



DEFENSE
HEALTH AGENCY

MB&RO

**OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
HEALTH AFFAIRS**

16401 EAST CENTRETECH PARKWAY
AURORA, CO 80011-9066

**CHANGE 117
6010.57-M
SEPTEMBER 22, 2014**

**PUBLICATIONS SYSTEM CHANGE TRANSMITTAL
FOR
TRICARE POLICY MANUAL (TPM), FEBRUARY 2008**

The TRICARE Management Activity has authorized the following addition(s)/revision(s).

**CHANGE TITLE: UPDATE INTERNATIONAL CLASSIFICATION OF DISEASES-10 COMPLIANCE
DATE**

CONREQ: 16287

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): This change updates current ICD-10 language to comply with the Protecting Access to Medicare Act of 2014 (H.R. 4302), which precludes International Classification of Diseases, 10th Revision (ICD-10) code sets from being adopted by the Department of Health and Human Services (HHS) prior to 1 October 2015.

EFFECTIVE DATE: September 3, 2014.

IMPLEMENTATION DATE: October 1, 2015.

This change is made in conjunction with Feb 2008 TOM, Change No. 129, Feb 2008 TRM, Change No. 103, and Feb 2008 TSM, Change No. 67.

**FAZZINI.ANN.NO
REEN.119980227**

1

**Ann N. Fazzini
Team Chief, Medical Benefits &
Reimbursement Office (MB&RO)
Defense Health Agency (DHA)**

Digitally signed by
jFAZZINI.ANN.NOREEN.1199802271
DN: c=US, o=U.S. Government, ou=DoD,
ou=PKI, ou=TMA,
cn=FAZZINI.ANN.NOREEN.1199802271
Date: 2014.09.18 10:54:45 -06'00'

**ATTACHMENT(S): 12 PAGE(S)
DISTRIBUTION: 6010.57-M**

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

CHANGE 117
6010.57-M
SEPTEMBER 22, 2014

REMOVE PAGE(S)

CHAPTER 7

Section 3.5, pages 1 and 2

Section 3.18, pages 1 and 2

Section 3.19, pages 3 and 4

CHAPTER 8

Section 2.6, pages 1 and 2

CHAPTER 9

Section 2.2, page 1

Section 2.3, pages 1 and 2

INSERT PAGE(S)

Section 3.5, pages 1 and 2

Section 3.18, pages 1 and 2

Section 3.19, pages 3 and 4

Section 2.6, pages 1 and 2

Section 2.2, pages 1 and 2

Section 2.3, pages 1 and 2

Preauthorization Requirements For Substance Use Disorder Detoxification And Rehabilitation

Issue Date: March 13, 1992

Authority: [32 CFR 199.4\(b\)\(6\)\(iii\)](#) and 10 USC 1079(a)

1.0 BACKGROUND

In the National Defense Authorization Act for Fiscal Year 1991 (NDAA FY 1991), Public Law 101-510 and the Defense Appropriations Act for 1991, Public Law 101-511, Congress addressed the problem of spiraling costs for mental health services under TRICARE. These statutes made two principal changes. First, they established new day limits for inpatient mental health services and secondly, they mandated prior authorization for all nonemergency inpatient mental health admissions, with required certification of emergency admissions within 72 hours.

2.0 POLICY

Effective October 1, 1991, preadmission and continued stay authorization is required before services for substance use disorders may be cost-shared. Preadmission and continued stay authorization is required for both detoxification and rehabilitation services. To comply with the statutory requirements and to avoid denial, requests for preadmission authorization on weekends and holidays are discouraged. All admissions for rehabilitation are elective and must be certified as medically/psychologically necessary prior to admission. The admission criteria shall not be considered satisfied unless the patient has been personally evaluated by a physician or other authorized health care professional with admitting privileges to the facility to which the patient is being admitted prior to the admission.

