B. Liver and LDLT is covered when the transplantation is performed at a TRICARE or Medicare-certified liver transplantation center or TRICARE-certified pediatric consortium liver transplantation center for beneficiaries who:

1. Are suffering from irreversible hepatic disease; and
2. Have exhausted alternative medical and surgical treatments; and
3. Are approaching the terminal phase of their illness.
4. Demonstrate plans for a long-term adherence to a disciplined medical regimen are feasible and realistic.

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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 4, SECTION 24.5

LIVER TRANSPLANTATION

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C. Liver and LDLT transplants performed for beneficiaries suffering from irreversible hepatic disease resulting from hepatitis B or C is covered.

D. Liver transplantation for severe classical Maple Syrup Urine Disease (MSUD) not controlled by dietary restriction may be considered on a case-by-case basis under the TRICARE provisions for the treatment of rare diseases.

E. Services and supplies related to liver and LDLTs are covered for:

1. Evaluation of a potential candidate's suitability for liver 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. 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 nationally accepted standards of practice in the medical community (proven).

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 determining histocompatibility.

13. Transportation of the patient by air ambulance and the services of a certified life support attendant.

### III. POLICY CONSIDERATIONS

A. For beneficiaries who reside in TRICARE regions but fail to obtain preauthorization for liver or LDLT, 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

## COMBINED LIVER-KIDNEY TRANSPLANTATION

ISSUE DATE: October 26, 1994

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

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### I. CPT<sup>1</sup> PROCEDURE CODES

47133 - 47135, 50300, 50340, 50360, 50365

### II. POLICY

#### A. Benefits are allowed for combined liver-kidney transplantation (CLKT).

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. Combined liver-kidney transplantation (CLKT) is covered when the transplant is performed at a TRICARE or Medicare-certified liver transplant center or TRICARE-certified pediatric consortium liver transplantation center, for beneficiaries who:

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

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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 4, SECTION 24.6

COMBINED LIVER-KIDNEY TRANSPLANTATION

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C. Transplants performed for beneficiaries suffering from hepatic failure resulting from hepatitis B or C are covered.

D. Services and supplies related to CLKT are covered for:

1. Evaluation of a potential candidate's suitability for CLKT 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.
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).
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. 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.

### III. POLICY CONSIDERATIONS

A. In those cases where the beneficiary fails to obtain preauthorization, 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 CLKT 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.

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

ISSUE DATE: February 5, 1996

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

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### I. CPT<sup>1</sup> PROCEDURE CODES

48550 - 48556

### II. 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

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.

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**TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002**

CHAPTER 4, SECTION 24.7

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

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.

### III. 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 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 CMS 1450 UB-04 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.

#### IV. 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).

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.

**TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002**

CHAPTER 4, SECTION 24.7

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

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 (CPT<sup>2</sup> procedure code 48160) for the treatment of chronic pancreatitis. Allogeneic islet cell transplantation for the treatment of diabetes mellitus.

V. EFFECTIVE DATES

A. October 1, 1995, for SPK transplants.

B. January 1, 1996, for PAK and PTA transplants.

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## KIDNEY TRANSPLANTATION

ISSUE DATE: February 27, 1996

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

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### I. CPT<sup>1</sup> 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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## TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

### CHAPTER 4, SECTION 24.8

#### KIDNEY TRANSPLANTATION

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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 **CMS 1450 UB-04** 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.

## 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)

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### I. CPT<sup>1</sup> 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 interchangeably referred to as either a CT or CAT scan. This diagnostic test uses x-ray

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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 5, SECTION 1.1

DIAGNOSTIC RADIOLOGY (DIAGNOSTIC IMAGING)

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

IV. POLICY

A. MRI and MRI with contrast media are covered when medically necessary, appropriate, and the standard of care. (CPT<sup>2</sup> procedure codes 70336, 70540-70543, 70551-70553, 71550-71552, 72141-72158, 72195-72197, 73218-73223, 73718-73723, 74181-74183, 75552-75556, and 76400.)

B. Breast MRI (CPT<sup>2</sup> procedure codes 77058 and 77059) is covered for the following indications:

1. To detect breast implant rupture (the implantation of the breast implants must have been covered by TRICARE).
2. For detection of occult breast cancer in the setting of axillary nodal adenocarcinoma with negative physical exam and negative mammography.
3. For presurgical planning for locally advanced breast cancer before and after completion of neoadjuvant chemotherapy, to permit tumor localization and characterization.
4. For presurgical planning to evaluate the presence of multicentric disease in patients with locally advanced cancer who are candidates for breast conservation treatment.
5. Evaluation of suspected cancer recurrence.
6. To determine the presence of pectoralis major muscle/chest wall invasion in patients with posteriorly located tumor.

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

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

D. MRA is covered when medically necessary, appropriate and the standard of care. (CPT<sup>2</sup> procedure codes 70544-70549, 71555, 72159, 72198, 73225, 73725, and 74185.)

E. 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. (CPT<sup>2</sup> procedure codes 70450-70498, 71250-71275, 72125-72133, 72191-72194, 73200-73206, 73700-73706, 74150-74175, 75635, and 76355-76380.)

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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 5, SECTION 1.1

DIAGNOSTIC RADIOLOGY (DIAGNOSTIC IMAGING)

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F. TRICARE considers three-dimensional (3D) rendering (CPT<sup>3</sup> procedure codes 76376 and 76377) medically necessary under certain circumstances (see [Chapter 5, Section 2.1](#)).

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

H. Chest x-rays (CPT<sup>3</sup> procedure codes 71010-71035) are covered.

I. Diagnostic mammography (CPT<sup>3</sup> procedure codes 76090-76092/HCPCS codes G0204-G0207) to further define breast abnormalities or other problems is covered.

J. 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.

K. Bone density studies (CPT<sup>3</sup> procedure codes 76070-76078) are covered for the following:

1. The diagnosis and monitoring of osteoporosis.

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.

L. Radiological supervision and interpretation, percutaneous vertebroplasty or vertebral augmentation including cavity creation, per vertebral body; under fluoroscopic guidance (CPT<sup>3</sup> procedure code 72291) or under CT guidance (CPT<sup>3</sup> procedure code 72292) is covered.

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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 (CPT<sup>4</sup> procedure codes 76058 and 77059) to screen for breast cancer in asymptomatic women considered to be at low or average risk of developing breast cancer; for diagnosis of suspicious lesions to avoid biopsy, to evaluate response to neoadjuvant chemotherapy, to differentiate cysts from solid lesions.

D. MRIs (CPT<sup>4</sup> procedure codes 76058 and 77059) to assess implant integrity or confirm implant rupture, if implants were not originally covered or coverable.

E. 3D rendering (CPT<sup>4</sup> procedure codes 76376 and 76377) for monitoring coronary artery stenosis activity in patients with angiographically confirmed CAD is unproven.

F. 3D rendering (CPT<sup>4</sup> procedure codes 76376 and 76377) for evaluating graft patency in individuals who have undergone revascularization procedures is unproven.

G. 3D rendering (CPT<sup>4</sup> 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.

H. Computed tomography angiography (CPT<sup>4</sup> procedure codes 76376 and 76377) for acute ischemic stroke is unproven.

I. Computed tomography angiography (CPT<sup>4</sup> procedure codes 76376 and 76377) for intracerebral aneurysm and subarachnoid hemorrhage is unproven.

J. Computed tomography, heart, without contrast, including image post processing and quantitative evaluation of coronary calcium (CPT<sup>4</sup> procedure code 0144T) is unproven.

K. 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 (CPT<sup>4</sup> procedure code 0145T) is unproven.

L. Computed tomographic angiography of coronary arteries (including native and anomalous coronary arteries, coronary bypass grafts) without quantitative evaluation of coronary calcium (CPT<sup>4</sup> procedure code 0146T). Computed tomographic angiography of coronary arteries (including native and anomalous coronary arteries, coronary bypass grafts) with quantitative evaluative of coronary calcium (CPT<sup>4</sup> procedure code 0147T) is unproven.

M. 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 (CPT<sup>4</sup> procedure code 0148T). Cardiac

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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 5, SECTION 1.1

DIAGNOSTIC RADIOLOGY (DIAGNOSTIC IMAGING)

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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 (CPT<sup>5</sup> procedure code 0149T) is unproven.

N. Cardiac structure and morphology in congenital heart disease (CPT<sup>5</sup> 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 motion (CPT<sup>5</sup> procedure code 0152T)) is unproven.

VI. EFFECTIVE DATES

A. The effective date for MRIs with contrast media is dependent on the U.S. Food and Drug Administration (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.

C. March 1, 2007, for CPT<sup>5</sup> procedure codes 72291 and 72292.

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## DIAGNOSTIC ULTRASOUND

ISSUE DATE: November 1, 1983

AUTHORITY: 32 CFR 199.2, 32 CFR 199.4(a)(1), (b)(2), (b)(3), (b)(4), and (g)(36)

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### I. CPT<sup>1</sup> PROCEDURE CODE RANGES

Diagnostic Ultrasound: 76506 - 76778, 76801 - 76886

Ultrasonic Guidance: 76930 - 76965

Ultrasound Other: 76970 - 76999

### II. DESCRIPTION

The visualization of deep structures of the body by recording the reflections (echoes) of pulses of ultrasonic waves direct into the tissues. Ultrasound is used for diagnostic and guidance purposes.

### III. POLICY

A. Ultrasound procedures for diagnosis, guidance, and post-operative evaluation of surgical procedures may be cost-shared.

B. Maternity related ultrasound. Professional and technical components of medically necessary fetal ultrasounds are covered outside the maternity global fee. The medically necessary indications include (but are not limited to) clinical circumstances that require obstetric ultrasounds to: estimate gestational age, evaluate fetal growth, conduct a biophysical evaluation for fetal well being, evaluate a suspected ectopic pregnancy, define the cause of vaginal bleeding, diagnose or evaluate multiple gestations, confirm cardiac activity, evaluate maternal pelvic masses or uterine abnormalities, evaluate suspected hydatidiform mole, and evaluate the fetus' condition in late registrants for prenatal care.

C. Bone Density studies (CPT<sup>1</sup> procedure code 76977) are covered for:

1. The diagnosis and monitoring of osteoporosis.
2. For the diagnosis and monitoring of osteopenia.

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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 5, SECTION 2.1

DIAGNOSTIC ULTRASOUND

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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.

IV. EXCLUSIONS

A. Ultrasound for routine screening for breast disease.

B. Ultrasound performed to determine sex of an unborn child.

C. Bone density studies for routine screening for osteoporosis.

D. Ultrasound, spinal canal and contents (CPT<sup>2</sup> procedure code 76800) for spinal scanning in adults for inflammatory conditions of the spine and nerve roots or as guidance for facet joint or epidural injections (CPT<sup>2</sup> procedure codes 76880 and 76942).

E. 3D and 4D rendering (CPT<sup>2</sup> procedure codes 76376 and 76377) with maternity ultrasound is unproven.

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## RADIATION ONCOLOGY

ISSUE DATE: March 27, 1991

AUTHORITY: 32 CFR 199.4(b)(2), (c)(2), (c)(3), and (g)(15)

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### I. CPT<sup>1</sup> PROCEDURE CODES

61793, 61795, 77261 - 77421, 77427 - 77799

### II. DESCRIPTION

A. Radiation therapy is also known as radiotherapy, radiation treatment, x-ray therapy, cobalt therapy, and proton beam therapy. The primary purpose of radiation therapy is to eliminate or shrink localized cancers (as opposed to cancers that have spread to distant parts of the body).

B. Stereotactic radiosurgery/radiotherapy is a method of delivering ionizing radiation to small intracranial targets. Stereotactic radiosurgery entails delivering a high dose in a single session. Stereotactic radiotherapy entails fractionating the dose over a number of treatments.

1. There are three main variations of stereotactic radiosurgery/radiotherapy: gamma beam or gamma knife, linear accelerator (linac), and charged particle beam (proton or helium ion). The three radiation delivery devices differ technically in several ways: source of radiation, size and shape of the radiation field, and range of radiation dosages.

2. The radiosurgical/radiotherapy procedure is preceded by a process of localizing the target, which can be performed with one or more of the following techniques: skull x-ray, cerebral angiography, computerized tomography, or magnetic resonance imaging.

### III. POLICY

A. Radiation therapy (brachytherapy, fast neutron, hyperfractionated, and radioactive chromic phosphate synoviorthesis) is covered for those indications documented by reliable evidence as safe, effective and comparable or superior to standard care (proven).

B. Hyperthermia is covered for those indications documented by reliable evidence as safe, effective and comparable or superior to standard care (proven).

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C. Gamma knife radiosurgery/radiotherapy is covered for the following indications. This 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. Arteriovenous malformations.
2. Benign brain tumors.
3. Acoustic neuromas (vestibular Schwannomas).
4. Pituitary adenomas.
5. Craniopharyngiomas.
6. Other tumors of the skull base.
7. Pineal region tumors.
8. Metastatic brain tumors.
9. High grade gliomas (glioblastoma multiforme, anaplastic astrocytomas).

D. Linear accelerator radiosurgery/radiotherapy is covered for the following indications. This 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. Arteriovenous malformations.
2. Acoustic neuromas (vestibular Schwannomas).
3. Metastatic brain tumors.

E. Proton beam radiosurgery/radiotherapy is covered for the following indications. This 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. Arteriovenous malformations.
2. Cushing's disease or acromegaly caused by pituitary microadenomas.
3. As postoperative therapy in patients who have undergone biopsy or partial resection of the chordoma or low grade (I or II) chondrosarcoma of the basisphenoid region (skull-base chordoma or chondrosarcoma) or cervical spine.
4. As primary therapy for patients with uveal melanoma, with no evidence of metastasis or extrascleral extension, and with tumors up to 22 mm in largest diameter and 14 mm in height.

5. Prostate cancer.
6. Meningioma.
7. Low grade glioma (astrocytoma, grade I-II).
8. Glioblastoma multiforme.
9. Soft tissue sarcoma (liposarcoma).
10. Hodgkin's disease when conventional radiotherapy is contraindicated.
11. Acoustic neuromas.

F. Helium ion beam radiosurgery/radiotherapy is covered for the following indications. This 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. As primary therapy for patients with melanoma of the uveal tract, with no evidence of metastasis or extrascleral extension, and with tumors up to 24 mm in largest diameter and 14 mm in height.

2. As postoperative therapy in patients who have undergone biopsy or partial resection of the chordoma or low grade (I or II) chondrosarcoma of the basisphenoid region (skull-base chordoma or chondrosarcoma) or cervical spine.

G. Extracranial stereotactic radiosurgery/radiotherapy is covered for the following indication. This 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. Primary and metastatic lung carcinoma.

H. Frameless stereotaxy (neuronavigation) is covered for the following indications. This 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. Localization, surgical planning and guidance for intracranial tumors, skull base tumors, metastatic brain tumors, AVMs, cavernomas, chordomas, and pituitary adenomas.

2. Biopsy guidance.
3. Cerebrospinal fluid shunt placement.
4. Surgery for intractable epilepsy.
5. Spinal surgery.

I. The frameless stereotaxy device must be FDA-approved. The following devices are FDA-approved: StealthStation System, The Operating Arm, ISG Viewing Wand, MKM System, and Philips Easyguide. Other systems which are FDA-approved are also covered.

#### IV. EXCLUSIONS

A. Whole body hyperthermia in the treatment of cancer is unproven. Hyperthermia for recurrent breast current is unproven.

B. Helium ion beam radiosurgery/radiotherapy for arteriovenous malformations and ependymoma is unproven.

C. Intra-Operative Radiation Therapy (IORT) is unproven.

D. High energy neutron radiation treatment delivery, single treatment area using a single port or parallel-opposed ports with no blocks or simple blocking (CPT<sup>2</sup> procedure code 77422) is unproven.

E. High energy neutron radiation treatment delivery, single treatment area using a single port or parallel-opposed ports with no blocks or simple blocking **one** or more isocenter(s) with coplanar or non-coplanar geometry with blocking and/or wedge, and/or compensator(s) (CPT<sup>2</sup> procedure code 77423) is unproven.

#### V. EFFECTIVE DATES

A. February 26, 1986, for proton beam radiosurgery/radiotherapy for arteriovenous malformations.

B. March 1, 1988, for proton beam radiosurgery/radiotherapy for patients with Cushing's disease or acromegaly caused by pituitary microadenoma.

C. October 6, 1988, for gamma beam (gamma knife) radiosurgery/radiotherapy for treatment of arteriovenous malformation, benign brain tumors, acoustic neuromas, pituitary adenomas, craniopharyngiomas, other tumors of the posterior fossa and pineal region tumors.

D. January 1, 1990, for proton beam radiosurgery/radiotherapy for soft tissue sarcoma (liposarcoma).

E. June 18, 1990, for proton beam radiosurgery/radiotherapy for chordomas or chondrosarcomas.

F. January 1, 1994, for gamma beam (gamma knife) and linear accelerator radiosurgery/radiotherapy for metastatic brain tumors.

