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**CHANGE 138
6010.57-M
AUGUST 19, 2015**

**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: CONSOLIDATED CHANGE 15-002

CONREQ: 17366

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): The changes to the TPM provides clarifying language on the following: adds a new section to clarify coverage of Chronic Care Management, adds a new exclusion to the Male Genital System section, clarifies coverage requirements concerning cochlear implantation and cochlear implants, and adds a new section to clarify TRICARE coverage of drug screening. The changes to the TRM removes Inpatient/Outpatient Cost to Charge Ratio Caps used in comparing cost that is no longer needed.

EFFECTIVE DATE: See page 2.

IMPLEMENTATION DATE: September 21, 2015.

This change is made in conjunction with Feb 2008 TRM, Change No. 114.

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CHANGE 138
6010.57-M
AUGUST 19, 2015

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SUMMARY OF CHANGES

CHAPTER 1

1. Section 15.2. This change updates the Chronic Care Management code. EFFECTIVE DATE: 01/01/2015.

CHAPTER 4

2. Section 15.1. This change adds a new exclusion to the Male Genital System section. EFFECTIVE DATE: 04/01/2015.
3. Section 22.2. This change clarifies coverage requirements concerning cochlear implantation and cochlear implants. EFFECTIVE DATE: 04/05/2005.

CHAPTER 6

4. Section 4.1. This change adds a new section to clarify TRICARE coverage of drug screening. EFFECTIVE DATE: 01/01/2015.

Chapter 1

Administration

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1.1	General Policy And Responsibilities
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15.1	Transitional Care Management Services
15.2	Chronic Care Management (CCM) Services

Chronic Care Management (CCM) Services

Issue Date: August 19, 2015

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

1.0 CPT¹ PROCEDURE CODE

99490

2.0 DESCRIPTION

2.1 CCM services -- at least 20 minutes of clinical staff time directed by a physician or other qualified healthcare professional, per calendar month, with the following required elements:

- Multiple (two or more) chronic conditions expected to last at least 12 months or until death of the patient;
- Chronic conditions place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline; and
- Comprehensive care plan established, implemented, revised, or monitored.

2.2 CCM reflects services provided over a monthly period to specified patients with chronic health conditions who have consented to receipt of such services.

3.0 POLICY

CCM services are not covered by TRICARE because the services are not medically necessary as a separately itemized service.

4.0 EFFECTIVE DATE

January 1, 2015.

- END -

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TRICARE Policy Manual 6010.57-M, February 1, 2008

Chapter 4, Section 15.1

Male Genital System

4.4 Arterial revascularization for distal lesions and venous leakage when treatment is for organic impotency.

4.5 Intersex surgery, except when performed to correct ambiguous genitalia, which is documented to have been present at birth (CPT² procedure code 55970).

4.6 Reversal of surgical sterilization (CPT² procedure code 55400).

4.7 Cryosurgery for prostate metastases M or N is unproven.

4.8 Electroejaculation (CPT² procedure code 55870).

4.9 Prophylactics (condoms).

4.10 Over-The-Counter (OTC) spemicidal products.

4.11 Prostate saturation biopsy (CPT² procedure code 55706).

4.12 Penile Vibratory Stimulation (PVS) devices, such as Ferticare Personal 2 medical vibrator.

- 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\(c\)\(2\)](#)

1.0 CPT¹ PROCEDURE CODES

69930, 90669, 90732, 92601 - 92604, 92626, 92627

2.0 HCPCS PROCEDURE CODES

Level II Codes L8614 - L8624

3.0 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 awareness and identification of sounds and to facilitate communication for persons who are hearing impaired.

4.0 POLICY

4.1 Cochlear implantation using a [United States \(U.S.\)](#) Food and Drug Administration (FDA) approved single or multichannel cochlear implant is a covered benefit **when all of the following criteria are met:**

4.1.1 The cochlear implant is used in accordance with FDA approved labeling for the specific device prescribed; and

4.1.2 The individual has had an assessment by an audiologist and from an otolaryngologist experienced in this procedure indicating the likelihood of success with this device; and

4.1.3 The individual has the cognitive ability to use auditory clues and a willingness to undergo an extended program of rehabilitation. A post-cochlear implant rehabilitation program is necessary to achieve benefit from the cochlear implant. The rehabilitation program consists of six to 10 sessions that last approximately 2.5 hours each. The rehabilitation program includes development of skills in understanding running speech, recognition of consonants and vowels, and tests of speech perception ability. See [Chapter 7, Sections 7.1 and 18.1](#).

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4.1.4 In addition to the above, the recipient of a cochlear implant should be up-to-date on age appropriate pneumococcal vaccination at least two weeks prior to the implant, in accordance with the Centers for Disease Control and Prevention (CDC).

4.2 Simultaneous or sequential bilateral cochlear implantation is a covered benefit for:

4.2.1 Adults aged 18 years and older with bilateral, pre or post-linguistic, sensorineural, moderate to profound hearing impairment who have received limited benefit from appropriately fitted binaural hearing aids. Limited benefit from amplification is defined by test scores of 40% correct or less in best-aided listening condition on open-set sentence cognition (e.g., Central Institute for the Deaf (CID) sentences, Hearing in Noise Test (HINT) sentences).