3.0 POLICY CONSIDERATIONS

3.1 Treatment of Mental Disorders

In order to qualify for mental health benefits, the patient must be diagnosed by a licensed, qualified mental health professional to be suffering from a mental disorder, according to the criteria listed in the current edition of the **Diagnostic and Statistical Manual of Mental Disorders** (DSM) or a mental health diagnosis in International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) for **diagnoses made before the mandated date, as directed by Health and Human Services (HHS), for the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) implementation, after which the ICD-10-CM diagnosis must be used.** Benefits are limited for certain mental disorders, such as specific developmental disorders. No benefits are payable for "Conditions Not Attributable to a Mental Disorder." In order for treatment of a mental disorder to be medically or psychologically necessary, the patient must, as a result of a diagnosed mental disorder, be experiencing both physical or psychological distress and an

Preauthorization Requirements For Substance Use Disorder Detoxification And Rehabilitation

impairment in his or her ability to function in appropriate occupational, educational or social roles. It is generally the degree to which the patient's ability to function is impaired that determines the level of care (if any) required to treat the patient's condition.

3.2 Admissions occurring on or after October 1, 1991, to all facilities (includes Diagnosis Related Group (DRG) and non-DRG facilities).

3.2.1 Detoxification. Stays for detoxification are covered if preauthorized as medically/psychologically necessary. Days of detoxification must be counted toward the statutory day limit which went into effect October 1, 1991, 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). In determining the medical or psychological necessity of detoxification and rehabilitation for substance use disorder, the evaluation conducted by the contractor shall consider the appropriate level of care for the patient and the intensity of services required by the patient. Emergency and inpatient hospital services are covered when medically necessary for the active medical stabilization, and for treatment of medical complications of substance use disorder. Authorization prior to admission is not required in the case of an emergency requiring an inpatient acute level of care, but authorization for a continuation of services must be obtained promptly. Admissions resulting from a bona fide emergency should be reported within 24 hours of the admission or the next business day after the admission, but must be reported to the contractor within 72 hours of the admission. Emergency and inpatient hospital services are considered medically necessary only when the patient's condition is such that the personnel and facilities of a hospital are required. Stays for detoxification in a substance use disorder facility are limited to seven days unless the limit is waived by the contractor and must be provided under general medical supervision.

3.2.2 Rehabilitative care. The patient's condition must be such that rehabilitation for substance use disorder must be provided in a hospital or in an organized inpatient substance use disorder treatment program. Rehabilitation stays are covered if preauthorized as medically/psychologically necessary. Coverage during a single benefit period is limited to no more than one inpatient stay (prior to October 1, 2008, exclusive of stays classified in DRG 433; and on or after October 1, 2008, exclusive of stays classified in DRG 894) in hospitals subject to the DRG-based payment system or 21 days in a DRG-exempt facility for rehabilitative care unless the limit is waived by the contractor. Days of rehabilitation 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.

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

3.2.3.1 Active treatment has taken place during the period of the benefit limit and substantial progress has been made according to the plan of treatment.

3.2.3.2 Further progress has been delayed due to the complexity of the illness.

3.2.3.3 Specific evidence has been presented to explain the factors that interfered with further treatment progress during the period of the benefit limit.

3.2.3.4 The waiver request includes specific time frames and a specific plan of treatment which will complete the course of treatment.

Applied Behavior Analysis (ABA)

Issue Date: August 10, 2012

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

1.0 CPT¹ PROCEDURE CODES

90887, 99080

2.0 HCPCS CODE

S5108

3.0 DESCRIPTION

Applied Behavior Analysis (ABA) is covered under the TRICARE Basic Program as an interim benefit **until December 31, 2014**.

4.0 POLICY

4.1 TRICARE covers ABA services for all eligible beneficiaries, including retirees and their dependent family members, with a diagnosis of Autism Spectrum Disorder (ASD). ABA reinforcement is covered separately for Active Duty Family Members (ADFM) under the Autism Demonstration and for Non-Active Duty Family Members (NADFM) under the ABA Pilot.

4.2 Autism Spectrum Disorder (ASD)

4.2.1 The covered ASD diagnoses are described under the Neurodevelopmental Disorders category of the most current edition of the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V). The DSM-V was released in May 2013. The DSM-V diagnostic code for ASD (299.00) is equivalent to the corresponding codes for Autistic Disorder (299.0) in the currently used edition of the International Classification of Diseases, Clinical Modification manual (currently ICD-9-CM) used for claims processing under TRICARE for services provided on or before September 30, 2014.