G. January 1, 1996, for proton beam radiosurgery/radiotherapy for uveal melanoma.

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## NUCLEAR MEDICINE

ISSUE DATE: June 30, 1993

AUTHORITY: 32 CFR 199.4(b)(2)(vii) and (c)(2)(ix)

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### I. CPT<sup>1</sup> PROCEDURE CODE RANGE

78000 - 79999

### II. DESCRIPTION

Nuclear Medicine uses very small amounts of radioactive materials or radiopharmaceuticals to diagnose and treat disease. Radiopharmaceuticals are substances that are attracted to specific organs, bones, or tissues. The radiopharmaceutical used in nuclear medicine emit gamma rays that can be detected externally by gamma or PET cameras. These cameras work in conjunction with computers used to form images that provide data and information about the area of body being imaged. The following techniques are used in the diagnosis, management, treatment, and prevention of disease: (1) Planar, Single Photon Emission Computed Tomography (SPECT); (2) Positron Emission Tomography (PET); (3) Tomography; (4) Nuclear Medicine Scan; (5) Radiopharmaceutical; (6) Gamma Camera; (7) In Vitro done in test tubes; and (8) In Vitro done in patients.

### III. POLICY

#### A. Positron emission tomography (PET) is covered for:

1. The diagnosis and management of seizure disorders.
2. Evaluation of ischemic heart disease.
3. The diagnosis and management of lung cancer.
4. PET and PET/CT for the diagnosis, staging, restaging, and monitoring of treatment of lymphoma.
5. PET scans for other indications are covered when documented by reliable evidence as safe, effective and comparable or superior to standard care (proven).

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B. Single Photon Emission Computed Tomography (SPECT) is covered for:

1. Myocardial perfusion imaging utilizing SPECT.
2. Brain imaging utilizing SPECT for the evaluation of seizure disorder.
3. Prostatic radioimmunoscinigraphy imaging utilizing SPECT for the following indications:
  - a. Metastatic spread of prostate cancer and for use in post-prostatectomy patients in whom there is a high suspicion of undetected cancer recurrence.
  - b. Newly diagnosed patients with biopsy-proven prostate cancer at high risk for spread of their disease to pelvic lymph nodes.
4. Indium<sup>111</sup> - for detecting the presence and location of myocardial injury in patients with suspected myocardial infarction.
5. Indium<sup>111</sup> - labeled anti-TAG72 for tumor recurrence in colorectal and ovarian cancer.
6. SPECT for other indications is covered when documented by reliable evidence as safe, effective, and comparable or superior to standard care (proven).

C. Indium<sup>111</sup> Pentetreotide (Octreoscan) Scintigraphy is covered for:

1. The localization and monitoring of treatment of primary and metastatic neuroendocrine tumors.
2. Other indications when documented by reliable evidence as safe, effective, and comparable or superior to standard care (proven).

D. Bone Density Studies (CPT<sup>2</sup> procedure codes 78350, 78351) are covered for:

1. The diagnosis and monitoring of osteoporosis.
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 a clinical risk of or 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.

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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 5, SECTION 4.1

NUCLEAR MEDICINE

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- 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.

IV. EXCLUSIONS

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

B. PET for the diagnosis and monitoring of treatment of Alzheimer's disease, fronto-temporal dementia or other forms of dementia is unproven.

V. EFFECTIVE DATES

A. January 1, 1995, for PET for ischemic heart disease.

B. December 1, 1996, for PET for lung cancer.

C. October 14, 1990, for SPECT for myocardial perfusion imaging.

D. January 1, 1991, for SPECT for brain imaging.

E. October 28, 1996, for <sup>111</sup>In-Capromab Pendetide, CyT 356 (ProstaScint™).

F. June 1, 1994, for Octreoscan Scintigraphy.

G. May 26, 1994, for bone density studies.

H. January 1, 2007, for PET and PET/CT for lymphoma.

- END -



## GENERAL

ISSUE DATE:

AUTHORITY: 32 CFR 199.4(a)(1)(i), (b)(2)(ix), (b)(3)(vi), (c)(2)(x) and (g)(60)

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### I. CPT<sup>1</sup> PROCEDURE CODES

80048 - 87622, 87650 - 87999, 88104 - 89264, 89330 - 89399

### II. DESCRIPTION

A. Pathology is the medical science and specialty practice that deals with all aspects of disease, but with special reference to the essential nature, the causes, and development of abnormal conditions, as well as the structural and functional changes that result from disease processes.

B. The surgical pathology services include accession, examination, and reporting for a specimen which is defined as tissue that is submitted for individual and separate attention, requiring individual examination and pathologic diagnosis. These codes require gross and microscopic examination.

### III. POLICY

A. Pathology and laboratory services are covered except as indicated.

B. Surgical pathology procedures, billed by a pathologist, are covered services.

C. If the operating surgeon bills for surgical pathology procedures, they will be denied as incidental, since the definitive (microscopic) examination will be performed later, after fixation of the specimen, by the pathologist who will bill separately.

D. Dermatologists are qualified to perform surgical pathology services. Therefore, if a dermatologist bills for both the surgical procedure (e.g. CPT<sup>1</sup> procedure code 11100, skin biopsy) as well as the surgical pathology, both procedures are covered in full.

E. Human papillomavirus testing (CPT<sup>1</sup> procedure codes 87620 - 87622) is covered for the assessment of women with Atypical Squamous Cells of Undetermined Significance (ASCUS) cells detected upon initial pap smear.

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F. For Transfusion Services refer to [Chapter 6, Section 2.1](#).

#### IV. EXCLUSIONS

A. Autopsy and postmortem (CPT<sup>2</sup> procedure codes 88000-88099).

B. Sperm penetration assay (hamster oocyte penetration test or the zona-free hamster egg test) is excluded for IVF (CPT<sup>2</sup> procedure code 89329).

C. In-vitro chemoresistance and chemosensitivity assays (stem cell assay, differential staining cytotoxicity assay and thymidine incorporation assay) are unproven.

D. Hair analysis to identify mineral deficiencies from the chemical composition of hair is unproven. Hair analysis testing (CPT<sup>2</sup> procedure code 96902) may be reimbursed when necessary to determine lead poisoning.

E. Insemination of oocytes (CPT<sup>2</sup> procedure code 89268).

F. Extended culture of oocyte(s) embryo(s) 4-7 days (CPT<sup>2</sup> procedure code 89272).

G. Assisted oocyte fertilization, microtechnique; less than or equal to 10 oocytes (CPT<sup>2</sup> procedure code 89280).

H. Assisted oocyte fertilization, microtechnique; greater than 10 oocytes (CPT<sup>2</sup> procedure code 89281).

I. Biopsy oocyte polar body or embryo blastomere (CPT<sup>2</sup> procedure code 89290).

J. Biopsy oocyte polar body or embryo blastomere; greater than 4 embryos (CPT<sup>2</sup> procedure code 89291).

K. Cryopreservation reproductive tissue, testicular (CPT<sup>2</sup> procedure code 89335).

L. Storage (per year) embryo(s) (CPT<sup>2</sup> procedure code 89342).

M. Storage (per year) sperm/semen (CPT<sup>2</sup> procedure code 89343).

N. Storage (per year) reproductive tissue, testicular/ovarian (CPT<sup>2</sup> procedure code 89344).

O. Storage (per year) oocyte (CPT<sup>2</sup> procedure code 89346).

P. Thawing of cryopreserved, embryo(s) (CPT<sup>2</sup> procedure code 89352).

Q. Thawing of cryopreserved, sperm/semen, each aliquot (CPT<sup>2</sup> procedure code 89353).

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**TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002**

CHAPTER 6, SECTION 1.1

GENERAL

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R. Thawing of cryopreserved, reproductive tissue, testicular/ovarian (CPT<sup>3</sup> procedure code 89354).

S. Thawing of cryopreserved, oocytes, each aliquot (CPT<sup>3</sup> procedure code 89356).

T. CPT<sup>3</sup> procedure codes 83701, and 83704 and not covered for low density lipoprotein (LDL) subclass testing.

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## TRANSFUSION SERVICES FOR WHOLE BLOOD, BLOOD COMPONENTS AND BLOOD DERIVATIVES

ISSUE DATE: March 27, 1991

AUTHORITY: 32 CFR 199.4(b)(2)(ix) and (c)(2)(x)

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### I. CPT<sup>1</sup> PROCEDURE CODES

36430 - 36460, 86077 - 86079, 86900 - 86906, 86920 - 86922

### II. DESCRIPTION

Transfusions are the introductions of either whole blood, and blood components (red cells, platelets, plasma, or leukocytes), or blood derivatives (albumin, gamma globulin, Factors VIII and IX, or Rho (D) immune globulins (RhoGAM), and prothrombin) directly into the bloodstream. Transfusion services are those services necessary to test donor blood and administer transfusions. Transfusion services include equipment, supplies, storage, administration, processing, typing and cross-matching.

### III. POLICY

A. Whole blood and blood components are covered when the whole blood and blood components are actually administered to the patient.

B. Transfusion services for whole blood and blood components are covered as supplies or laboratory services for transfusions of both allogeneic and autologous blood when the whole blood or blood components are used by the patient.

C. Blood derivatives, outlined above under DESCRIPTION, which are classified as formulary drugs are covered as prescription drugs.

### IV. EXCLUSIONS

A. Blood typing for paternity testing (CPT<sup>1</sup> procedure codes 86910, 86911) is not covered.

B. Unused whole blood and blood components are not covered.

C. Preoperative collection, processing, and storage of autologous blood (CPT<sup>1</sup> procedure codes 86890, 86891) are included within the DRG payment. No separate payment is allowed. Charges for the collection and storage of autologous blood by other than an inpatient facility

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**TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002**

CHAPTER 6, SECTION 2.1

TRANSFUSION SERVICES FOR WHOLE BLOOD, BLOOD COMPONENTS AND BLOOD DERIVATIVES

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are to be reimbursed by the inpatient facility since they are included in the DRG payment. This policy does not apply to claims for outpatient services.

D. The testing of autologous blood is not covered.

E. Transfusion services for autologous blood and blood components in the absence of a scheduled covered surgical procedure is not covered.

- END -

## CLINICAL PREVENTIVE SERVICES - TRICARE STANDARD

ISSUE DATE: April 19, 1983

AUTHORITY: [32 CFR 199.4\(e\)\(3\)\(ii\)](#) and [\(g\)\(37\)](#)

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### I. CPT<sup>1</sup> PROCEDURE CODES

45300 - 45339, 45355 - 45385, 76092, 77058, 77059, 80061, 82270, 82274, 84153, 86580, 86585, 86762, 87340, 88141 - 88155, 88160 - 88162, 88164 - 88167, 88174, 88175, 90281 - 90396, 99172, 99173, 99201 - 99215, 99381 - 99387, 99391 - 99397

### II. HCPCS PROCEDURE CODES

Level II Codes G0104, G0105, G0107, G0121, G0202, G0206

### III. BACKGROUND

The National Defense Authorization Act for Fiscal Year (NDAA FY) 1996 (P.L. 104-106, Section 701) signed into effect on February 10, 1996, expands well-baby visits and immunizations to family members under the age of six and establishes immunizations and comprehensive preventive benefits for family members age six and above to include health promotion and disease preventive visits provided in connection with immunizations, Papanicolaou (Pap) smears, and mammograms. The NDAA FY 1997 (P.L. 104-201, Section 701) signed into effect on September 23, 1996, further expands health care preventive services for colon and prostate cancer examinations. Periodic health examinations that include risk assessment, physical examination, laboratory tests, x-rays, and risk specific counseling will allow for the prevention, early detection and treatment of diseases before they manifest themselves as major health problems. Prior to these Acts, preventive services were quite limited. In addition to Pap smears, mammograms, and well-baby care up to the age of two, the only related services authorized under Extra and Standard plans in the absence of symptoms were immunizations for family members accompanying an active duty member on overseas duty. The expanded preventive services will generally be reflective of those currently being offered to Prime enrollees under the Uniform Health Maintenance Organization (HMO) Benefit (see [32 CFR 199.18\(b\)\(2\)](#)), except for the application of appropriate cost-sharing and deductibles under Extra and Standard plans.

While immunizations are provided as a specific exception to the general preventive care exclusion under the Regulation ([32 CFR 199.4\(g\)\(37\)](#)) and can be provided independently of other preventive services for those age six and older, the other expanded services (i.e.,

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preventive services reflective of those currently being offered to Prime enrollees under Uniform HMO Benefit) must be provided in connection with immunizations, Pap smears, mammograms, and other cancer screening authorized by 10 U.S.C. 1079. For example, if a eligible female goes in for a routine Pap smear, she is also eligible to receive a wide variety of other preventive services such as tuberculosis screening, rubella antibody screening, blood pressure screening, cholesterol screening test and preventive counseling services, to name a few. However, the same coverage will not be extended if she simply makes an appointment for a routine health promotion visit, where one or more of the associated preventive services (i.e., Pap smear, mammogram, immunization and/or other cancer screening authorized by 10 U.S.C. 1079) are not performed.

Preventive physical examinations (for example, oral cavity examinations for pharyngeal cancer, palpation for thyroid nodules, skin cancer screening, and examinations for testicular cancer) are paid under the same comprehensive health promotion and disease prevention examination office visit code (CPT<sup>2</sup> procedure codes 99381-99387 and 99391-99397) as the associated Pap smear, mammogram, immunization or other cancer screening examination authorized by 10 U.S.C. 1079. In other words, these additional physical examinations are being performed during the same office visit as required to perform the associated Pap smear, mammogram, immunization or other cancer screening authorized by 10 U.S.C. 1079.

#### IV. POLICY

Preventive care is not directly related to specific illness, injury, a definitive set of symptoms, or obstetrical care, but rather is performed as a periodic health screening, health assessment, or periodic health maintenance. The following services may be provided during acute and chronic care visits or during preventive care visits for asymptomatic individuals to maintain and promote good health:

A. Health Promotion and Disease Prevention Examinations. The following prevention services are specific exceptions to the general preventive care exclusion under the Regulation. 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:

##### 1. Cancer Screening Examinations and Services.

###### a. Breast Cancer:

(1) 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.

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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 7, SECTION 2.1

CLINICAL PREVENTIVE SERVICES - TRICARE STANDARD

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(2) X-ray mammography. Mammography is recommended as a routine screening procedure (i.e., performed in the absence of any signs or symptoms of breast disease) when ordered by a physician, or upon self-referral as outlined below for:

(a) An asymptomatic woman over the age of 39, for one screening mammography every 12 months.

(b) An asymptomatic woman 35 years of age for a baseline mammogram and one screening mammogram every 12 months thereafter if the woman is considered to be at high risk of developing breast cancer. Acceptable indicators for high risk are:

- 1 A personal history of breast cancer;
- 2 A personal history of biopsy-proven benign breast disease;
- 3 A mother, sister, or daughter who has had breast cancer;
- 4 Not given birth prior to age 30; or

5 Other acceptable high risk factors as may be recommended by major authorities (e.g., the American Academy of Family Physicians, American Cancer Society, American College of Obstetricians and Gynecologists, American College of Physicians, and U.S. Preventive Services Task Force (USPSTF)).

NOTE: Screening mammography procedures should be billed using CPT<sup>3</sup> procedure code 76092 except when performed in connection with other preventive services, in which case a comprehensive health promotion and disease prevention examination office visit code (CPT<sup>3</sup> procedure codes 99381-99387 and 99391-99397) should be used.

(c) A 30 day administrative tolerance will be allowed for internal requirements between mammograms; e.g., if an asymptomatic woman 39 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.

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

(3) Breast Magnetic Resonance Imaging (MRI) (CPT<sup>3</sup> procedure codes 77058 and 77059). Breast MRI is recommended as an annual screening procedure for asymptomatic women age 35 or older considered to be at high risk of developing breast cancer per the guidelines published by the American Cancer Society (ACS) as follows:

(a) Women with a BRCA1 or BRCA2 gene mutation.

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**TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002**

CHAPTER 7, SECTION 2.1

CLINICAL PREVENTIVE SERVICES - TRICARE STANDARD

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(b) Women with a first degree relative (parent, child, sibling) with a BRCA1 or BRCA2 mutation, even if untested.

(c) Lifetime risk approximately 20-25% or greater as defined by BRCAPRO or other models that are largely dependent on family history.

(d) History of chest radiation between the ages of 10 and 30.

(e) History of LiFraumeni, Cowden, or Bannayan-Riley-Ruvalcaba syndromes or first degree relative with the syndrome.

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

b. Cancer of Female Reproductive Organs.

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

(2) Pap smears. Cancer screening Pap tests should be performed for women who are at risk for sexually transmissible diseases, women who have or have had multiple sexual partners (or if their partner has or has had multiple sexual partners), women who smoke cigarettes, and women 18 years of age and older when provided under the terms and conditions contained in the guidelines adopted by the Executive Director, TRICARE Management Activity (TMA). The frequency of the Pap tests will be at the discretion of the patient and clinician but not less frequent than every three years.

(c) Reimbursement for screening Pap smears shall not exceed the reimbursement for the intermediate office level visit except when performed in connection with other preventive services, in which case reimbursement will be allowed for the appropriate comprehensive health promotion and disease prevention examination office visit (CPT<sup>4</sup> procedure codes 99381-99387 and 99391-99397).

(b) Claims for screening Pap smears which are coded at a level greater than the intermediate level office visit and for which no additional preventive services have been provided will be reimbursed at the allowable charge for either CPT<sup>4</sup> procedure code 99203 or 99213 using the EOB message: "Charge reimbursed at the intermediate office visit level." Separate charges for the preparation, handling, and collection of the screening cervical Pap test are considered to be an integral part of the routine office examination visit and will not be allowed.