4.2.2 Children with bilateral sensorineural hearing impairment who meet both of the following criteria:

4.2.2.1 Child has limited benefit from appropriately fitted binaural hearing aids. For children four years of age or younger, limited benefit is defined as failure to reach developmentally appropriate auditory milestones measured using the Infant-Toddler Meaningful Auditory Integration Scale, the Meaningful Auditory Integration Scale, or the Early Speech Perception test, or less than 20% correct on open-set word recognition test (Multisyllabic Lexical Neighborhood Test (MLNT)) in conjunction with appropriate amplification and participation in intensive aural habilitation over a three to six month period. For children older than four years of age, limited benefit is defined as less than 12% correct on the Phonetically Balanced-Kindergarten Test, or less than 30% correct on the Hearing in Noise Test for children, the open-set MLNT or Lexical Neighborhood Text (LNT), depending on the child's cognitive ability and linguistic skills; and

4.2.2.2 A three to six month hearing aid trial has been undertaken and failed by a child without previous experience with hearing aids.

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

5.0 EXCLUSIONS

5.1 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).

5.2 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 auditor nerve or acoustic area of the central nervous system.

5.3 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.

6.0 EFFECTIVE DATES

6.1 April 4, 2005.

TRICARE Policy Manual 6010.57-M, February 1, 2008

Chapter 4, Section 22.2

Cochlear Implantation

6.2 July 27, 2012, for children under 12 months of age.

- END -

Chapter 6

Pathology And Laboratory

Section/Addendum	Subject/Addendum Title
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1.1	General
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2.1	Transfusion Services For Whole Blood, Blood Components, And Blood Derivatives
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3.1	Diagnostic Genetic Testing
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4.1	Drug Testing
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Chapter 6

Section 4.1

Drug Testing

Issue Date: August 19, 2015

Authority: 10 USC 1079(h)(1); [32 CFR 199.4\(c\)](#); [32 CFR 199.14](#)

1.0 CPT¹ PROCEDURE CODES

G0431, G0434, G6030 - G6058, 80150 - 80299

2.0 DESCRIPTION

Drug testing may be performed with either a blood or urine sample. This policy clarifies TRICARE coverage of drug testing and provides guidance on the appropriate use and billing for these services, in accordance with TRICARE statute and regulation.

3.0 POLICY

3.1 TRICARE covers medically necessary and appropriate qualitative and quantitative drug testing.

3.2 Qualitative drug testing (Current Procedural Terminology (CPT)¹ procedure codes G0431 and G0434) may be cost-shared for patients with any of the following:

3.2.1 An unreliable history.

3.2.2 Multiple drug ingestion.

3.2.3 Delirium or coma, or other unexplained altered mental status.

3.2.4 Severe or unexplained cardiovascular instability.

3.2.5 Unexplained metabolic or respiratory acidosis.

3.2.6 Seizures with an undetermined history.

3.2.7 For the diagnosis of a medical condition where drug toxicity may be a contributing factor.

3.2.8 For monitoring patient compliance during active treatment for substance abuse. (See [paragraph 4.0](#) for exclusions for medico-legal purposes.)

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3.3 In accordance with 10 USC 1079(h)(1), TRICARE is required to reimburse like Medicare, where practicable.

3.3.1 TRICARE may cost-share CPT² procedure codes G0431 and G0434 for the reporting of qualitative drug screening. TRICARE does not recognize CPT² procedure codes 80300-80377 for reimbursement at this time.

3.3.2 There may be rare instances where a patient requires multiple, medically necessary screening tests for drugs of abuse to be performed in a single day; the use of CPT² procedure codes G0431 and G0434 on a per patient encounter basis allows payment to be made for this rare situation. Multiple claims for these codes on the same date of service shall be evaluated by the contractor for medical necessity.

3.4 Drug screening to identify specific drugs, to indicate when antagonists may be used, or to provide quantitative information regarding specific drugs may be cost-shared. Definitive and quantitative drug testing (CPT² procedure codes G6030-G6058) is covered when all of the following indications are met:

3.4.1 To verify and further analyze initial drug testing;

3.4.2 When medically necessary and appropriate; and

3.4.3 When the results will impact the medical management of the patient.

3.5 Therapeutic drug assays (CPT² procedure codes 80150-80299), performed to monitor clinical response to a known, prescribed medication, are covered when medically necessary and appropriate.

4.0 EXCLUSIONS

4.1 Drug screening using blood and urine simultaneously.

4.2 Drug screening for medico-legal purposes (i.e., court-ordered, forensic, criminal, social service agency investigations, parents involved in legal cases), employment purposes (i.e., as a pre-requisite for employment or continuation of employment), or for drug testing or compliance in school settings. These services are not medically necessary.

4.3 Routine drug screening, except when permitted by policy noted above (e.g., monitoring for patient compliance during active treatment).

4.4 Other drug screening for purposes unrelated to medical necessity, and for situations where drug testing will not impact the medical management of the patient.

- END -

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