4.2.2 For services provided on or before September 30, 2014, as the Military Health System (MHS) and mental health provider community transitions to use of the DSM-V, a covered diagnosis for ASD also includes those found under the Pervasive Developmental Disorders (PDD) section of the DSM, Fourth Edition, Text Revision, (DSM-IV-TR). The covered DSM-IV-TR ASD diagnoses are: Autistic Disorder (299.00), Rett's Disorder (299.80), Childhood Disintegrative Disorder (CDD) (299.10), Asperger's Disorder (299.80), and Pervasive Development Disorder Not Otherwise

¹ CPT only © 2006 American Medical Association (or such other date of publication of CPT). All Rights Reserved.

TRICARE Policy Manual 6010.57-M, February 1, 2008

Chapter 7, Section 3.18

Applied Behavior Analysis (ABA)

Specified (PDDNOS) (including Atypical Autism) (299.80). The corresponding ICD-9-CM codes for the five DSM-IV-TR ASD diagnoses are: Autistic Disorder (299.0), Rett's Syndrome (330.8) (found under "Other Specific Cerebral Degenerations"), CDD (299.1), Asperger's Disorder (299.8), and PDDNOS (to include Atypical Autism) (299.9).

Note: The DSM-IV-TR and the ICD-9-CM use the same numeric diagnosis codes for three of the five ASD Diagnoses found in the DSM-IV-TR (Autistic Disorder (299.00 & 299.0), CDD (299.10 & 299.1), and Asperger's (299.80 & 299.8)). The DSM-IV-TR uses one code 299.80 to refer to Rett's Disorder, PDD, and Asperger's Disorder whereas the ICD-9-CM designates a unique code for each diagnosis.

4.2.3 The DoD and the rest of the United States will transition to **International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)** on the mandated date, as directed by **Health and Human Services (HHS), for ICD-10 implementation.** Those **beneficiaries** diagnosed with one of the five ASD diagnoses under the DSM-IV-TR (**ASD, Rett's Disorder, CDD, Asperger's Disorder, and PDDNOS**) are given the single diagnosis of **ASD (299.00)** under the DSM-V (released in May 2013). The corresponding ICD-10-CM code is **Autistic Disorder (F84.0).**

4.3 Payable services include:

4.3.1 An initial beneficiary assessment;

4.3.2 Development of a treatment plan;

4.3.3 One-on-one ABA interventions with an eligible beneficiary, training of immediate family members to provide services in accordance with the treatment plan; and

4.3.4 Monitoring of the beneficiary's progress toward treatment goals.

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

4.4.1 Physician board-certified or board-eligible in behavioral developmental pediatrics, neurodevelopmental pediatrics, pediatric neurology or child psychiatry; or

4.4.2 Ph.D. or Psy.D. clinical psychologist working primarily with children.

5.0 REIMBURSEMENT

5.1 Claims for ABA services will be submitted by an authorized provider on Centers for Medicare and Medicaid Services (CMS) 1500 Claim Form as follows:

5.1.1 Functional Behavioral Assessment and Analysis.

5.1.1.1 The Functional Behavioral Assessment and Analysis and initial treatment plan will be billed using Healthcare Common Procedure Coding System (HCPCS) code S5108, "Home care training to home care client, per 15 minutes".

TRICARE Policy Manual 6010.57-M, February 1, 2008

Chapter 7, Section 3.19

Applied Behavior Analysis (ABA) For Non- Active Duty Family Members (NADFM) Who Participate In The ABA Pilot

through direct administration of the ABA specialized interventions during one-on-one (i.e., face-to-face) interactions.

4.8 ABA Treatment Plan Objectives. ABA TP objectives are the short, simple, measurable steps that must be accomplished in order to reach the short-term and long-term goals of ABA.

4.9 ABA Treatment Plan Goals. These are the broad spectrum, complex short-term and long-term desired outcomes of ABA.

4.10 ABA includes: an initial ABA assessment, the initial ABA TP, the delivery of ABA specialized interventions delivered by the BCBA or BCBA-D, TRICARE eligible parent/caregiver ABA training, repeat ABA assessments, and ABA TP updates. "ABA reinforcement" refers to supplemental services provided by Board Certified Assistant Behavior Analysts (BCaBAs) and ABA Tutors to assist with the practice and execution of the ABA TP when under the supervision of a BCBA or BCBA-D.