(c) Reimbursement for the cytopathology laboratory procedure associated with screening Pap tests should be billed using CPT<sup>4</sup> procedure codes 88141-88155, 88164-88167, 88174, and 88175. Reimbursement of these procedures is limited to the total CHAMPUS Maximum Allowable Charge (CMAC) and will only be paid once regardless of whether the attending physician or the laboratory bills for the services.

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(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., CPT<sup>5</sup> 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 (CPT<sup>5</sup> 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

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and prostate examination or preventive services provided as a result of a referral made during that same office visit. The contractor shall apply all appropriate claims processing and rebundling edits before determining if the following preventive services are individually reimbursable. The contractor need not establish additional edits to identify claims within the age, sex, race, or clinical history parameters included below, or research claims history to ensure that an association exists between the following preventive services and an immunization, Pap smear, mammogram, or colon and prostate cancer examination:

1. Cancer Screening Examinations.

a. Testicular Cancer. 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

## 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 <sup>1</sup> CODE
<b>SCREENING EXAMINATIONS:</b>		
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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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 7, SECTION 2.2

CLINICAL PREVENTIVE SERVICES - TRICARE PRIME

SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT CPT <sup>1</sup> CODE
<b>TARGETED HEALTH PROMOTION AND DISEASE PREVENTION EXAMINATIONS</b>	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.	
<b>School Physicals:</b>	<b>Physical Examinations:</b> 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.	99201-99205*, 99211-99214*, 99383 and 99393
	NOTE: Standard office visit evaluation and management CPT <sup>1</sup> procedure codes (i.e., code ranges 99201-99205 and 99211-99214) may be used in billing for school physicals; however, payment may not exceed what would have otherwise been reimbursed under the comprehensive preventive medicine service codes for beneficiaries ages five through 11 (CPT <sup>1</sup> procedure codes 99383 and 99393).	
<b>Breast Cancer:</b>	<b>Physical Examination:</b> 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.
	<b>Mammography:</b> 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
	<b>Magnetic Resonance Imaging (MRI):</b> Annual screening breast MRI for asymptomatic women age 30 or older considered to be at high risk of developing breast cancer per the guidelines of the American Cancer Society (ACS) as follows: 1) Women with a BRCA1 or BRCA2 gene mutation; 2) Women with a first degree relative (parent, child, sibling) with a BRCA1 or BRCA2 mutation, even if untested; 3) Lifetime risk approximately 20-25% or greater as defined by BRCAPRO or other models that are largely dependent on family history; 4) History of chest radiation between the ages of 10 and 30; 5) History of LiFraumeni, Cowden, or Bannayan-Riley-Ruvalcaba syndromes or first degree relative with the syndrome. The effective date for breast cancer screening MRI is March 1, 2007.	77058 and 77059

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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 7, SECTION 2.2

CLINICAL PREVENTIVE SERVICES - TRICARE PRIME

SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT CPT <sup>1</sup> CODE
<b>Cancer of Female Reproductive Organs:</b>	<b>Physical Examination:</b> Pelvic examination should be performed in conjunction with Pap smear testing for cervical neoplasms and premalignant lesions.	See appropriate level evaluation and management codes.
	<b>Papanicolaou smears:</b> 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.
<b>Testicular Cancer:</b>	<b>Physical Examination:</b> 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.
<b>Prostate Cancer:</b>	<b>Physical Examination:</b> Digital rectal examination should be offered annually for all men aged 50 years and over; men aged 45 and over with a family history of prostate cancer in at least one other family member; all African American men aged 45 and over regardless of family history; and men aged 40 and over with a family history of prostate cancer in two or more other family members.	See appropriate level evaluation and management codes.
	<b>Prostate Specific Antigen:</b> Annually for the following categories of males: all men aged 50 years and older; men aged 45 years and over with a family history of prostate cancer in at least one other family member; all African American men aged 45 and over regardless of family history; and men aged 40 and over with a family history of prostate cancer in two or more other family members.	84153
<b>Colorectal Cancer:</b>	<b>Physical Examination:</b> Digital rectal examination should be included in the periodic health examination of individuals 40 years of age and older.	See appropriate level evaluation and management codes.
	<b>Fecal occult blood testing:</b> Once every 12 months (either guaiac-based testing or immunochemical-based testing) for beneficiaries who have attained age 50 (i.e., at least 11 months have passed following the month in which the last covered screening fecal-occult blood test was done). The effective date for coverage of immunochemical-based testing is August 20, 2003.	82270, 82274, and HCPCS code G0107.

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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 7, SECTION 2.2

CLINICAL PREVENTIVE SERVICES - TRICARE PRIME

SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT CPT <sup>1</sup> CODE
Colorectal Cancer (Continued):	<b>Proctosigmoidoscopy or Sigmoidoscopy:</b> Once every three to five years beginning at age 50.	45300-45321, 45327, 45330-45339.
	<b>Colonoscopy for Individuals at Average Risk for Colon Cancer:</b> Once every 10 years for individuals age 50 or above. The effective date for coverage of colonoscopy for individuals at average risk is March 15, 2006. <b>Colonoscopy for Individuals at Increased Risk for Colon Cancer:</b> Performed every two years beginning at age 25, or five years younger than the earliest age of diagnosis of colorectal cancer, whichever is earlier and then annually after age 40 for individuals with hereditary non-polyposis colorectal cancer syndrome. Individuals with familial risk of sporadic colorectal cancer (i.e., individuals with first degree relatives with sporadic colorectal cancer or adenomas before the age 60 or multiple first degree relatives with colorectal cancer or adenomas) may receive a colonoscopy every three to five years beginning at age 10 years earlier than the youngest affected relative.	45355, 45378-45385, and HCPCS codes G0105 and G0121.
<b>Skin Cancer:</b>	<b>Physical Examination:</b> Skin examination should be performed for individuals with a family or personal history of skin cancer, increased occupational or recreational exposure to sunlight, or clinical evidence of precursor lesions.	See appropriate level evaluation and management codes.
<b>Oral Cavity and Pharyngeal Cancer:</b>	<b>Physical Examination:</b> A complete oral cavity examination should be part of routine preventive care for adults at high risk due to exposure to tobacco or excessive amounts of alcohol. Oral examination should also be part of a recommended annual dental check-up.	See appropriate level evaluation and management codes.
<b>Thyroid Cancer:</b>	<b>Physical Examination:</b> Palpation for thyroid nodules should be performed in adults with a history of upper body irradiation.	See appropriate level evaluation and management codes.
<b>Infectious Diseases:</b>	<b>Tuberculosis screening:</b> Screen annually, regardless of age, all individuals at high risk for tuberculosis (as defined by CDC) using Mantoux tests.	86580 and 86585
	<b>Rubella antibodies:</b> females, once, age 12-18, unless documented history of adequate rubella vaccination with at least one dose of rubella vaccine on or after the first birthday.	86762

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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 7, SECTION 2.2

CLINICAL PREVENTIVE SERVICES - TRICARE PRIME

SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT CPT <sup>1</sup> CODE
<b>Infectious Diseases (Continued):</b>	<b>Hepatitis B screening:</b> Screen pregnant women for HBsAG during prenatal period.	87340
<b>Cardiovascular Diseases:</b>	<b>Cholesterol:</b> Non-fasting total blood cholesterol: At least once every five years, beginning age 18.	80061
	<b>Blood pressure screening:</b> For children: annually between three and six years of age, and every two years thereafter. For adults: a minimum frequency of every two years.	See appropriate level evaluation and management codes.
	<b>Abdominal Aortic Aneurysm (AAA):</b> One time AAA screening by ultrasonography for men, age 65-75, who have ever smoked.	76999
<b>Other:</b>	<b>Body Measurement:</b> 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.
	<b>Vision Care:</b> Pediatric vision screening at birth and approximately six months of age to include determination of vision on visual acuity, ocular alignment and red reflex, along with external examination of ocular abnormalities. Routine eye examination once every two years for all TRICARE Prime enrollees age three and older. Diabetic patients, at any age, should have routine eye examinations at least yearly.	92002, 92004, 92012, 92014, 92015, 99172, and 99173.
	NOTE: Routine eye examinations are meant to be more than the standard visual acuity screening test conducted by the member's primary care physician through the use of a standard Snellen wall chart. Self-referral will be allowed for routine eye examinations since PCMs are incapable of providing this service; i.e., a prime beneficiary will be allowed to set up his or her own appointment for a routine eye examination with any network optometrist and/or ophthalmologist.	

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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 7, SECTION 2.2

CLINICAL PREVENTIVE SERVICES - TRICARE PRIME

SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT CPT <sup>1</sup> CODE
<b>Other (Continued):</b>	<b>Hearing screening:</b> 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
	<b>Pediatric Blood Lead:</b> 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
<b>COUNSELING SERVICES:</b>		
<b>These are expected components of good clinical practice that are integrated into the appropriate office visit at no additional charge.</b>	<b>Patient &amp; parent education counseling:</b> 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.
<b>IMMUNIZATIONS:</b>		
	Age appropriate dose of vaccines that have been recommended and adopted by the Advisory Committee on Immunization Practices (ACIP) and accepted by the Director of the CDC and the Secretary of Health and Human Services (HHS) and published in a CDC <i>Morbidity and Mortality Weekly Report</i> (MMWR). Refer to the CDC's home page ( <a href="http://www.cdc.gov">http://www.cdc.gov</a> ) for current schedule of CDC recommended vaccines. The effective date of coverage for the Human Papilloma Virus (HPV) vaccine is October 13, 2006. The effective date of coverage for the zoster vaccine is October 19, 2007.	
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- END -

## PAPANICOLAOU (PAP) TESTS

ISSUE DATE: February 23, 1994

AUTHORITY: [32 CFR 199.4\(g\)\(1\)](#), [\(g\)\(2\)](#), and [\(g\)\(37\)](#)

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### I. CPT<sup>1</sup> PROCEDURE CODES

88141 - 88155, 88164 - 88167, 99201 - 99215 or 99301 - 99313

### II. DESCRIPTION

Papanicolaou (Pap) test is an exfoliative cytological staining procedure for the detection and diagnosis of various conditions, particularly malignant and premalignant conditions of the female genital tract. Pap tests are performed as either a diagnostic or screening test. For TRICARE purposes diagnostic Pap tests are tests performed on symptomatic females presenting with signs or symptoms of malignant or premalignant disease or pregnancy; screening Pap tests are performed on asymptomatic females who do not present with signs or symptoms of cervical or medical disease.

### III. POLICY

Cervical Pap tests are covered on either a diagnostic or screening basis. [For additional information on screening pap tests, see Clinical Preventive Services - TRICARE Standard ([Chapter 7, Section 2.1](#)) and Clinical Preventive Services - TRICARE Prime ([Chapter 7, Section 2.2](#)).]

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## WELL-CHILD CARE

ISSUE DATE: April 19, 1983

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

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### I. CPT<sup>1</sup> 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, ophthalmologist or optometrist, certified Nurse Practitioner (NP), or certified Physician Assistant (PA). Well-child services are considered preventive and are subject to the same cost sharing/copayment and authorization requirements prescribed under 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 TRICARE Preventive Services (see [Chapter 7, Sections 2.1 and 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.
    - (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 tested before three months of age using Evoked Otoacoustic Emission (EOE) and/or Auditory Brainstem Response (ABR) testing.

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

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

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

1. Immunizations 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: (CPT<sup>2</sup> procedure code 83655): Assessment of risk for lead exposure by structured questionnaire based on CDC's Preventing Lead Poisoning in Young (October 1991) during each well-child visit from age six months to under six years of age.

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

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

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**TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002**

CHAPTER 7, SECTION 2.5

WELL-CHILD CARE

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

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, Sections 2.1](#) and [2.2](#)).

- END -

## ROUTINE PHYSICAL EXAMINATIONS

ISSUE DATE: March 3, 1992

AUTHORITY: [32 CFR 199.4\(g\)](#)

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### I. CPT<sup>1</sup> PROCEDURE CODES

96110, 99382 - 99387, 99392 - 99397

### II. DESCRIPTION

A routine physical examination is an evaluation and management of the general health of adults and children conducted in the absence of a presenting complaint or other indication of illness or injury.

### III. POLICY

A. A physical examination which leads directly to the diagnosis of a diseased condition is not a routine physical examination and is covered.

B. A physical examination associated with well-child care or associated with a covered clinical preventive care is covered.

C. A physical examination provided when required in the case of a family member who is traveling outside the United States as a result of the member's assignment and such travel is being performed under orders issued by a Uniformed Service is covered.

### IV. EXCLUSIONS

A. A routine physical examination.

B. A physical examination required for an application to the United States Department of State for an immigrant visa.

C. An ancillary procedure in support of a routine physical examination.

- END -

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## CHELATION THERAPY

ISSUE DATE: October 12, 1984

AUTHORITY: 32 CFR 199.4(c)(2)(iii), (d)(3)(vi), and (g)(15)

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### I. CPT<sup>1</sup> PROCEDURE CODE

90784

### II. DESCRIPTION

The intravenous administration of chelation techniques for the therapeutic or preventive effects of removing unwanted metal ions from the body.

### III. POLICY

Chelation therapy is covered if the chelator is FDA approved and the therapy is for an FDA approved indication.

### IV. EXCLUSIONS

A. Chelation therapy (or chemical endarterectomy) is considered an unproven therapeutic modality for the treatment of the following conditions, and is not covered:

1. Multiple sclerosis
2. Arthritis
3. Hypoglycemia
4. Diabetes
5. Arteriosclerosis
6. Malaria
7. Cancer

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8. Alzheimer's disease

- END -

## HYDRATION, THERAPEUTIC, PROPHYLACTIC, AND DIAGNOSTIC INJECTIONS AND INFUSIONS (EXCLUDES CHEMOTHERAPY)

ISSUE DATE:

AUTHORITY: 32 CFR 199.4(b)(2)(v), (b)(3)(iii), (b)(5)(v), (d)(3)(vi), (e)(11)(ii), (e)(11)(iii), (g)(15)

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### I. CPT<sup>1</sup> PROCEDURE CODES

90760, 90761, 90765, 90767, 90768, 90772 - 90775, 90779

### II. DESCRIPTION

Previously intravenous (IV) hydration infusion services were not specifically described within the CPT code book. Hydration infusion services were reported with the same codes as chemotherapy. To more accurately report infusion services, several secondary service categories of new codes have been established.

### III. POLICY

A. Hydration IV infusion consistent of a pre-packaged fluid and electrolytes (e.g., normal saline, D5-1/2 normal saline +30mEq KCl/liter), but are not used to report infusion of drugs or other substances are covered.

B. Intravenous or intra-arterial push (an injection in which the health care professional who administers the substance/drug is continuously present to administer the injection and observe the patient or an infusion of 15 minutes or less) for therapy, prophylactic, or diagnosis is covered.

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(2) Coverage during a single benefit period is limited to 21 days unless the limit is waived in accordance with the criteria in [paragraph III.E](#).

2. Outpatient care is subject to the following:

a. Outpatient care (substance use disorder) must be provided by an approved substance use disorder rehabilitation facility, whether freestanding or hospital-based. Certified addiction rehabilitation counselors or certified alcohol counselors employed by the SUDRF may provide the care.

b. The SUDRF must bill for the services using the appropriate Level III code. Payment is made based on billed charges but is not to exceed the allowable amount for CPT<sup>1</sup> procedure code 90853.

c. Coverage is up to 60 visits in a benefit period unless the limit is waived in accordance with the criteria in [paragraph III.E](#).

d. Outpatient care is covered in a group setting only. Individual outpatient care will be denied. For patients with a primary diagnosis of mental disorder (DSM IV) that coexists with an alcohol and other drug abuse disorder see [Chapter 7, Section 3.13](#).

3. Family Therapy.

a. Family therapy provided on an outpatient basis by an approved substance use disorder rehabilitation facility, whether freestanding or hospital-based, is covered beginning with the completion of the patient's rehabilitative care as outlined in [paragraph III.C.1](#). The family therapy is covered for up to 15 visits in a benefit period unless the limit is waived in accordance with the criteria in [paragraph III.E](#). Services provided on an outpatient basis will be reimbursed under the appropriate allowable charge for the procedure code(s) billed.

b. Family therapy must be provided by a qualified mental health provider (psychiatrists or other physicians, clinical psychologists, certified psychiatric nurse specialists or clinical social workers; and certified marriage and family therapists, pastoral, and mental health counselors, under a physician's supervision).

D. Coverage limitations.

1. Detoxification. Admissions to all facilities (includes DRG and non-DRG facilities) for detoxification are covered if preauthorized as medically/psychologically necessary. Days of detoxification must be counted toward the statutory day limit, limiting care for adults (age 19 and over) to 30 days in a fiscal year or 30 days in an admission and to 45 days for children (age 18 and under).

2. Rehabilitation. Rehabilitation stays are subject to a limit of **three** benefit periods in a lifetime unless this limit is waived. Preadmission and continued stay authorization is required for substance use disorder detoxification and rehabilitation. Rehabilitation stays are covered if preauthorized as medically/psychologically necessary. Days of rehabilitation

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## TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

### CHAPTER 7, SECTION 3.7

#### SUBSTANCE USE DISORDERS

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must be counted toward the statutory day limit, restricting care for adults (age 19 and over) to 30 days in a fiscal year or 30 days in an admission and to 45 days for children (aged 18 and under). The concept of an emergency admission does not apply to rehabilitative care.