4.11 Referral and Supervision. "Referral and supervision" means that the TRICARE authorized provider who refers the beneficiary for ABA must actually see the beneficiary to evaluate the qualifying ASD condition to be treated prior to referring the beneficiary for ABA; the referring provider also provides ongoing oversight of the course of referral-related ABA throughout the period during which the beneficiary is receiving ABA in response to the referral. Only those providers listed under [paragraph 5.6.1](#) may refer beneficiaries for ABA in accordance with [paragraph 5.7.1](#).

5.0 POLICY

5.1 TRICARE covers ABA as a TRICARE Basic Program benefit for eligible NADFM with a diagnosis of any of the five listed diagnoses of a Pervasive Developmental Disorder (PDD), also known as ASD, defined in [paragraph 5.2](#). ABA reinforcement is covered for eligible NADFM under this section as part of the ABA Pilot.

5.2 Autism Spectrum Disorder (ASD)

5.2.1 The covered ASD diagnoses are described under the Neurodevelopmental Disorders category of the most current edition of the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V). The DSM-V was released in May 2013. The DSM-V diagnostic code for ASD (299.00) is equivalent to the corresponding codes for Autistic Disorder (299.0) in the currently used edition of the International Classification of Diseases, Clinical Modification manual (currently ICD-9-CM) used for claims processing under TRICARE for services provided on or before September 30, 2014.

5.2.2 For services provided on or before September 30, 2014, as the Military Health System (MHS) and mental health provider community transitions to use of the DSM-V, a covered diagnosis for ASD also includes those found under the PDD section of the DSM, Fourth Edition, Text Revision, (DSM-IV-TR). The covered DSM-IV-TR ASD diagnoses are: Autistic Disorder (299.00), Rett's Disorder (299.80), Childhood Disintegrative Disorder (CDD) (299.10), Asperger's Disorder (299.80), and Pervasive Development Disorder Not Otherwise Specified (PDDNOS) (including Atypical Autism) (299.80). The corresponding ICD-9-CM codes for the five DSM-IV-TR ASD diagnoses are: Autistic

TRICARE Policy Manual 6010.57-M, February 1, 2008

Chapter 7, Section 3.19

Applied Behavior Analysis (ABA) For Non- Active Duty Family Members (NADFM) Who Participate In The ABA Pilot

Disorder (299.0), Rett's Syndrome (330.8) (found under "Other Specific Cerebral Degenerations"), CDD (299.1), Asperger's Disorder (299.8), and PDDNOS (to include Atypical Autism) (299.9).

Note: The DSM-IV-TR and the ICD-9-CM use the same numeric diagnosis codes for three of the five ASD Diagnoses found in the DSM-IV-TR (Autistic Disorder (299.00 and 299.0), CDD (299.10 and 299.1), and Asperger's (299.80 and 299.8)). The DSM-IV-TR uses one code 299.80 to refer to Rett's Disorder, PDD, and Asperger's Disorder whereas the ICD-9-CM designates a unique code for each diagnosis.

5.2.3 The DoD and the rest of the United States will transition to **International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) on the mandated date, as directed by Health and Human Services (HHS), for ICD-10 implementation. Those beneficiaries diagnosed with one of the five ASD diagnoses under the DSM-IV-TR (ASD, Rett's Disorder, CDD, Asperger's Disorder, and PDDNOS) are given the single diagnosis of ASD (299.00) under the DSM-V (released in May 2013). The corresponding ICD-10-CM code is Autistic Disorder (F84.0).**

5.3 ABA under the TRICARE Basic Program refers to ABA provided one-to-one, in person to the NADFM beneficiary by TRICARE authorized ABA providers (described in [paragraphs 5.4](#) and [5.8](#)) to improve social interaction, communication and behavior as related to the core deficits and symptoms of an ASD. ABA reinforcement provided by BCaBAs and ABA tutors is covered separately under the ABA Pilot for NADFM.

5.4 ABA is a specialized intervention administered by an authorized provider described in [paragraph 5.8](#) who is a professional with advanced formal training in behavior analysis, to include at least a master's degree and several hundred hours of graduate level instruction, or mentored or supervised experience with another BCBA. The only providers qualified to deliver ABA under the TRICARE Basic Program are masters-level BCBA or BCBA-Ds certified by the BACB or other TRICARE authorized ABA providers practicing within the scope of their state license or state certification. In accordance with qualifications of other TRICARE-authorized individual providers of behavioral health care (see [32 CFR 199.6\(c\)\(2\)](#)), these providers possess the education, required experience and supervision, and scope of practice consistent with TRICARE Basic Program regulations. Qualifications for individuals providing ABA reinforcement under the ABA Pilot are set forth in the TOM, [Chapter 18, Section 15](#).

5.5 The requirements of this section apply ONLY to NADFM who elect to participate in the ABA reinforcement covered separately under the ABA Pilot.

5.6 ASD Diagnosing Providers

5.6.1 Diagnosis of ASD shall be rendered by a TRICARE-authorized Physician Primary Care Managers (P-PCM) or by a specialized ASD provider:

5.6.1.1 For the purposes of the diagnosis of ASD, TRICARE authorized P-PCMs include: TRICARE authorized family practice, internal medicine and pediatric physicians whether they work in the Purchased Care or Direct Care (DC) system. In cases where the beneficiary does not have a P-PCM (as is sometimes the case for beneficiaries with TRICARE Prime Remote (TPR)), the diagnosis may be rendered by a TRICARE authorized physician in any of the disciplines described above under P-PCM,

Chapter 8

Section 2.6

Breast Pumps

Issue Date: August 8, 2005

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

1.0 HCPCS PROCEDURE CODES

Level II Codes E0604, A4281 - A4286.

2.0 DESCRIPTION

Electric breast pumps facilitate the transfer of protective maternal immunoglobulins through breast milk for premature infants. Premature infants suffer varying degrees of immunological immaturity because they do not experience full transplacental transfer of maternal immunoglobulins which mainly occurs during the last several weeks of gestation. In lieu of active maternal transfer, immunoglobulins can be transferred to the premature infant via breast milk. Since premature infants often cannot breastfeed successfully, an electric breast pump ensures that these infants receive an adequate supply of breast milk to address their immunological challenges.

3.0 POLICY

3.1 Heavy-duty hospital grade (E0604) electric breast pumps are covered (including services and supplies related to the use of the pump) for the mother of a premature infant. A premature infant is defined as a newborn with International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) codes 765.0 (extreme immaturity), 765.1 (other preterm infants), or 765.21 through 765.28 (up to 36 weeks gestation) for services provided before **the mandated date, as directed by Health and Human Services (HHS)**, for International Classification of Diseases, 10th Revision (ICD-10) **implementation** or ICD-10-CM codes P07.00 - P07.03 (extremely low birth weight (unspecified weight-999 grams)), P07.10 - P07.18 (other low birth weight (unspecified weight, 1000-2499 grams)), P07.20 - P07.26 (extreme immaturity (unspecified weeks-27 completed weeks)), P07.30 - P07.39 (other preterm (unspecified, 28-36 completed weeks)) for services provided on or after **the mandated date, as directed by HHS, for ICD-10 implementation**.

3.1.1 An electric breast pump is covered while the premature infant remains hospitalized during the immediate postpartum period.

3.1.2 Electric breast pumps may be covered after the premature infant is discharged from the hospital. However, a physician must document the medical reason for continued use of an electric breast pump after the infant has been discharged. This documentation is also required for those premature infants (as defined in [paragraph 3.1](#)) who are delivered in non-hospital settings.

TRICARE Policy Manual 6010.57-M, February 1, 2008

Chapter 8, Section 2.6

Breast Pumps

3.2 Equipment cost-sharing is subject to the provisions of the Durable Medical Equipment (DME)/Basic Program.

4.0 EXCLUSIONS

4.1 Electric breast pumps are specifically excluded for reasons of personal convenience (e.g., to facilitate a mother's return to work), even if prescribed by a physician. Coverage is limited to the conditions described in [paragraph 3.0](#).

4.2 Manual breast pumps (E0602) are excluded.

4.3 Basic electric breast pumps (E0603) are excluded.

- END -

Eligibility - Qualifying Condition: Mental Retardation

Issue Date: July 3, 1997

Authority: [32 CFR 199.5\(b\)\(2\)\(i\)](#), 10 USC 1079(d)(3)

1.0 POLICY

1.1 A diagnosis of moderate or severe mental retardation in accordance with the criteria in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association, is a Extended Care Health Option (ECHO) qualifying condition.