NOTE: The beneficiary may have either 21 days of rehabilitation in a residential (inpatient) basis or 21 days of rehabilitation in a partial hospital setting or a combination of both, as long as the 21-day limit for the total rehabilitation period is not exceeded.

E. Waiver of benefit limits. The specific benefit limits set forth in this section may be waived by the contractor in special cases based on a determination that all of the following criteria are met:

1. Active treatment has taken place during the period of the benefit limit and substantial progress has been made according to the plan of treatment.
2. Further progress has been delayed due to the complexity of the illness.
3. Specific evidence has been presented to explain the factors that interfered with further treatment progress during the period of the benefit limit.
4. The waiver request includes specific time frames and a specific plan of treatment which will complete the course of treatment.

F. Payment responsibility. Providers may not hold patients liable for payment for services for which payment is disallowed due to the provider's failure to follow established procedures for preadmission and continued stay authorization. With respect to such services, providers may not seek payment from the patient or the patient's family, unless the patient has agreed to personally pay for the services knowing that payment would not be made. Any such effort to seek payment is a basis for termination of the provider's authorized status.

G. Coverage is allowed for Antabuse® in the treatment of alcoholism.

H. Confidentiality. Release of any patient identifying information, including that required to adjudicate a claim, must comply with the provisions of section 544 of the Public Health Service Act, as amended, (42 U.S.C. 290dd-3), which governs the release of medical and other information from the records of patients undergoing treatment of substance use disorder. If the patient refuses to authorize the release of medical records which are, in the opinion of the contractor necessary to determine benefits on a claim for treatment of substance use disorder the claim will be denied.

#### IV. EXCEPTIONS

A. Aversion therapy. The programmed use of physical measures, such as electric shock, alcohol or other drugs (except Antabuse®) as negative reinforcement is not covered, even if recommended by a physician. All professional and institutional charges associated with a rehabilitation treatment program that uses aversion therapy must also be denied.

## TREATMENT OF MENTAL DISORDERS

ISSUE DATE: December 5, 1984

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

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### I. CPT<sup>1</sup> PROCEDURE CODE RANGE

90801 - 90899

### II. POLICY

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

### III. POLICY CONSIDERATIONS

#### A. Professional and institutional providers of mental health services.

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

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

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g. Mental health counselors

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

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

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

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

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

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

IV. EXCLUSIONS

A. Sexual dysfunctions, paraphilias and gender identity disorders.

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

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**TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002**

CHAPTER 7, SECTION 3.10

TREATMENT OF MENTAL DISORDERS

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C. Specific developmental disorders.

V. EFFECTIVE DATE            November 13, 1984.

- END -



## PSYCHOLOGICAL TESTING

ISSUE DATE: March 13, 1992

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

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### I. CPT<sup>1</sup> PROCEDURE CODES

96101-96103, 96118-96120

### II. DESCRIPTION

Psychological testing, with written report, per hour (assessment).

### III. POLICY

A. Psychological testing and assessment is a covered benefit when medically or psychologically necessary and is provided in conjunction with otherwise covered psychotherapy. Testing and assessment is generally limited to six hours in a fiscal year.

B. Psychological testing and assessment in the excess of six hours in a fiscal year may be considered for coverage upon review for medical necessity.

NOTE: Psychological tests are considered diagnostic services and are not counted against the **two** psychotherapy visits per week. Copay for retirees and their dependents would be \$12.00 per visit.

### IV. EXCLUSIONS

A. Payment is specifically excluded for the Reitan-Indiana battery when administered to a patient under age five and for self-administered tests to patients under age 13.

B. Psychological testing and assessment as part of an assessment for academic placement. This exclusion encompasses all psychological testing related to educational programs, issues or deficiencies. Testing to determine whether a beneficiary has a learning disability if the primary or sole basis for the testing is to assess for a learning disability.

C. Psychological testing related to child custody disputes or job placement.

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**TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002**

CHAPTER 7, SECTION 3.12

PSYCHOLOGICAL TESTING

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D. Psychological testing done for general screening (in the absence of specific symptoms of a covered mental disorder) to determine if individuals being tested are suffering from a mental disorder.

E. Teacher and parental referrals for psychological testing.

F. Testing related to diagnosed specific learning disorders or learning disabilities is excluded (encompasses reading disorder (also called dyslexia), mathematics disorder, disorder of written expression and learning disorder not otherwise specified).

G. Testing for a patient in a residential treatment center or partial hospitalization program is included in the per diem rate and can not be separately reimbursed. Also, payment billed by an individual professional provider not employed by or under contract with the residential treatment center or partial hospitalization program is included in the per diem rate.

- END -

## PSYCHOTHERAPY

ISSUE DATE: December 5, 1984

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

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### I. CPT<sup>1</sup> PROCEDURE CODE RANGE

90804 - 90857

### II. DESCRIPTION

Psychotherapy is the treatment for mental illness and behavioral disturbances in which the clinician establishes a professional contact with the patient and, through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development.

### III. POLICY

A. Benefits are available for inpatient and outpatient psychotherapy that is medically or psychologically necessary to treat a covered mental disorder.

B. Individual psychotherapy for patients with a mental disorder (DSM IV) that coexists with an alcohol and other drug abuse disorder is a covered benefit.

C. Charges for outpatient psychotherapy are not covered when the patient is an inpatient in an institution. Claims for outpatient psychotherapy must be denied for the entire period during which the beneficiary is an inpatient in the institution.

D. Employees of institutional providers are not authorized to bill for services rendered as part of that employment. Such services billed by the employee must be denied.

E. Eye Movement Desensitization and Reprocessing (EMDR) is not psychotherapy.

F. Psychotherapy is not a Health and Behavior Assessment/Intervention. See [Chapter 7, Section 16.2](#).

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IV. POLICY CONSIDERATIONS

A. Maximum duration of psychotherapy sessions:

1. Inpatient or outpatient individual psychotherapy (CPT<sup>2</sup> procedure codes 90806, 90807, 90818, 90819) approximately 45 to 50 minutes; or (CPT<sup>2</sup> procedure codes 90804, 90805, 90816, 90817) approximately 20 to 30 minutes.

2. Inpatient or outpatient group, conjoint or family psychotherapy: 90 minutes (CPT<sup>2</sup> procedure codes):

*90846 - FAMILY PSYTX W/O PATIENT*

*90847 - FAMILY PSYTX W/ PATIENT*

*90849 - MULTIPLE FAMILY GROUP PSYTX*

*90853 - GROUP PSYCHOTHERAPY*

3. Crisis intervention (CPT<sup>2</sup> procedure codes):

*90808 - PSYTX, OFFICE, 75-80 MIN*

*90809 - PSYTX, OFF, 75-80, W/E&M*

*90821 - PSYTX, HOSP, 75-80 MIN*

*90822 - PSYTX, HOSP, 75-80 MIN W/E&M*

B. Frequency of psychotherapy sessions.

NOTE: Beginning October 1, 1993, the mental health benefit year is changed from a calendar year to fiscal year. A patient is not automatically entitled to a designated number of sessions, and review can be more frequent when determined necessary.

1. The frequency limitations on outpatient psychotherapy apply to any psychotherapy performed on an outpatient basis, whether by an individual professional provider or by staff members of an institutional provider.

2. Treatment sessions may not be combined, i.e., 30 minutes on one day added to 20 minutes on another day and counted as one session, to allow reimbursement and circumvent the frequency limitation criteria.

3. Multiple sessions the same day: If the multiple sessions are of the same type--two individual psychotherapy sessions or two group therapy sessions--payment may be made only if the circumstances represent crisis intervention and only according to the restrictions applicable to crisis intervention. A collateral session not involving the identified patient on the same day the patient receives a therapy session does not require review.

4. Collateral visits (CPT<sup>2</sup> procedure code 90887). Collateral visits are payable when medically or psychologically necessary for treatment of the identified patient. A collateral visit is considered to be a psychotherapy session for purposes of reviewing the duration or frequency of psychotherapy.

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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 7, SECTION 3.13

PSYCHOTHERAPY

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5. Psychoanalysis (CPT<sup>3</sup> procedure code 90845). Psychoanalysis is covered when provided by a graduate or candidate of a psychoanalytic training institution recognized by the American Psychoanalytic Association and when preauthorized by the contractor.

6. Play therapy. Play therapy is a form of individual psychotherapy which is utilized in the diagnosis and treatment of children with psychiatric disorders. Play therapy is a benefit, subject to the regular points of review and frequency limitations applicable to individual psychotherapy.

7. Marathon therapy. Marathon therapy is a form of group therapy in which the therapy sessions last for an extended period of time, usually one or more days. Marathon therapy is not covered since it is not medically necessary or appropriate.

8. Inpatient psychotherapy and medical care. The allowable charge for inpatient psychotherapy includes medical management of the patient. A separate charge for hospital visits rendered by the provider on the same day as he/she is rendering psychotherapy is not covered. Payment is authorized only for medically necessary hospital visits billed on a day that psychotherapy was not rendered. If the provider who is primarily responsible for treatment of the mental disorder is not a physician, charges for medical management services by a physician are coverable, but only if the physician is rendering services that the non-physician provider is prohibited from providing. Concurrent inpatient care by providers of the same or different disciplines is covered only if second or third level review determines that the patient's condition requires the skills of multiple providers.

9. Physical examination. A physical examination is an essential component of the workup of the psychiatric patient, and for all admissions should be performed either by the attending psychiatrist or by another physician. The examination may lead to confirmation of a known psychiatric diagnosis or consideration of other unsuspected psychiatric or medical illness. When not performed by the attending psychiatrist, payment may be made to another physician for performance of the initial physical examination. Any additional concurrent care provided by a physician other than the attending psychiatrist may be covered only if it meets the criteria under inpatient concurrent care.

V. EFFECTIVE DATE            November 13, 1984.

- END -

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## FAMILY THERAPY

ISSUE DATE: August 31, 1987

AUTHORITY: Federal Register, Vol. 46, No. 72, 4/15/81  
[32 CFR 199.4\(c\)\(3\)\(ix\)](#)

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### I. CPT<sup>1</sup> PROCEDURE CODES

90846, 90847, 90849

### II. DESCRIPTION

**Family Therapy Defined.** Family therapy is a form of psychotherapy directed toward the family as a unit, instead of toward a single individual. Family therapy is based on the assumption that the mental or emotional illness and the functional impairment of the identified-patient is related to family interactions and, therefore, the family is the unit that should be treated. Problems and dysfunctional behaviors are dealt with as responsibilities of all family members and are not necessarily focused on any one individual. Family therapy may involve the complete or partially available family unit and normally would involve the same therapist or treatment team. When geographical distance necessitates therapy be given to partial family units at separate locations, collaboration between treating therapists is acceptable. For the purposes of coverage, the family generally would include the husband or wife of the patient, his or her children or, in the case of child patients, the parents, stepparents and siblings. When determined appropriate, other family members residing in the same household could also be included.

### III. POLICY

Family therapy can be cost-shared when rendered in conjunction with otherwise covered treatment of a beneficiary suffering a diagnosed mental disorder.

### IV. POLICY CONSIDERATIONS

A. Frequency. Professional review of the medical or psychological necessity is required for therapy in excess of the parameters indicated below.

1. Outpatient psychotherapy is limited to a maximum of two psychotherapy sessions per week in any combination of individual, family, collateral, or group sessions.

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2. Inpatient psychotherapy is limited to five sessions per week in any combination of individual, family, collateral, or group sessions.

NOTE: Two consecutive family therapy sessions with the same family members present is considered to be a single session and not two distinct sessions with a different focus (e.g., a different child being the focus of each). In such cases, the reimbursement will be treated as if the therapy had occurred at a single session.

B. Telephone calls, therapeutic leaves and visits among family members are not a substitute for family therapy, although they can be important adjuncts to a child's treatment. Multi-family group therapy does not meet the family therapy requirement. A collateral visit, a session between an authorized provider and a significant person in the identified-patient's life, is primarily for the purpose of information gathering and does not constitute a family therapy session, although such visits do count toward the psychotherapy limits.

C. Special Considerations Involving Partial Hospitalization and Residential Treatment Center (RTC) Care.

1. Family Therapy involving Partial Hospitalization and RTC Admissions. In accordance with the appropriate medical care standard, discharge planning should start with the day of admission. The goal should be to restore the patient's ability to function in one or more major life activities. In the case of a child under age 21, the environment to which the patient is to be discharged is a major consideration. To be authorized, RTCs and partial hospitalization programs are required to address the feasibility of family therapy as part of the treatment plan.

a. Standards. A compliance requirement of the RTC standards (see [32 CFR 199.4\(b\)\(4\)\(vii\)](#)) and the partial hospitalization standards is that the admission process must include the family's (or responsible relative's or legal guardian's) understanding of residential or partial hospitalization treatment and of their involvement in treatment as well as the probable length of stay of the patient. The RTC standards dictate that if the patient is not returning to the family, appropriate documentation in the clinical record should indicate the type of preparation made with other persons who will be involved with the patient upon discharge. The RTC and partial hospitalization standards require that all specific therapeutic modalities be spelled out in the treatment plan, including family therapy.

b. Joint Commission on Accreditation of Health Organizations (JCAHO) Mental Health Manual (formerly Consolidated Standards). Under the Mental Health Manual, JCAHO requires a specific plan for involving the family in the treatment plan, when indicated. There is also a requirement that the patient's record shall contain documentation of family members involvement in the patient's treatment program. If appropriate, a separate record may need to be maintained on each family member involved in the patient's treatment program.

2. Detailed Description of Family Therapy in Treatment Plan. Family therapy is an integral part of the treatment of children and adolescents and should be included in all mental health treatment plans unless circumstances exist which make such treatment contraindicated. Treatment plans must include a detailed description of the plans for family therapy (name and qualifications of therapist, frequency, length of sessions) or provide

## PSYCHOTROPIC PHARMACOLOGIC MANAGEMENT

ISSUE DATE: December 5, 1984

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

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### I. CPT<sup>1</sup> PROCEDURE CODE

90862

### II. DESCRIPTION

Pharmacologic management, including prescription use, and review of medication with no more than minimal medical psychotherapy.

### III. POLICY

A. Psychotropic pharmacologic management is covered when provided as an independent procedure. If the provider is also providing psychotherapy, services provided in connection with psychotropic pharmacologic management are included in the allowable charge for the psychotherapy. A separate charge for psychology pharmacologic management is not payable.

NOTE: Office visits for psychotropic pharmacologic management are routine medical services and do not count against the **two** visits per week or the initial **eight** visits for psychotherapy.

B. Charges for psychotropic pharmacologic management may be cost-shared when services are rendered by authorized providers, to include certified nurse practitioners and certified psychiatric nurse specialists, practicing within the scope of their licensure. Services may be provided in either an inpatient or outpatient setting.

C. The allowable charge for psychotropic pharmacologic management shall be based on the CHAMPUS Maximum Allowable Charge (**CMAC**) methodology.

IV. EFFECTIVE DATE            November 13, 1984.

- END -

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## COLLATERAL VISITS

ISSUE DATE: December 5, 1984

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

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### I. CPT<sup>1</sup> PROCEDURE CODE

90887

### II. DESCRIPTION

Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient.

### III. POLICY

A. Collateral visits that are medically or psychologically necessary for the treatment of the patient are covered. It is not a therapy session, a treatment planning session, or a discussion with the milieu staff. It is conducted for the purpose of information gathering and implementing treatment goals. A responsible person is generally a parent, the husband, wife, or siblings. Other individuals also may qualify for collateral visits for both the adult and the child or adolescent patient provided it can be demonstrated that the individual is, in fact, a significant person in the life of the identified patient.

B. A collateral visit does not involve treatment of the collateral person(s). It is for purposes of information exchange regarding the patient or implementing treatment goals for the patient. Collateral visits are considered as services rendered on behalf of the patient, are billed in the name of the patient, and are counted as individual psychotherapy sessions for purposes of utilization review. Duration up to 60 minutes is allowed.

### IV. EXCLUSIONS

A. Group visits. A group collateral visit is when the therapist meets with a group of parents of the children he/she sees in group therapy. The focus of the sessions is on improving parenting techniques and fostering better implementation goals.

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**TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002**

CHAPTER 7, SECTION 3.16

COLLATERAL VISITS

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B. A collateral visit rendered on the same day that the patient receives individual or group psychotherapy is coverable. Collateral visits do not count toward crisis intervention sessions.

V. EFFECTIVE DATE            October 1, 1980.

- END -

## BIOFEEDBACK

ISSUE DATE: January 23, 1984

AUTHORITY: [32 CFR 199.4\(e\)\(17\)](#)

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### I. CPT<sup>1</sup> PROCEDURE CODES

90901, 90911

### II. DESCRIPTION

Biofeedback therapy is a technique by which a person is taught to exercise control over a physiologic process occurring within the body. By using modern biomedical instruments the patient learns how a specific physiologic system within his body operates and how to modify the performance of this particular system.

### III. POLICY

A. Benefits are payable for services and supplies in connection with electrothermal, electromyograph and electrodermal biofeedback therapy when there is documentation that the patient has undergone an appropriate medical evaluation, that their present condition is not responding to or no longer responds to other forms of conventional treatment and only provided in treatment of the following conditions:

1. Adjunctive treatment for Raynaud's Syndrome.
2. Adjunctive treatment for muscle re-education of specific muscle groups or for treating pathological muscle abnormalities of spasticity, or incapacitating muscle spasm or weakness.
3. Payable benefits include initial intake evaluation. Treatment following the initial intake evaluation is limited to a maximum of 20 inpatient and outpatient biofeedback treatments per calendar year.