1.2 For a beneficiary less than three years of age, the following conditions (International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) codes cited for services provided before **the mandated date, as directed by Health and Human Services (HHS), for International Classification of Diseases, 10th Revision (ICD-10) implementation, or ICD-10-CM codes cited for services provided on or after the mandated date, as directed by HHS, for ICD-10 implementation**) may be presumed to precede a diagnosis of moderate or severe mental retardation:

- Rett's syndrome: ICD-9-CM 330.8 / ICD-10-CM F84.2
- Down syndrome: ICD-9-CM 758.0 / ICD-10-CM Q90.0-Q90.9
- Fragile X syndrome: ICD-9-CM 759.83 / ICD-10-CM Q99.2
- Fetal alcohol syndrome: ICD-9-CM 760.71 / ICD-10-CM Q86.0

1.3 For a beneficiary less than three years of age, a developmental delay qualifies as moderate or severe mental retardation when standardized diagnostic psychometric tests demonstrate developmental delay equivalent to two standard deviations below the mean in adaptive, cognitive, or language function

2.0 EXCLUSIONS

2.1 Unless the requirements of [paragraph 1.3](#) are met, the spectrum of Attention-Deficit and Disruptive Behavior Disorders are not considered qualifying conditions for the ECHO.

2.2 Learning disorders, individually and collectively, are not qualifying conditions for eligibility under the ECHO.

3.0 EFFECTIVE DATE

September 1, 2005.

- END -

Eligibility - Qualifying Condition: Serious Physical Disability

Issue Date: July 3, 1997

Authority: [32 CFR 199.5\(b\)\(2\)\(ii\)](#), 10 USC 1079(d)(3)

1.0 POLICY

1.1 Any physiological disorder or condition or anatomical loss affecting one or more body systems which has lasted, or with reasonable certainty is expected to last, for a minimum period of 12 contiguous months, and which precludes the person with the disorder, condition or anatomical loss from unaided performance of at least one of the following major life activities is an Extended Health Care Option (ECHO) qualifying condition: breathing, cognition, hearing, seeing, and age appropriate ability essential to bathing, dressing, eating, grooming, speaking, stair use, toilet use, transferring, and walking.

1.2 For a beneficiary less than three years of age, a developmental delay qualifies as a serious physical disability when the score on the standardized diagnostic psychometric tests of motor function is 2 standard deviations below the mean.

1.3 Serious physical disabilities include, but are not limited to the following conditions (International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) codes cited for services provided before **the mandated date, as directed by Health and Human Services (HHS)**, for International Classification of Diseases, 10th Revision (**ICD-10**) implementation or ICD-10-CM codes cited for services provided on or after **the mandated date, as directed by HHS, for ICD-10 implementation**) for the purpose of establishing an ECHO qualifying condition:

1.3.1 Infantile Cerebral Palsy: ICD-9-CM 343.0 - 343.9 / ICD-10-CM G80.0 - G80.9.

1.3.2 Spina Bifida: ICD-9-CM 741.0 - 741.93 / ICD-10-CM Q05.0 - Q05.9.

1.3.3 Vision: ICD-9-CM 369.01 - 369.08 inclusive; 369.11 - 369.14 inclusive; 369.21; 369.22; 369.4 / ICD-10-CM H54.0 - H54.12 inclusive; H54.8.

1.3.4 Hearing-Testable Patients: as determined by audiologic function tests:

- A pure tone hearing threshold level of 45 decibels or greater in one ear; or by
- A pure tone hearing threshold level of 30 decibels or greater in both ears; or by
- Speech discrimination of 60% or poorer with either ear.

1.3.5 Hearing-Non-Testable Patients: Where pure tone audiometry or speech discrimination testing is not available or reliable, the attending physician must submit documentation which

TRICARE Policy Manual 6010.57-M, February 1, 2008
Chapter 9, Section 2.3
Eligibility - Qualifying Condition: Serious Physical Disability

demonstrates the patient is unable to engage in basic productive activities of daily living expected of unimpaired persons of the same age group.

- 1.3.6** Breathing: Total reliance upon a respirator.
- 1.3.7** Acquired or congenital total loss, or loss of use, of an arm or leg.
- 1.3.8** Autism: Associated with deficits in one or more body systems.
- 1.3.9** Multiple Sclerosis (MS): ICD-9-CM 340.

2.0 EFFECTIVE DATE

September 1, 2005.

- END -