### IV. EXCLUSIONS

- A. Treatment of ordinary muscle tension states or for psychosomatic conditions.
- B. Rental or purchase of biofeedback equipment.

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**TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002**

CHAPTER 7, SECTION 4.1

BIOFEEDBACK

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C. Hypertension.

D. Treatment of psychosomatic (i.e., psychophysiological or psychological factors affecting medical condition) conditions and for CPT<sup>2</sup> procedure codes 90875 and 90876.

- END -

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## DIALYSIS

ISSUE DATE: January 23, 1984

AUTHORITY: [32 CFR 199.4\(e\)\(17\)](#)

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### I. CPT<sup>1</sup> PROCEDURE CODES

90918 - 90999

### II. POLICY

End Stage Renal Disease (ESRD) services, hemodialysis, and other dialysis services and supplies are covered.

- END -

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## GASTROENTEROLOGY

ISSUE DATE: April 19, 1983

AUTHORITY: [32 CFR 199.4\(a\)\(1\)](#)

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I. CPT<sup>1</sup> PROCEDURE CODE RANGE

91000 - 91299

II. DESCRIPTION

Non-surgical procedures performed to diagnose conditions of the gastrointestinal system.

III. POLICY

Gastroenterological services may be cost-shared.

- END -

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## OPHTHALMOLOGICAL SERVICES

ISSUE DATE: November 3, 1992

AUTHORITY: 32 CFR 199.4(c)(2)(xvi), (e)(6), (g)(46) and (g)(50)

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### I. CPT<sup>1</sup> PROCEDURE CODE RANGES

92002 - 92060, 92070 - 92335, 92390 - 92499

### II. DESCRIPTION

Ophthalmological services may include an examination and other specialized services. The purpose of an examination is to diagnose or treat a medical condition of the eye, eyelid, lacrimal system, or orbit. A "routine eye examination" is an evaluation of the eyes, including but not limited to refractive services, that is not related to a medical or surgical condition or to the medical or surgical treatment of a covered illness or injury.

### III. POLICY

A. For all beneficiaries, ophthalmological services (including refractive services) provided in connection with the medical or surgical treatment of a covered illness or injury are covered.

B. Section 632 of P.L. 98-525 signed into effect on October 19, 1994, authorizes payment under TRICARE for one routine eye examination per year for dependents of active duty members.

1. Routine eye examinations as defined in 32 CFR 199.2 includes coverage of those services rendered in order to determine the refractive state of the eyes. The CPT<sup>2</sup> procedure codes for payment of routine eye examinations are as follows:

92002 - EYE EXAM, NEW PATIENT  
92004 - EYE EXAM, NEW PATIENT  
92012 - EYE EXAM, ESTABLISHED PATIENT  
92014 - EYE EXAM & TREATMENT  
92015 - REFRACTION  
99172 - OCULAR FUNCTION SCREEN  
99173 - VISUAL ACUITY SCREEN

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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 7, SECTION 6.1

OPHTHALMOLOGICAL SERVICES

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2. TRICARE Prime and Standard Active Duty Family Members (ADFM) are entitled to one annual routine eye examination. Prime ADFMs may receive their annual routine eye exam from any network provider without referral, authorization, or preauthorization from the Primary Care Manager (PCM), or any other authority; i.e., a Prime ADFM will be allowed to set up his or her own appointment for a routine eye examination with any network optometrist or ophthalmologist. Standard ADFMs may self-refer to any TRICARE authorized provider regardless of whether or not they are a network provider; i.e., a Standard ADFM may set up his or her own appointment with either a network or non-network TRICARE authorized optometrist or ophthalmologist.

C. For Prime enrollees, see [Chapter 7, Section 2.2](#) for additional information on routine eye examinations.

IV. EXCLUSIONS

A. Routine eye examinations are NOT covered for Standard retirees or their dependents that are not enrolled in Prime except for eye exams allowed under the well-child benefit in [Chapter 7, Section 2.5](#).

B. Orthoptics, also known as vision training, vision therapy, eye exercises, eye therapy, is excluded by [32 CFR 199.4\(g\)\(46\)](#) (CPT<sup>2</sup> procedure code 92065).

C. Heidelberg Retina Tomograph (HRT) is unproven.

- END -

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## LENSES (INTRAOCULAR OR CONTACT) AND EYE GLASSES

ISSUE DATE: January 23, 1984

AUTHORITY: 32 CFR 199.4(d)(3)(vii), (e)(6)(i), and (e)(6)(ii)

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### I. CPT<sup>1</sup> PROCEDURE CODES

92070, 92310 - 92326, 92390 - 92396

### II. POLICY

A. Lenses must be FDA approved.

B. Lenses or eye glasses are only cost-shared for the following conditions:

1. Contact lenses for treatment of infantile glaucoma.
2. Corneal or scleral lenses for treatment of keratoconus.
3. Scleral lenses to retain moisture when normal tearing is not present or is inadequate.
4. Corneal or scleral lenses prescribed to reduce a corneal irregularity other than astigmatism.
5. Intraocular lenses, contact lenses, or eyeglasses to perform the function of the human lens, lost as the result of intraocular surgery or ocular injury or congenital absence.

C. Benefits are also specifically limited to one set of intraocular lenses necessary to restore vision. A set may also include a combination of both intraocular lenses and eyeglasses when a combination is necessary to restore vision.

D. When there is a prescription change still related to the qualifying eye condition, a new set may be cost-shared.

### III. EXCLUSIONS

A. When the prescription remains unchanged, replacement for lenses that are lost, have deteriorated or that have become unusable due to physical growth is not covered.

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**TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002**

CHAPTER 7, SECTION 6.2

LENSES (INTRAOCULAR OR CONTACT) AND EYE GLASSES

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B. Adjustments, cleaning, or repairs of glasses are not covered (CPT<sup>2</sup> procedure codes 92340-92371).

- END -

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## CARDIOVASCULAR THERAPEUTIC SERVICES

ISSUE DATE:

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

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### I. CPT<sup>1</sup> PROCEDURE CODES

92950 - 93799

### II. DESCRIPTION

Cardiovascular therapeutic services include, but are not limited to, intravascular ultrasound, percutaneous transluminal coronary angioplasty, cardiography, echocardiography, cardiac catheterization, intracardiac electrophysiological procedures studies, peripheral arterial disease rehabilitation, and other vascular studies.

### III. POLICY

Cardiovascular therapeutic services are covered.

- END -

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## SPEECH SERVICES

ISSUE DATE: April 19, 1983

AUTHORITY: 32 CFR 199.4(g)(45), 32 CFR 199.5(c), and Public Law 107-107

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### I. CPT<sup>1</sup> PROCEDURE CODE RANGE

92506 - 92508

### II. DESCRIPTION

Medical services that provide evaluation, treatment, habilitation, and rehabilitation of speech, language, and voice dysfunctions resulting from congenital anomalies, disease, injury, hearing loss, communication or pervasive developmental disorders or a therapeutic process.

### III. POLICY

A. Speech services provided or prescribed and supervised by a physician may be cost-shared.

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

B. For beneficiaries under the age of 3, services and items provided in accordance with the beneficiary's Individualized Family Service Plan as required by Part C of the Individuals with Disabilities Education Act, and which are otherwise allowable under the TRICARE Basic Program or the Extended Care Health Option (ECHO) but determined not to be medically or psychologically necessary, are excluded.

C. For beneficiaries ages 3 to 21 who are receiving special education services from a public educational agency, cost-sharing of outpatient speech services that are required by the Individuals with Disabilities Education Act and which are indicated in the beneficiary's

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**TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002**

CHAPTER 7, SECTION 7.1

SPEECH SERVICES

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Individualized Education Program (IEP), may not be cost-shared except when the intensity or timeliness of speech services as proposed by the educational agency are not appropriate medical care.

D. Myofunctional or tongue thrust therapy.

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

F. Videofluoroscopy evaluation in speech pathology.

- 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)

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### I. CPT<sup>1</sup> 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 (CPT<sup>1</sup> procedure codes 92601, 92602), and age seven years or older with programming (CPT<sup>1</sup> procedure codes 92603, 92604). See [Chapter 4, Section 22.2](#).

E. Evaluation for prescription of non-speech-generating augmentative and alternative communication device, including programming and modification, may be cost-shared only

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**TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002**

CHAPTER 7, SECTION 8.1

SPECIAL OTORHINOLARYNGOLOGIC SERVICES

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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 (CPT<sup>2</sup> procedure codes 92605 - 92609).

- END -

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## HEARING AIDS AND HEARING AID SERVICES

ISSUE DATE: April 19, 1983

AUTHORITY: [32 CFR 199.4\(e\)\(24\)](#), [\(g\)\(51\)](#), and Public Law 107-107

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### I. CPT<sup>1</sup> PROCEDURE CODE RANGE

92590 - 92595

### II. HCPCS PROCEDURE CODES

V5000 - V5267, V5275, V5298

### III. POLICY

A. Hearing aids and hearing aid services and supplies may be covered for those active duty family members with a profound hearing loss as described below.

1. Profound hearing loss (adult). An “adult” (a spouse as defined in [32 CFR 199.3\(b\)](#) of a member of the Uniformed Services on active duty for more than 30 days) with a hearing threshold of:

a. 40 dB HL or greater in one or both ears when tested at 500, 1,000, 1,500, 2,000, 3,000, or 4,000Hz; or

b. 26 dB HL or greater in one or both ears at any three or more of those frequencies; or

c. A speech recognition score less than 94%.

2. Profound hearing loss (child). A “child” (an unmarried child of an active duty member who otherwise meets the criteria (including age requirements) in [32 CFR 199.3](#) of this part) with a 26dB HL or greater hearing threshold level or one or both ears when tested in the frequency range at 500, 1,000, 2,000, 3,000, or 4,000Hz.

B. Medically necessary and appropriate services and supplies, including hearing examinations provided by authorized providers, required in connection with this hearing aid benefit are covered.

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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 7, SECTION 8.2

HEARING AIDS AND HEARING AID SERVICES

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IV. EXCLUSIONS

A. Hearing aid and hearing aid services for retirees and their family members.

B. Implantable hearing aid.

NOTE: Not to be confused with cochlear implants which are covered under TRICARE.

V. EFFECTIVE DATE           September 1, 2005.

- END -

## ELECTRONYSTAGMOGRAPHY

ISSUE DATE: July 8, 1998

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

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### I. CPT<sup>1</sup> PROCEDURE CODE RANGE

92541 - 92547

### II. DESCRIPTION

Electronystagmography (ENG) refers to the recording of ocular nystagmus or eye movements by electrooculography in response to vestibular dysfunction. During ENG testing, the eye movements are recorded and analyzed by placing small electrodes on the skin around the eyes.

### III. POLICY

A. ENG testing may be considered for cost-sharing to determine the diagnosis of vestibular system abnormalities including disorders that affect the peripheral or central vestibular system when ordered by a physician.

B. ENG testing should be reserved for the assessment of patients with vertigo, dizziness, or dysequilibrium and who are suspected of suffering from the following vestibular system abnormalities: [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. Meniere's disease/Endolymphatic hydrops
2. Vestibular neuritis
3. Labyrinthine concussion
4. Recurrent vestibulopathy
5. Migraine-associated dizziness, benign paroxysmal vertigo of childhood
6. Labyrinthine ischemia

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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 7, SECTION 9.1

ELECTRONYSTAGMOGRAPHY

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7. Chemical-induced vestibulotoxicity

IV. EXCLUSIONS

A. Dynamic Posturography (CPT<sup>2</sup> procedure code 92548) is unproven.

B. Vestibular rehabilitation therapy for the treatment of benign paroxysmal positional vertigo is unproven.

V. EFFECTIVE DATE            June 1, 1996.

- END -

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## ECHOCARDIOGRAM FOR DENTAL AND INVASIVE PROCEDURES

ISSUE DATE: May 4, 1998

AUTHORITY: [32 CFR 199.4\(e\)\(10\)](#)

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### I. CPT<sup>1</sup> PROCEDURE CODE RANGE

93303 - 93350

### II. DESCRIPTION

An echocardiogram is a non-invasive diagnostic test performed to evaluate the heart's function. It is able to monitor the performance of the valves. It can help to diagnose structural abnormalities in the heart wall, valves, and blood vessels. It can detect tumors, clots or pericardial effusions (abnormal fluid collection around the heart). It is sometimes used after a heart attack to evaluate the cardiac wall motion and function. The most frequent use of an echocardiogram is for diagnosing or monitoring congenital heart disease, cardiomyopathies or aneurysms.

### III. POLICY

A. An echocardiogram is a covered procedure to evaluate the valves and chambers of the heart, to aid the diagnosis of cardiomyopathies, to detect atrial tumors or pericardial effusions or to evaluate cardiac wall motion and function after a heart attack.

B. An echocardiogram is a covered diagnostic procedure for cardiac valvulopathy associated with ingestion of Pondimin and Redux (Phen-Fen):

1. After a thorough medical history and cardiovascular physical examination reveals a new murmur or symptoms (shortness of breath) of cardiac problems; or

2. Before dental procedures in patients who have been found to have clinically significant valvular abnormalities. Abnormalities that create the risk for developing endocarditis include, but are not limited to:

- a. Implanted heart valves as a replacement for their own heart valve.
- b. Abnormal native heart valves (leakage, blockage).

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**TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002**  
CHAPTER 7, SECTION 10.1  
ECHOCARDIOGRAM FOR DENTAL AND INVASIVE PROCEDURES

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- c. Any congenital heart defect (VSD, ASD, PDA, complex anomaly).
- d. Dacron or Teflon vascular grafts or patches over cardiac defects.
- e. Mitral valve prolapse - only if there is significant valve leakage.
- f. Pacemakers.

- END -

## CARDIAC REHABILITATION

ISSUE DATE: November 1, 1983

AUTHORITY: [32 CFR 199.4\(e\)\(18\)](#)

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### I. CPT<sup>1</sup> PROCEDURE CODE RANGE

93797 - 93798

### II. DESCRIPTION

Cardiac rehabilitation is the process by which individuals are restored to their optimal physical, medical, and psychological status, after a cardiac event. Cardiac rehabilitation is often divided into three phases. Phase I begins during inpatient hospitalization and is managed by the patient's personal physician. Phase II is a medically supervised outpatient program which begins following discharge. Phase III is a lifetime maintenance program emphasizing continuation of physical fitness with periodic follow-up. Each phase includes an exercise component, patient education, and risk factor modification. There may be considerable variation in program components, intensity and duration.

### III. POLICY

A. Cardiac rehabilitation services are cost-shared on an inpatient or outpatient basis for services and supplies provided in connection with a cardiac rehabilitation program when ordered by a physician and provided as treatment for patients who have experienced the following cardiac events within the preceding 12 months:

1. Myocardial infarction.
2. Coronary artery bypass graft.
3. Coronary angioplasty.
4. Percutaneous transluminal coronary angioplasty.
5. Chronic stable angina.
6. Heart valve surgery.

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**TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002**

CHAPTER 7, SECTION 11.1

CARDIAC REHABILITATION

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7. Heart transplants, to include heart-lung.

B. Payable benefits include separate allowance for the initial evaluation and testing. Outpatient treatment following the initial intake evaluation and testing is limited to a maximum of 36 sessions per cardiac event, usually provided 3 sessions per week for 12 weeks. Patient's diagnosed with chronic stable angina are limited to one treatment episode (36 sessions) in a calendar year.

IV. EXCLUSION

Phase III cardiac rehabilitation for lifetime maintenance performed at home or in medically unsupervised settings.

- END -

## NON-INVASIVE VASCULAR DIAGNOSTIC STUDIES

ISSUE DATE: April 25, 1988

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

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I. CPT<sup>1</sup> PROCEDURE CODE RANGE

93875 - 93990

II. POLICY

Cerebrovascular Arterial Studies, Extremity Arterial Studies (Including Digits), Extremity Venous Studies (Including Digits), Visceral and Penile Vascular Studies, and Extremity Arterial-Venous Studies are covered.

III. EXCLUSION

In conjunction with podiatry service.

- END -

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## PULMONARY SERVICES

ISSUE DATE: April 19, 1983

AUTHORITY: [32 CFR 199.4\(b\)\(2\)\(xviii\)](#)

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### I. CPT<sup>1</sup> PROCEDURE CODE RANGE

94010 - 94799

### II. DESCRIPTION

Services provided for the diagnosis or treatment of conditions involving the lungs.

### III. POLICY

A. Pulmonary services including pulmonary services provided as part of a treatment program on an inpatient or outpatient basis are covered.

B. For an indication to be covered the efficacy of the pulmonary services must be proven.

NOTE: Examples of proven indications are: cardiopulmonary or pulmonary rehabilitation for pre- and post-lung transplant patients when preauthorized by the appropriate preauthorizing authority as outlined in the Policy on heart-lung and lung transplantation; effective September 13, 1999, severe chronic obstructive pulmonary disease (COPD) on an inpatient basis; and moderate and severe COPD on an outpatient basis.

- END -

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## ALLERGY TESTING AND TREATMENT

ISSUE DATE: April 19, 1983

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

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### I. CPT<sup>1</sup> PROCEDURE CODE RANGE

95004 - 95199

### II. DESCRIPTION

The testing and treatment of conditions related to allergies.

### III. POLICY

Services and supplies required in the diagnosis and treatment of allergies are covered.

### IV. EXCLUSIONS

A. Unproven allergy testing. The following are examples of unproven allergy testing. This list is NOT intended to be all-inclusive:

1. In vitro histamine release.
2. Provocative and neutralization testing for food, environmental chemicals, inhalant allergens, and endogenous hormones.
3. Sublingual testing.
4. Cytotoxic leukocyte test for food and inhalant allergies.
5. Reback skin window test.
6. Passive transfer (Prausnitz-Kustner) test.
7. Serial skin-test end point titration for routine testing.
8. Kinesiology testing. This test involves muscle strength measurements after food ingestion or sublingual application of food extracts.

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9. Reaginic Pulse test. This test measures the increase of pulse rates after ingestion of a suspected allergic food substance.

10. ELISA - Enzyme-linked immunoabsorbent assay.

11. Electrodermal diagnosis.

12. Chemical analysis of body tissue.

13. Recall skin tests.

14. In vitro lymphocyte proliferation.

15. Food challenge testing performed in connection with clinical ecology programs.

B. Unproven allergy treatment. The following are examples of unproven allergy treatment. This list is NOT intended to be all-inclusive:

1. Sublingual antigen therapy.

2. Sublingual neutralization therapy for food and inhalant allergy.

3. Urine autoinjection (autogenous urine immunization).

4. Intracutaneous (intradermal) and subcutaneous neutralization therapy for food allergies.

5. Immunotherapy involving any injection of a food antigen.

6. Chemical exposure avoidance, special diet therapy, drug therapy and neutralization therapy for environmental allergies.

7. Total serum IgE concentration in cord blood.

- END -

## NEUROLOGY AND NEUROMUSCULAR SERVICES

ISSUE DATE: April 19, 1983

AUTHORITY: 32 CFR 199.4(b)(2)(vii) and (b)(3)(v)

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### I. CPT<sup>1</sup> PROCEDURE CODE RANGE

95812 - 95999

### II. DESCRIPTION

The diagnosis and treatment of muscle and nerve disorders.

### III. POLICY

Neurology and neuromuscular services are covered.

### IV. EXCLUSIONS

A. Topographic brain mapping (brain electrical activity mapping, quantitative EEG, digital EEG, topographic EEG, brain mapping EEG) is unproven.

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

1. Palmar hyperhidrosis.
2. Urinary urge incontinence.
3. Lower back pain/lumbago.
4. Migraine headaches and other primary headache disorders.
5. Strabismus in patients under 12.

- END -

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## SENSORY EVOKED POTENTIALS (SEP)

ISSUE DATE: September 23, 1991

AUTHORITY: 32 CFR 199.4(a)(1), (b)(2)(vii), (c)(2)(iii), and (c)(2)(iv)

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### I. CPT<sup>1</sup> PROCEDURE CODES

92585, 95925 - 95930

### II. DESCRIPTION

Sensory evoked potentials (SEP) are electrical waves that are generated by the response of sensory neurons to stimuli. Changes in the electrical waves are averaged by a computer and then interpreted by a physician. Computer-averaged SEPs can be used to assist the diagnosis of certain neuropathologic states or to provide information for treatment management. Intraoperative monitoring of sensory evoked potentials is used during orthopedic or neurologic surgical procedures to reduce surgically induced morbidity and/or to monitor the level of anesthesia.

### III. POLICY

Visual, auditory, and somatosensory evoked potential recordings that are medically necessary to diagnose, evaluate, assess recovery of brainstem function, measure the type and extent of hearing impairment, and to assess somatosensory function in unconscious patients or to supplement the EEG in evaluating brain death or irreversibility of coma are covered.

### IV. EXCLUSION

Intraoperative monitoring of SEPs to define conceptional or gestational age in pre-term infants is unproven.

V. EFFECTIVE DATE            May 18, 1993.

- END -

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## CENTRAL NERVOUS SYSTEM ASSESSMENTS/TESTS

ISSUE DATE:

AUTHORITY: [32 CFR 199.4\(b\)\(2\)](#), [\(b\)\(3\)](#), and [\(b\)\(4\)](#)

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### I. CPT<sup>1</sup>PROCEDURE CODES

96101 - 96103, 96105, 96110, 96111, 96116, 96118 - 96120

### II. POLICY

Central nervous system assessments/tests are covered.

- END -

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## HEALTH AND BEHAVIOR ASSESSMENT/INTERVENTION

ISSUE DATE: March 11, 2002

AUTHORITY: [32 CFR 199.4\(a\)\(1\)](#)

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### I. CPT<sup>1</sup>PROCEDURE CODE RANGE

96150 - 96154

### II. DESCRIPTION

Health and behavior assessment procedures are used to identify the psychological, behavioral, emotional, cognitive, and social factors important to the prevention, treatment, or management of physical health problems. The focus of the assessment is not on mental health but on the biopsychosocial factors important to physical health problems and treatment.

### III. POLICY

Health and behavior assessment performed by a clinical psychologist in conjunction with the medical or surgical treatment of a covered illness or injury is covered.

### IV. EXCLUSIONS

A. Family evaluation and assessment (without the patient present) (CPT<sup>1</sup> procedure code 96155).

B. Patient meeting criteria for a psychiatric diagnosis.

- END -

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## CHEMOTHERAPY ADMINISTRATION

ISSUE DATE:

AUTHORITY: 32 CFR 199.4(b)(2)(v), (b)(3)(iii), (b)(5)(v), (d)(3)(vi), (e)(11)(i), (e)(11)(ii), (e)(11)(iii), (g)(15)

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### I. CPT<sup>1</sup> PROCEDURE CODES

96401, 96402, 96405, 96406, 96409, 96411, 96413, 96415 - 96417, 96420, 96422, 96423, 96425, 96440, 96445, 96450, 96521 - 96523, 96542, 96549

### II. DESCRIPTION

Chemotherapy administration applies to parenteral administration of non-radionuclide anti-neoplastic drugs; and also to anti-neoplastic agents provided in treatment of noncancerous diagnoses (e.g., cycphosphamide for auto-immune conditions) or to substances such as monoclonal antibody agents, and other biologic response modifiers.

### III. POLICY

A. Chemotherapy administration, subcutaneous or intramuscular; non-hormonal and anti-neoplastic is covered.

B. Chemotherapy administration, intralesional, up to and including **seven** lesions, more than **seven** lesions, intravenous push technique, single, initial substance/drug, each additional substance/drug is covered.

C. Chemotherapy administration, intravenous infusion technique; up to one hour, single or initial substance/drug; each additional hour, initiation of prolonged chemotherapy infusion (more than **eight** hours requiring use of a portable or implantable pump and each additional sequential infusion (different substance/drug) up to **one** hour) is covered.

D. Chemotherapy administration, intra-arterial; push technique/infusion technique, up to **one** hour; infusion technique, each additional hour up to **eight** hours infusion technique (more than **eight** hours) requiring the use of a portable or implantable pump is covered.

E. Chemotherapy administration into pleural cavity, requiring and including thoracentesis; into the peritoneal cavity requiring and including peritoneocentesis is covered.

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**TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002**

CHAPTER 7, SECTION 16.3

CHEMOTHERAPY ADMINISTRATION

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- F. Chemotherapy administration into CNS (e.g., intrathecal requiring and including spinal puncture) is covered.
  
- G. Refilling and maintenance of portable pump is covered. Refilling and maintenance of implantable pump or reservoir for drug delivery, systemic (e.g., intravenous-intera arterial) is covered.
  
- H. Irrigation of implanted venous access device for drug delivery systems is covered.
  
- I. Chemotherapy injection, subarachnid or intraventricular via subcutaneous reservoir, single or multiple agents is covered.

- END -

## EDUCATION AND TRAINING FOR PATIENT SELF MANAGEMENT

ISSUE DATE:

AUTHORITY: [32 CFR 199.4\(g\)\(42\)](#)

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### I. CPT<sup>1</sup> PROCEDURE CODES

98960 - 98962

### II. DESCRIPTION

Education and training services to teach the patient (may include care giver) how to effectively self manage the patient's illness(es)/disease(es) or delay disease comorbidity(ies) in conjunction with the patient's professional health care team.

### III. POLICY

Self help services is excluded from coverage by regulation.

- END -

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## DERMATOLOGICAL PROCEDURES - GENERAL

ISSUE DATE: April 19, 1983

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

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I. CPT<sup>1</sup> PROCEDURE CODE RANGE

96567 - 96999

II. DESCRIPTION

The diagnosis and treatment of skin disorders.

III. POLICY

A. Dermatological services may be cost-shared for the treatment of a covered condition unless otherwise limited or excluded by this manual.

B. Topical treatment for hypertrophic scarring and keloids resulting from burns, surgical procedures or traumatic events may be cost-shared only if there is evidence of impaired function.

C. Medically appropriate treatment for acne is covered.

D. Photodynamic therapy and photochemotherapy may be cost-shared for a covered condition.

- END -

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## REHABILITATION - GENERAL

ISSUE DATE: June 5, 1995

AUTHORITY: 32 CFR 199.4(a)(1), (e)(24), and Public Law 107-107

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### I. DESCRIPTION

Rehabilitation is the reduction of an acquired loss of ability to perform an activity in the manner, or within the range considered normal, for a human being.

### II. POLICY

A. Section 704 of the FY02 National Defense Authorization Act (NDAA), Public Law 107-107, states the Department "may" provide any rehabilitative therapy to improve, restore, or maintain function, or to minimize or prevent deterioration of function, of a patient when prescribed by a physician. Any therapy for the purpose of improving restoring, maintaining, or preventing deterioration of function, must be medically necessary and appropriate medical care. The rehabilitation therapy must be rendered by an authorized provider, necessary to the establishment of a safe and effective maintenance program in connection with a specific medical condition, provided at a skilled level and must not be custodial care or otherwise excluded from coverage (e.g., exercise or able to be provided at a non-skilled level).

B. Services which have been demonstrated to be capable of reliably confirming the severity of impaired function attributable to a physical impairment may be cost-shared when medically necessary and appropriate.

C. Services or items which have been demonstrated to be usually capable of reducing or arresting the severity of impaired function attributable to a physical impairment may be cost-shared when medically necessary and appropriate.

D. Otherwise services that incidentally address cognitive deficits as factors involved with the restoration of lost neuromuscular functions are covered.

E. Otherwise services such as diagnostic or assessment tests and examinations that are prescribed specifically and uniquely to measure the severity of cognitive impairment are covered.

F. The following therapies and services rendered by an employee of an authorized institutional provider may be cost-shared when part of a comprehensive rehabilitation treatment plan:

1. Physical therapy.
2. Rehabilitation counseling.
3. Mental health services.
4. Speech pathology services.
5. Occupational therapy.

G. The specialized knowledge of a skilled provider may be required to establish a maintenance program intended to prevent or minimize deterioration caused by a medical condition. Establishing such a program is a skilled service. The initial evaluation of the patient's needs, the designing by a skilled provider of a maintenance program which is appropriate to the capacity and tolerance of the patient, the instruction of the patient or family members in carrying out the program and infrequent evaluations may be required.

H. While a patient is under a restorative rehabilitative therapy program, the skilled provider should reevaluate his/her condition when necessary and adjust any exercise program that the patient is expected to carry out himself/herself or with the aid of family members to maintain the function being restored. Consequently, by the time it is determined that no further restoration is possible, i.e., by the end of the last restorative session, the provider will have already designed the maintenance program required and instructed the patient or family member in the carrying out of the program. Therefore, where a maintenance program is not established until after the restorative rehabilitative therapy has been completed, it would not be considered medically necessary and appropriate medical care and would be excluded from coverage.

I. Once a patient has reached the point where no further significant practical improvement can be expected, the skills of an authorized provider will not be required in the carrying out of an activity/exercise program required to maintain function at the level to which it has been restored. The services of a skilled provider in designing a maintenance program will be covered, carrying out the program is not considered skilled care, medically necessary or appropriate medical care consequently such services are not covered.

J. Services that are palliative in nature are not considered medically necessary and appropriate medical care and are not covered. These services generally do not require physician judgement and skill for safety and effectiveness.

### III. EXCLUSIONS

A. Community and work integration training, such as listed in CPT<sup>1</sup> procedure code 97537 is excluded.

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**TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002**

CHAPTER 7, SECTION 18.1

REHABILITATION - GENERAL

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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 -



## PHYSICAL MEDICINE/THERAPY

ISSUE DATE: April 19, 1983

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

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### I. CPT<sup>1</sup> PROCEDURE CODES

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

### II. DESCRIPTION

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

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

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

### III. POLICY

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

B. Physical therapy services must be prescribed by a physician and professionally administered to aid in the recovery from disease or injury to help the patient in attaining greater self-sufficiency, mobility, and productivity through exercises and other modalities intended to improve muscle strength, joint motion, coordination, and endurance.

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

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D. Reimbursement for covered physical therapy services is based on the appropriate CPT<sup>2</sup> procedure codes for the services billed on the claim.

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

#### IV. EXCLUSIONS

A. The following services are not covered:

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

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

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**TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002**

CHAPTER 7, SECTION 18.2

PHYSICAL MEDICINE/THERAPY

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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 or the Extended Care Health Option (ECHO) but determined not to be medically or psychologically necessary, are excluded.

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

- END -



## OCCUPATIONAL THERAPY

ISSUE DATE: July 3, 1997

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

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### I. CPT<sup>1</sup> 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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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 7, SECTION 18.3

OCCUPATIONAL THERAPY

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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. CPT<sup>2</sup> 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. CPT<sup>2</sup> procedure codes 97532 and 97533 for sensory integration training is excluded.

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

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

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

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

V. EFFECTIVE DATE            October 28, 1997.

- END -

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## OSTEOPATHIC MANIPULATIVE THERAPY

ISSUE DATE: April 19, 1983

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

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I. CPT<sup>1</sup> PROCEDURE CODE RANGE

98925 - 98929

II. DESCRIPTION

Treatment of ailments by manipulation to detect and correct faulty structure based in part on the theory that the human body is capable of making its own remedies if its physical and physiological integrity is intact.

III. POLICY

Benefits for osteopathic manipulative therapy are covered.

- END -

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## CHIROPRACTIC MANIPULATIVE TREATMENT

ISSUE DATE: December 3, 1997

AUTHORITY: [32 CFR 199.4\(g\)\(38\)](#)

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### I. CPT<sup>1</sup> PROCEDURE CODE RANGE

98940 - 98943

### II. DESCRIPTION

Chiropractic manipulative treatment (CMT) is a form of manual treatment, using a variety of techniques, to influence joint and neurophysiological function.

### III. POLICY

Manipulation and treatment of the structures of the human body provided by a chiropractor may not be cost-shared.

- END -

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## DIAGNOSTIC SLEEP STUDIES

ISSUE DATE: October 12, 1984

AUTHORITY: [32 CFR 199.4\(a\)\(1\)](#)

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### I. CPT<sup>1</sup> PROCEDURE CODES

95805-95811, 95822, 95827

### II. DESCRIPTION

Sleep studies and polysomnography refer to the continuous simultaneous monitoring and recording of various physiological and pathophysiological parameters of sleep for six or more hours with physician review, interpretation, and report. The studies are performed to diagnose a variety of sleep disorders and to evaluate a patient's response to therapies such as nasal continuous positive airway pressure (NCPAP). Polysomnography is distinguished from sleep studies by the inclusion of sleep staging which is defined to include a 1-4 lead electroencephalogram (EEG), electro-oculogram (EOG), and a submental electromyogram (EMG). Additional parameters of sleep include: ECG; airflow; ventilation and respiratory effort; gas exchange by oximetry, transcutaneous monitoring, or end tidal gas analysis; extremity muscle activity, motor activity-movement; extended EEG monitoring; penile tumescence; gastroesophageal reflux; continuous blood pressure monitoring; snoring; body positions; etc.

### III. POLICY

Diagnostic testing can be covered only if the patient has the symptoms or complaints of one of the conditions listed below:

A. Narcolepsy. This term refers to a syndrome characterized by abnormal sleep tendencies, including excessive daytime sleepiness, disturbed nocturnal sleep and pathological manifestation of rapid eye movement (REM) sleep. The most typical REM sleep manifestations are cataplexy and sleep-onset REM periods, but sleep paralysis and hypnagogic hallucinations may also be present. Related diagnostic testing (e.g., Multiple Sleep Latency Test - CPT<sup>1</sup> procedure code 95805) is covered if the patient has inappropriate sleep episodes (e.g., while driving, in the middle of a meal, in the midst of conversation), amnesiac episodes, or continuous agonizing drowsiness.

B. Obstructive Sleep Apnea Syndrome (OSAS).

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**TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002**

CHAPTER 7, SECTION 19.1

DIAGNOSTIC SLEEP STUDIES

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C. Impotence effective February 1, 1988.

D. Diagnostic testing for Obstructive Sleep Apnea Syndrome is a covered benefit. An FDA approved dental orthosis may be covered for the treatment of OSAS. The device must be used for the treatment of OSAS and not for adjunctive dental.

E. Effective February 3, 1991, for parasomnias, that is abnormal sleep behavior, such as bruxism, sleepwalking, enuresis, and seizure disorder evaluations when the distinction between seizure activity and other forms of sleep disturbances is uncertain.

IV. POLICY CONSIDERATIONS

A. Referral by Attending Physician. The patient must be referred to the sleep disorder center by the attending physician, and the center must maintain a record of the attending physician's referral. If a copy of the referral is not submitted with the claim, the contractor must develop for a referral.

B. Diagnostic Testing. The need for diagnostic testing is confirmed by medical evidence, e.g., physical examinations and laboratory tests.

C. For narcolepsy there must be documentation that the condition is severe enough to interfere with the patient's health and well-being. Ordinarily, a maximum of two clinic sleep sessions is sufficient for diagnosis. Claims in excess of two clinic sleep sessions must be referred to the contractor's medical review.

D. Claims for diagnostic sleep studies shall be processed and paid as outpatient services. Patients who undergo the testing are not considered inpatients, although they may come to the facility in the evening for testing and then leave after their tests are over.

E. Institutional and professional charges related to sleep diagnostic testing performed in a TRICARE-approved hospital are covered only for narcolepsy, sleep apnea, impotency, parasomnia, and suspected epilepsy when the distinction between seizure activity and other forms of sleep disturbances is uncertain on an outpatient cost-sharing basis.

F. Authorized-Freestanding Clinics. Payment may be made for sleep diagnostic testing performed by a freestanding clinic under the "physician-directed clinic" category.

NOTE: A "physician-directed clinic" is one where (a) a physician (or a number of physicians) is present to perform medical (rather than administrative) services at all times the clinic is open; (b) each patient is under the care of a clinic physician; and (c) the non-physician services are under medical supervision.

V. EXCLUSIONS

A. Electrosleep Therapy. Electrosleep therapy is the application of short duration, low-amplitude pulses of direct current to the patient's brain by externally placed occipital electrodes. Passage of the weak electric current through the tissues of the head induces sleep. This modality is considered unproven, as its efficacy has not been established in the United States. Claims for electrosleep therapy must, therefore, be denied.

**TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002**

CHAPTER 7, SECTION 19.1

DIAGNOSTIC SLEEP STUDIES

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B. Study, Grant, or Research Programs. Payment may not be made for any services or supplies provided as a part of or under a grant or research program.

C. Sleep testing is not indicated for patients whose complaint is of short duration or for patients who do not experience functional disability during the day.

D. Diagnostic testing that is duplicative of previous testing done by the attending physician, to the extent the results are still pertinent, is not covered.

E. Payment may not be made for diagnostic sleep testing of the conditions listed below. These conditions can be diagnosed through other, more appropriate means:

1. Drug dependency
2. Hypersomnia (pathologically excessive sleep)
3. Insomnia
4. Night terrors or dream anxiety attacks
5. Nocturnal myoclonus (muscle jerks)
6. Restless leg syndrome
7. Shift work and schedule disturbances
8. Migraine headaches

F. If the patient has had documented episodes of cataplexy, diagnostic testing for narcolepsy would not be necessary and is, therefore, not covered.

G. Sleep studies, polysomnography, and diagnostic testing performed in the home is considered medically inappropriate and is not covered.

H. Somnoplasty system for obstructive sleep apnea is unproven.

- END -



## HYPERBARIC OXYGEN THERAPY

ISSUE DATE: October 7, 1982

AUTHORITY: [32 CFR 199.4\(b\)\(2\)\(xviii\)](#) and [\(c\)\(2\)\(xiv\)](#)

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### I. CPT<sup>1</sup> PROCEDURE CODE

99183

### II. DESCRIPTION

Hyperbaric oxygen therapy (HBO) is a mode of medical treatment in which the patient is entirely enclosed in a pressure chamber breathing oxygen at a pressure greater than one atmosphere.

### III. POLICY

HBO is covered when provided by an approved institutional provider, such as a hospital or specialized treatment facility and only when provided as treatment for approved indications listed by the Hyperbaric Oxygen Therapy Committee of the Undersea Medical Society (<http://www.uhms.org>).

NOTE: The Hyperbaric Oxygen Therapy Committee is the one national body that regularly reviews all applications of HBO therapy and are supported by current reliable scientific evidence.

### IV. EXCLUSION

Topical application of oxygen in unproven.

- END -

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## TELEMEDICINE/TELEHEALTH

ISSUE DATE: [April 17, 2003](#)

AUTHORITY: [32 CFR 199.4](#) and [32 CFR 199.14](#)

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### 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

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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 (CPT<sup>1</sup> procedure codes 99241 - 99275) (Effective August 1, 2003 - December 31, 2005)
- Consultations (CPT<sup>1</sup> procedure codes 99241 - 99255) (Effective January 1, 2006)
- Office or other outpatient visits (CPT<sup>1</sup> procedure codes 99201 - 99215)
- Individual psychotherapy (CPT<sup>1</sup> procedure codes 90804 - 90809)
- Psychiatric diagnostic interview examination (CPT<sup>1</sup> procedure code 90801)
- Pharmacologic management (CPT<sup>1</sup> 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, CPT<sup>1</sup> 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 amount for the professional service provided via a telecommunication system by the

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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 7, SECTION 22.1

TELEMEDICINE/TELEHEALTH

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.

**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 -



## AUGMENTATIVE COMMUNICATION DEVICES (ACD)

ISSUE DATE: December 8, 2004

AUTHORITY: [32 CFR 199.4\(e\)\(24\)](#) and Public Law 107-107

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### I. CPT<sup>1</sup> PROCEDURE CODES

92605, 92607, 92608, 97755, and 97608

### II. HCPCS PROCEDURE CODES

E2500 - E2599, and V5336

### III. POLICY

A. ACDs (also referred to as speech generating devices (SGDs) and medically necessary services and supplies that provide an individual who has a severe speech impairment with the ability to meet functional speaking needs are covered. ACDs/SGDs are characterized by:

1. Being a dedicated speech device, used solely by the individual who has severe speech impairment;
2. May have digitized speech output, using pre-recorded messages, less than or equal to 8 minutes recording time;
3. May have digitized speech output, using pre-recorded messages, greater than 8 minutes recording time;
4. May have synthesized speech output, which requires message formulation by spelling and device access by physical contact with the device-direct selection techniques;
5. May have synthesized speech output, which permits multiple methods of message formulation and multiple methods of device access; or
6. May be software that allows a laptop computer, desktop computer or personal digital assistant (PDA) to function as a speech generating device.

B. ACDs and SGDs as defined in 32 199.2 are considered voice prostheses. The prosthesis provisions found at [Chapter 8, Section 4.1](#) apply.

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**TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002**

CHAPTER 7, SECTION 23.1

AUGMENTATIVE COMMUNICATION DEVICES (ACD)

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IV. EXCLUSIONS

Examples of devices that do not meet the above definition and are excluded from coverage as ACDs/SGDs include, but are not limited to:

A. Devices that are not dedicated speech devices, but are devices that are capable of running software for purposes other than for speech generation, e.g., devices that can also run a word processing package, an accounting program, or perform other non-medical functions.

B. Laptop computers, desktop computers, or PDAs, which may be programmed to perform the same function as a speech generating device, are non-covered since they are not primarily medical in nature and do not meet the definition of prosthetic, prosthetic device, prosthetic supply, or durable medical equipment.

C. A device that is useful to someone without severe speech impairment is not considered an SGD.

D. Communication aids that do not generate speech are not covered. Communication aids that are not ACDs/SGDs are not considered prosthetics for speech. Examples of noncovered communication aids include the following: picture books; flashcards; Braille typewriters; TTY devices; devices that allow the patient to communicate messages to others with writing (e.g., a display screen or printout) rather than with synthesized speech; and devices that allow the user to communicate with a computer rather than with another person. Although these devices may be useful, they do not meet the definition of an ACD/SGD, prosthetic, or durable medical equipment.

E. Altered auditory feedback devices are communication aids that are excluded because they are not augmentative communication devices/voice prostheses.

V. EXCEPTION

Computer based and PDA based ACDs/SGDs are covered when they have been modified to run only ACD/SGD software.

VI. EFFECTIVE DATE           September 1, 2005.

- END -

## EXTERNAL AND IMPLANTABLE INFUSION PUMP

Issue Date: February 26, 1986

Authority: [32 CFR 199.4\(d\)\(1\)](#)

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### I. CPT<sup>1</sup> PROCEDURE CODES

36260 - 36262, 36530 - 36535, 62350 - 62368, 96530

### II. HCPCS PROCEDURE CODES

Level II Codes E0780, E0784, Q0081, Q0084-Q0085

### III. DESCRIPTION

A. An External Infusion Pump (EIP) is a device designed to deliver measured amounts of a drug through injection over a period of time into a patient in a controlled manner.

B. An Implantable Infusion Pump (IIP) system delivers therapeutic plasma levels of active drug to a target organ or body compartment for prolonged periods of time. The bulk flow of drug is generated either by fluorocarbon propellant (nonprogrammable IIP) or direct electromechanical action powered by a battery (programmable IIP). The pump is surgically implanted in a subcutaneous pocket and connects to a dedicated catheter that has been placed in the appropriate compartment. Constant or variable-rate infusions are possible over long periods of time (several weeks to years) with minimal human intervention (refilling or reprogramming) while retaining the capability for external control of rate and volume of primary and supplemental drug delivery. In addition to the pump itself, dependent on the type of pump used, the components of the system may include any of the following: reservoir, optional access port, connectors, various size catheters, micropore filter, hand-held programmer, and a variety of accessories.

### IV. POLICY

#### A. External Infusion Pump (EIP)

1. Claims may be reimbursed for medically necessary U.S. Food and Drug Administration (FDA)-approved EIPs when used according to label specifications in delivering continuous or intermittent drug therapy on an inpatient or outpatient basis.

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2. Supplies for the effective use of the EIP must be FDA approved. Such supplies include those drugs and biologicals prescribed for usage directly into the EIP in order to achieve the therapeutic benefit of the EIP, or to assure the proper functioning of the equipment.

3. EIPs and otherwise covered medical supplies required in the administration of the drug therapy performed in the home are covered.

4. Other medical conditions requiring the use of an infusion of medicine from a FDA-approved EIP may be cost shared when medical review determines the treatment to be medically necessary and generally accepted medical practice.

Examples of covered medical conditions requiring the use of FDA-approved EIPs.

a. Cancer chemotherapy agents.

b. Morphine when used in the treatment of intractable pain.

c. Desferoxamine.

d. Insulin: only when the diagnosis is insulin dependent Type 1 diabetes mellitus and there is documentation by the physician of poor diabetic control.

e. Antibiotic therapy.

f. Heparin therapy in treatment of thromboembolic disease.

5. EIPs are cost shared as Durable Medical Equipment (DME). (See the TRICARE Reimbursement Manual (TRM), Chapter 1, Section 11 for more information on reimbursement of DME.)

## B. Implantable Infusion Pump (IIP)

Claims may be reimbursed for services and supplies related to the use of medically necessary, FDA-approved IIPs when used according to pump label specifications. This may include but is not limited to implantation, refilling, servicing, maintenance, and removal of the pump and/or accessories. Uses may include but are not limited to the following (please note "EXCEPTIONS" and "EFFECTIVE DATES" listed below):

1. Treatment of primary liver cancer or metastatic colorectal liver cancer where the metastases are limited to the liver with continuous hepatic artery infusions of chemotherapeutic agents (e.g., floxuridine, doxorubicin hydrochloride, cisplatin, methotrexate, with bacteriostatic water or physiologic saline and/or heparin);

2. Treatment of osteomyelitis with administration of antibiotics (e.g., clindamycin);

3. Treatment of chronic intractable pain of malignant or nonmalignant origin by administration of opioid drugs (e.g., morphine) intrathecally or epidurally in patients who have a life expectancy of at least 3 months and who have not responded to less invasive

## PULSED IRRIGATION EVACUATION (PIE)

ISSUE DATE: July 3, 2007

AUTHORITY: [32 CFR 199.2](#) and [32 CFR 199.4\(d\)\(3\)\(iii\)](#)

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### I. CPT<sup>1</sup> PROCEDURE CODES

91123, 99511

### II. HCPCS CODES

E0350, E0352

### III. DESCRIPTION

Pulsed Irrigation Evacuation (PIE) is an automated enema in which small pulses of warm tap water are delivered into the rectum, serving to rehydrate feces and promote peristalsis. The system consists of a speculum, tubing, a disposable collection container, and an electrical unit that delivers positive and negative air pressure through the tubing.

### IV. POLICY

PIE may be covered for the treatment of patients with neurogenic bowel who have failed conservative therapy with bowel retraining (e.g., suppositories, digital stimulation, abdominal massage, enemas).

### V. EXCLUSIONS

PIE is excluded when any of the following contraindications exist:

- A. Abdominal surgeries in the past 12 months.
- B. Renal insufficiency.
- C. Acute diverticulitis.
- D. Impactions not in the colon, i.e., ileus.
- E. Integrity of the colon is suspect (suspected perforation).

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**TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002**

CHAPTER 8, SECTION 2.7

PULSED IRRIGATION EVACUATION (PIE)

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VI. EFFECTIVE DATE

January 1, 1997.

- END -

## TRAINING

ISSUE DATE: July 3, 1997

AUTHORITY: 32 CFR 199.5(c)(3)

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### I. CPT<sup>1</sup> PROCEDURE CODES

97504, 97520, 97535, 97542, 99199, 99600

### II. POLICY

A. Training when required to allow the use of an assistive technology device or to acquire skills which are expected to assist the beneficiary in reducing the disabling effects of a qualifying condition may be cost-shared as an ECHO benefit subject to all applicable ECHO requirements.

B. Training for parents (or guardians) and siblings of an ECHO beneficiary when required as an integral part of the management of the qualifying condition may be cost-shared as an ECHO benefit subject to all applicable ECHO requirements.

C. Vocational training, in the beneficiary's home or a facility providing such, is an allowed ECHO benefit.

D. Services cost-shared through the ECHO may be provided by an authorized institutional or individual professional provider on an inpatient or outpatient basis and rendered in the beneficiary's natural environment. This includes at home, at school, or other location that is suitable for the type of services being rendered.

### III. EXCLUSIONS

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

IV. EFFECTIVE DATE           September 1, 2005.

- END -

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## SPECIAL EDUCATION

ISSUE DATE: July 3, 1997

AUTHORITY: [32 CFR 199.5\(c\)\(4\)](#)

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### I. CPT<sup>1</sup> PROCEDURE CODES

99199, 99600

### II. POLICY

A. Special education, within the meaning of such term as used in the Individuals with Disabilities Education Act (IDEA) and its implementing regulations and policies, may be cost-shared subject to all applicable ECHO requirements, and in particular, the requirement that other public programs and facilities be used to the extent available and adequate.

B. Identification of appropriate public facilities. The local educational agency with responsibility for the beneficiary is the sole public facility to provide public facility use certification for special education services.

C. The educational modality known as “Applied Behavioral Analysis (ABA)” is included as a benefit under this issuance when provided by a TRICARE-authorized provider. Payable services include periodic evaluation of the beneficiary, development of a treatment plan, and training of individuals to provide services in accordance with the treatment plan. TRICARE can also pay for the “hands-on” ABA services when provided by a TRICARE authorized provider. However, TRICARE can not pay for such services when provided by family members, trainers or other individuals who are not TRICARE-authorized providers (see [Chapter 9, Section 17.1](#)).

D. Services cost-shared through the ECHO may be provided by an authorized institutional or individual professional provider on an inpatient or outpatient basis and rendered in the beneficiary’s natural environment. This includes at home, at school, or other location that is suitable for the type of services being rendered.

E. See the TRICARE Operations Manual (TOM), [Chapter 20, Section 10](#) for information about the Department of Defense (DoD) Enhanced Access to Autism Services Demonstration.

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**TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002**

CHAPTER 9, SECTION 9.1

SPECIAL EDUCATION

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III. EXCLUSION

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

IV. EFFECTIVE DATE           September 1, 2005.

- END -

## INSTITUTIONAL CARE

ISSUE DATE: July 3, 1997

AUTHORITY: [32 CFR 199.5\(c\)\(5\)](#)

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### I. CPT<sup>1</sup> PROCEDURE CODE

99199

### II. POLICY

A. Institutional care when the severity of the qualifying condition requires protective custody or training in a residential environment, may be cost-shared subject to all applicable ECHO requirements.

B. In accordance with Title 10, Chapter 55, Section 1079(d)(4), United States Code, institutional care must be provided in private nonprofit, public and state institutions and facilities.

C. The requirements of [paragraph II.B.](#) notwithstanding, institutional care provided by a for-profit entity may be allowed only when the care for a specific ECHO beneficiary:

1. Is contracted for by a public facility, as defined in [32 CFR 199.2](#), as part of a publicly funded long-term inpatient care program; and
2. Is provided based upon the ECHO beneficiary's being eligible for the publicly funded program which has contracted for the care; and
3. Is authorized by the public facility as a part of a publicly funded program; and
4. Would cause a cost-share liability in the absence of TRICARE eligibility; and
5. Produces an ECHO beneficiary cost-share liability that does not exceed the maximum charge by the provider to the public facility for the contracted level of care.

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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 9, SECTION 10.1

INSTITUTIONAL CARE

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III. EXCLUSIONS

A. Regardless of the beneficiary's condition, care within any type of institution for the primary purpose of providing custodial, domiciliary, hospice, or respite care is excluded from the ECHO.

B. Institutional care available under the TRICARE Basic Program is not eligible to be cost-shared under the ECHO.

IV. EFFECTIVE DATE            September 1, 2005.

- END -

## TRANSPORTATION

ISSUE DATE: January 23, 1984

AUTHORITY: [32 CFR 199.5\(c\)\(6\)](#) and [\(g\)\(1\)](#)

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### I. CPT<sup>1</sup> PROCEDURE CODE

99082: Unusual travel

### II. HCPCS PROCEDURE CODES

Level II Codes A0100 - A0140, A0170

### III. POLICY

A. Transportation of an ECHO beneficiary to or from a facility or institution to receive otherwise allowable services or items through the ECHO may be cost-shared.

B. Transportation of an accompanying medical attendant to ensure the safe transport of the ECHO beneficiary may be cost-shared.

C. A public facility use certification is not required for the transportation unless the care is being provided by the public facility.

D. The reimbursement rate for the use of a privately-owned vehicle, regardless of the number of ECHO family members being transported, is limited to the Federal government employee mileage reimbursement rate in effect on the trip date.

E. Transportation by means other than a privately-owned vehicle will be reimbursed on the basis of actual costs.

IV. EFFECTIVE DATE           September 1, 2005.

- END -

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## ECHO RESPITE CARE

ISSUE DATE: February 14, 2005

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

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### I. CPT<sup>1</sup> PROCEDURE CODES

99600

### II. HCPCS PROCEDURE CODES

S9122 - S9124

### III. DESCRIPTION

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

### IV. POLICY

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

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

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

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

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

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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 9, SECTION 12.1

ECHO RESPITE CARE

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

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

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

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

H. [HHAs](#) will use CPT<sup>2</sup> procedure code 99600, Unlisted Home Visit Service or Procedure, to bill for benefits under this issuance.

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

J. The amount of the government's cost for respite care received in any month accrues to the maximum monthly benefit of \$2,500.

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

## V. EXCLUSIONS

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

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

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

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

VI. EFFECTIVE DATE           September 1, 2005.

- END -

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## OTHER ECHO BENEFITS

ISSUE DATE: July 3, 1997

AUTHORITY: [32 CFR 199.5\(c\)\(8\)](#)

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### I. CPT<sup>1</sup> 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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## ECHO HOME HEALTH CARE (EHHHC)

ISSUE DATE: February 15, 2005

AUTHORITY: 32 CFR 199.5(e), (f)(3), (g)(4), and 32 CFR 199.6(b)(4)(xv)

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### I. CPT<sup>1</sup> PROCEDURE CODES

99341-99350, 99361-99375, 99600

### II. HCPCS PROCEDURE CODES

G0151 - G0156, S9122 - S9124

### III. DESCRIPTION

The ECHO Home Health Care (EHHHC) benefit provides medically necessary skilled services to eligible homebound beneficiaries whose needs exceed the limits of the Home Health Agency-Prospective Payment System (HHA-PPS) as described in the TRICARE Reimbursement Manual (TRM). Also included in the EHHHC is respite care under certain circumstances.

### IV. BACKGROUND

Section 701 of the National Defense Authorization Act for Fiscal Year 2002 (NDAA FY 2002; Public Law 107-107; December 28, 2001) added a new Section 10 U.S.C. 1074j that establishes a comprehensive, part-time or intermittent home health care benefit to be provided in the manner and under the conditions described in Section 1861(m) of the Social Security Act (42 U.S.C. 1395x(m)). Consequently, the Department has adopted Medicare's benefit structure and prospective payment system for reimbursement of part-time or intermittent home health services. Known as the TRICARE HHA-PPS, this benefit limits coverage of home health services to a maximum of 35 hours per week and does not provide respite care services. NDAA-FY02 also established the program of "Extended Benefits for Disabled Beneficiaries" [10 U.S.C. 1079(d-f)]. This program of "comprehensive home health care supplies and services" includes cost effective and medically appropriate services other than part-time or intermittent services. As a result, eligible family members should be able to reside at home rather than be confined to institutional facilities.

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V. POLICY

A. Eligibility.

1. TRICARE beneficiaries who are registered in the ECHO are eligible to receive ECHO Home Health (EHHC) when:

a. The beneficiary physically resides within the 50 United States, the District of Columbia, Puerto Rico, the Virgin Islands, or Guam; and

b. The beneficiary is homebound as defined in [paragraph VI.A.1.](#); and

c. The beneficiary requires medically necessary skilled services beyond the level of coverage provided by the TRICARE HHA-PPS; and/or

d. The beneficiary requires frequent interventions that are normally provided by the beneficiary's primary caregiver(s); and

e. The beneficiary is case-managed and the required services are specified in a physician-certified plan of care.

2. To avoid delaying receipt of EHHC services while completing the ECHO registration process, in particular awaiting completion of enrollment in the Exceptional Family Member Program (EFMP) of the sponsor's service, otherwise ECHO-eligible beneficiaries may be granted provisional eligibility for a period of not more than 90 days. Examples of beneficiaries who may be granted such status include, but are not limited to:

a. Newborns;

b. Recently adopted family members;

c. Newly ascended active duty service members having a family member with an ECHO qualifying condition; and

d. Other family members, who, because of injury, illness, or trauma become ECHO-eligible.

3. Upon completion of the ECHO registration process, the provisional status will be converted to permanent and subject to all other applicable requirements and made retroactive to the date of the request for EHHC or respite care services.

4. If it is determined that the beneficiary is not eligible for the ECHO, the provisional status will be terminated; authorization and government liability for ECHO benefits will also terminate at that time. The government will not recoup claims paid for ECHO benefits provided during the provisional period.

B. EHHC. The following are covered when provided in the beneficiary's home by participating TRICARE-authorized HHAs.

**ENCLOSURE 2**

**APPENDIX B**

**SAMPLE**

**CLAIMS SUBMISSION REQUIREMENTS**

To facilitate the processing of Partnership Claims, the following guidelines must be followed.

1. Each claim must be identified by a large, bold "Partnership" stamp that does not obscure the claim information. If claims are not identified in this manner, they will be processed as TRICARE claims since it is impossible for the TMA claims processor to otherwise distinguish them.
2. All Partnership claims are to be submitted on either a CMS 1500 (08/05) or DD 2642 claims form. No beneficiary-submitted claims will be processed.
3. The claim form must clearly indicate that it is from a participating provider by checking the "Yes" block next to "participating" on the appropriate TRICARE-approved claim form.
4. Only TRICARE-approved procedure codes are to be used to bill for all services provided.
5. Only procedures/services that are within the scope of the approved Agreement are to be billed.
6. The procedures/services billed to TRICARE are only those provided to TRICARE-eligible beneficiaries.
7. All partnership procedures/services are to be performed within the Military Treatment Facility (MTF), and the appropriate block on the TRICARE claim form must indicate that the procedures/services were provided in the MTF.
8. If a beneficiary has other health insurance (OHI), the claims for Partnership procedures/services must first be filed with the other coverage before being submitted to TRICARE. Documentation of the action taken by the OHI plan must accompany the partnership claim submitted to TRICARE.
9. The beneficiary must not be billed for any deductibles or cost-shares.
10. Only the fees specified in the Partnership Agreement are to be billed to TRICARE.

**ENCLOSURE 2**

**APPENDIX C**

**SAMPLE**

**NEGOTIATED RATES**

**LETTER OF AGREEMENT  
BETWEEN  
(MTF Name)  
AND  
(Health Care Provider Name)**

SUBJECT: List of Providers, Locations, Specialties and Costs

1. The Health Care Provider agrees to provide pediatric, primary care, and family practice physician services for \$XX.XX per visit, and Physician Assistant Services at \$XX.XX per visit.
  - a. XXXXX Clinic: Family Practice and Pediatrics.
  - b. XXXXX Clinic: Pediatrics and Family Practice.
  - c. XXXXX MTF: Primary Care Services and Physician Assistant Services.
  - d. XXXXXX Clinic: Family Practice Service, to include obstetric care up to the 36th week of gestation, and Physician Assistant Services.
  - e. XXXXXX Clinic: Primary Care and Pediatrics.
  - f. Psychology Services at XXXXXX, XXXXXXXX and XXXXXX Clinics as listed below:

<b><u>CPT CODE</u></b> <sup>1</sup>	<b><u>PROCEDURE</u></b>	<b><u>RATE:</u></b>
90801	Diagnostic Interview (90 min)	\$XXX.XX
90804	Psychotherapy (30 min)	\$ XX.XX
90806	Psychotherapy (50 min)	\$ XX.XX
90808	Psychotherapy (80 min)	\$XXX.XX
90846	Family Therapy (w/o patient)	\$ XX.XX
90847	Family Therapy (with patient)	\$ XX.XX
90853	Group Therapy	\$ XX.XX
96100	Psychological Testing	\$ XX.XX
96115	Neurobehavioral Exam	\$ XX.XX
90901	Biofeedback Training	\$ XX.XX
90887	Exam Interpretation	\$ XX.XX

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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 12, SECTION 4.2

TOP PARTNERSHIP PROGRAM

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g. Psychiatry Services at XXXXXX, XXXXXX and XXXXXX

<u>CPT CODE</u> <sup>1</sup>	<u>PROCEDURE</u>	<u>RATE:</u>
90801	Diagnostic Interview (90 min.)	\$XXX.XX
90802	Diagnostic Interview, Interactive (90 min)	\$XXX.XX
90804	Psychotherapy (30 min.)	\$ XX.XX
90806	Psychotherapy (50 min.)	\$ XX.XX
90808	Psychotherapy (80 min.)	\$XXX.XX
90846	Family Therapy (w/o patient)	\$ XX.XX
90847	Family Therapy (with patient)	\$XXX.XX
90853	Group Therapy (Each)	\$ XX.XX
90862	Pharmacologic Management	\$ XX.XX
90887	Interpretation of Psychiatric Exams	\$ XX.XX
90901	Biofeedback Training	\$ XX.XX
96100	Psychological Testing	\$ XX.XX
96115	Neurobehavioral Status Exam	\$ XX.XX

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2. The MTF will endeavor to provide a nursing assistant, receptionist, and billing agent for each MTF location at no extra cost.

**ENCLOSURE 2**

**APPENDIX D**

**SAMPLE**

**APPROVAL OF THE PARTNERSHIP AGREEMENT**

**BETWEEN**

**(MTF Name)**

**AND**

**(Health Care Provider Name)**

The undersigned, as evidenced by their signatures below, approve this Military-Civilian Health Services Partnership Program Letter of Agreement.

\_\_\_\_\_  
**TAO Director**  
(Typed Name and Title)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Surgeon General of the (specify Service Branch)  
(Typed Name and Title)

\_\_\_\_\_  
Date

\_\_\_\_\_  
**Executive Director, TRICARE Management Activity**  
(Typed Name and Title)

\_\_\_\_\_  
Date

**ENCLOSURE 3**

**APPENDIX C**

**SAMPLE**

**NEGOTIATED RATES**

**LETTER OF AGREEMENT  
BETWEEN  
(MTF Name)  
AND  
(Health Care Provider Name)**

SUBJECT: List of Providers, Locations, Specialties and Costs

1. The Health Care Provider agrees to provide pediatric, primary care, and family practice physician services for \$XX.XX per visit, and Physician Assistant Services at \$XX.XX per visit.
  - a. XXXXX Clinic: Family Practice and Pediatrics.
  - b. XXXXX Clinic: Pediatrics and Family Practice.
  - c. XXXXX MTF: Primary Care Services and Physician Assistant Services.
  - d. XXXXXX Clinic: Family Practice Service, to include obstetric care up to the 36th week of gestation, and Physician Assistant Services.
  - e. XXXXXX Clinic: Primary Care and Pediatrics.
  - f. Psychology Services at XXXXXX, XXXXXXXX and XXXXXX Clinics as listed below:

<b><u>CPT CODE</u></b> <sup>1</sup>	<b><u>PROCEDURE</u></b>	<b><u>RATE:</u></b>
90801	Diagnostic Interview (90 min)	\$XXX.XX
90804	Psychotherapy (30 min)	\$XXX.XX
90806	Psychotherapy (50 min)	\$XXX.XX
90808	Psychotherapy (80 min)	\$XXX.XX
90846	Family Therapy (w/o patient)	\$XXX.XX
90847	Family Therapy (with patient)	\$XXX.XX
90853	Group Therapy	\$XXX.XX
96100	Psychological Testing	\$XXX.XX
96115	Neurobehavioral Exam	\$XXX.XX
90901	Biofeedback Training	\$XXX.XX
90887	Exam Interpretation	\$XXX.XX

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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 12, SECTION 4.2

TOP PARTNERSHIP PROGRAM

---

g. Psychiatry Services at XXXXXX, XXXXXX and XXXXXX:

<u>CPT CODE</u> <sup>1</sup>	<u>PROCEDURE</u>	<u>RATE:</u>
90801	Diagnostic Interview (90 min.)	\$XXX.XX
90802	Diagnostic Interview, Interactive (90 min)	\$XXX.XX
90804	Psychotherapy (30 min.)	\$XXX.XX
90806	Psychotherapy (50 min.)	\$XXX.XX
90808	Psychotherapy (80 min.)	\$XXX.XX
90846	Family Therapy (w/o patient)	\$XXX.XX
90847	Family Therapy (with patient)	\$XXX.XX
90853	Group Therapy (Each)	\$XXX.XX
90862	Pharmacologic Management	\$XXX.XX
90887	Interpretation of Psychiatric Exams	\$XXX.XX
90901	Biofeedback Training	\$XXX.XX
96100	Psychological Testing	\$XXX.XX
96115	Neurobehavioral Status Exam	\$XXX.XX

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2. The MTF will endeavor to provide a nursing assistant, receptionist, and billing agent for each MTF location at no extra cost.



TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 12, SECTION 12.2

FIGURES

**FIGURE 12-12.2-4 LIST OF OVERSEAS REMOTE, NON-REMOTE, & MTF COUNTRIES BY REGION**

TRICARE EUROPE	TRICARE EUROPE	TRICARE EUROPE
Afghanistan	Greece	Poland
Albania	Greenland	Portugal (Azores)*
Algeria	Guinea, Republic of	Qatar
Andorra	Guinea-bissau	Romania
Angola	Hungary	Russia
Armenia	Iceland*	Rwanda
Austria	Iran	St. Helena (Ascension Island)
Azerbaijan, Republic of	Iraq	St. Pierre and Miquelon
Bahrain, Kingdom of	Iraq (includes Saudi Arabia and Neutral Zone)	Saotane an Principe
Belarus	Ireland	San Marino
Belgium*	Isle of Mann	Senegal
Benin	Israel	Serbia and Montenegro
Bosnia and Herzegovina	Italy*	Seychelles
Botswana	Ivory Coast (Cote D' Ivoire)	Sierra Leone
Bowet (Bouvel) Island	Jordan	Slovakia
Bulgaria	Kazakhstan	Slovenia
Burkina-faso	Kenya	Somalia Republic
Burundi	Kuwait	South Africa
Cameroon	Kyrgyzstan	Spain*
Cape Verde Island	Latvia	Sudan
Central Africa Republic	Lebanon	Svalbard and Jan Mayan
Chad	Lesotho	Swaziland
Comorus	Liberia	Sweden
Congo (Brazzaville)	Libya	Switzerland
Croatia	Liechtenstein	Syria
Cyprus	Lithuania	Tajikistan
Czech Republic	Luxembourg	Tanzania
Democratic Republic of Kongo	Macedonia	Togo
Denmark	Malawi	Tunisia
Djibouti	Mali	Turkey*
Egypt (United Arabian Emirates)	Malta	Turkmenistan
Equatorial Guinea	Mauritania	Uganda
Eritrea	Moldova	Ukraine
Estonia	Monaco	United Arabian Emirates
Ethiopa	Morocco	United Kingdom (includes Isle of Man, Guernsey, and Jersey)*
Faroe Island	Mozambique	Uzbekistan
Finland	Namibia	Vatican City (Holy City)
France (includes Ile Europa)	Netherlands	Western Sahara (Port of Morocco)
Gabon	Niger	Yemen
Gambia	Nigeria	Yugoslavia
Georgia	Norway	Zaire
Germany*	Oman	Zambia
Ghana	Pakistan	Zimbabwe
Gibraltar		
<b>Asterisk (*) denotes countries requiring authorization when claim is submitted by other than the TGRO contractor.</b>	<b>Asterisk (*) denotes countries requiring authorization when claim is submitted by other than the TGRO contractor.</b>	<b>Asterisk (*) denotes countries requiring authorization when claim is submitted by other than the TGRO contractor.</b>

TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 12, SECTION 12.2

FIGURES

**FIGURE 12-12.2-6 MTF COUNTRIES**

TRICARE EUROPE	TRICARE PACIFIC	TRICARE LATIN AMERICA, CANADA, & CARIBBEAN BASIN
United Kingdom	South Korea	<b>Guantanamo Bay, Cuba</b>
Spain	Japan	This does not apply to city/countries identified as <b>remote</b> network locations (see <a href="#">Figure 12-12.2-5</a> ). <b>Aeromedical evacuation authorized under TGRO effective 04/01/2004.</b>
Belgium	<b>Guam</b>	
Germany	This does not apply to city/countries identified as <b>remote</b> (see <a href="#">Figure 12-12.2-5</a> ).	
Italy		
Turkey		
<b>Iceland</b>		
<b>Azores</b>		
This does not apply to city/countries identified as <b>remote</b> (see <a href="#">Figure 12-12.2-5</a> ).		

