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MB&RS

**CHANGE 162
6010.57-M
JUNE 14, 2016**

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

The Defense Health Agency has authorized the following addition(s)/revision(s).

CHANGE TITLE: REIMBURSEMENT AND CODING UPDATES 16-001

CONREQ: 17959

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): See page 3.

EFFECTIVE DATE: See page 3.

IMPLEMENTATION DATE: July 14, 2016.

This change is made in conjunction with Feb 2008 TRM, Change No. 129 and Feb 2008 TSM, Change No. 88.

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**ATTACHMENT(S): 14 PAGE(S)
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REMOVE PAGE(S)

CHAPTER 1

Section 13.1, pages 1 and 2

CHAPTER 4

Section 18.3, pages 1 and 2

Section 20.1, pages 1 through 4

CHAPTER 7

Section 7.1, pages 1 and 2

Section 9.1, pages 1 and 2

CHAPTER 8

Section 2.2, pages 1 and 2

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Section 20.1, pages 1 through 4

Section 7.1, pages 1 and 2

Section 9.1, pages 1 and 2

Section 2.2, pages 1 and 2

SUMMARY OF CHANGES

CHAPTER 1

1. Section 13.1. This change clarifies HCPCS code S0199. EFFECTIVE DATE: As stated in the issuance.

CHAPTER 4

2. Section 18.3. This change clarifies HCPCS code S0199. EFFECTIVE DATE: As stated in the issuance.
3. Section 20.1. This change removes deleted CPT codes 64622, 64623, 64626, and 64627 and adds new codes representing this service. EFFECTIVE DATE: 01/01/2012.

CHAPTER 7

4. Section 7.1. This change removes deleted CPT code 92506 and adds new codes representing this service. EFFECTIVE DATE: 01/01/2015.
5. Section 9.1. This change clarifies coding for exclusion of vestibular rehabilitation services. EFFECTIVE DATE: As stated in the issuance.

CHAPTER 8

6. Section 2.2. This change removes deleted HCPCS code E0608 and adds new codes representing this service. EFFECTIVE DATE: 01/01/2016.

Healthcare Common Procedure Coding System (HCPCS) "C" And "S" Codes

Issue Date: November 6, 2007
Authority:

1.0 HCPCS "C" AND "S" CODES

C1000 - C9999; S0000 - S9999

2.0 DESCRIPTION

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

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

3.0 POLICY

3.1 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 on or before May 1, 2009 (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 2.2](#).

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

3.2.1 S9122, S9123, S9124, and S8940 for the Extended Care Health Option (ECHO) respite care benefit and the ECHO Home Health Care (EHHC) benefit;

3.2.2 S0812, S1030, S1031, S1040, S2083, S2202, S2235, S2325, S2360, S2361, S2401 - S2405, S2411, S3620, S8030, S8185, S8265, S8270, and S9430 for all beneficiaries; and

3.2.3 S5108 for direct Educational Interventions for Autism Spectrum Disorders (EIA) services provided to TRICARE beneficiaries under the Department of Defense (DoD) Enhanced Access to Autism Services Demonstration. (See the TRICARE Operations Manual (TOM), [Chapter 18, Section 8](#).)

3.2.4 S2400 for prenatal surgical intervention of temporary tracheal occlusion of Congenital Diaphragmatic Hernia (CDH) for fetuses with prenatal diagnosis of CDH shall be determined on a

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Healthcare Common Procedure Coding System (HCPCS) "C" And "S" Codes

case-by-case basis, based on the Rare Disease policy, effective October 1, 2009. Procedural guidelines for review of rare disease are contained in [Section 3.1](#).

3.2.5 S0189 for testosterone pellets as provided in [Chapter 4, Section 5.1](#).

3.2.6 S8999 for resuscitation bag for use by the patient on artificial respiration during power failure or other catastrophic event. The bag must be U.S. Food and Drug Administration (FDA) approved, used in accordance with FDA indications, and must be prescribed by a physician.

3.2.7 S9900 for services rendered by an authorized Christian Science Practitioner as provided in [Chapter 11, Section 1.1](#).

3.2.8 S0190, S0191, and S0199 as provided in [Chapter 4, Section 18.3](#).

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

3.4 S2095 for the treatment of unresectable liver metastases from neuroendocrine tumors, as stated in [Chapter 1, Section 3.1](#).

3.5 S5110 and S5115 are covered as part of the Applied Behavior Analysis (ABA) benefit as outlined in [Chapter 7, Section 3.16](#). The end date is December 31, 2014.

3.6 S9480 as described in [Chapter 7, Section 3.4, paragraph 3.8](#) and [Chapter 7, Section 3.5, paragraph 3.3.1.2.3](#).

3.7 S2118 hip resurfacing with an FDA approved device is covered as a benefit as outlined in [Chapter 4, Section 6.1](#).

4.0 EXCLUSIONS

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

4.2 HCPCS S2066, S2067, and S2068 shall no longer be used. Current Procedural Terminology (CPT)¹ code 19364 is the more appropriate representation of these services.

- END -

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Abortions

Issue Date: April 19, 1983

Authority: [32 CFR 199.2\(b\)](#) and [32 CFR 199.4\(e\)\(2\)](#)

1.0 CPT¹ PROCEDURE CODE RANGE

59812 - 59857, 59866

2.0 HCPCS CODES

S0190, S0191, S0199

3.0 DESCRIPTION

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

4.0 POLICY

4.1 By law, abortions may not be cost-shared except:

4.1.1 In a case in which the pregnancy is the result of an act of rape or incest. A physician's note in the patient's medical record must support that it is the provider's good faith belief, based on all of the information available to the provider, that the patient was the victim of rape or incest; or,

4.1.2 When the life of the mother would be endangered if the fetus were carried to term. 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.

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

4.3 All medically and psychologically necessary services and supplies related to a covered abortion are covered. This may include ultrasound performed prior to the abortion, pathology services, pregnancy tests, office visits, and any applicable requirements mandated by state and/or local laws. It also may include otherwise covered follow-up care, such as psychotherapy.

4.4 Drugs such as Mifeprex (HCPCS S0190) and misoprostol (HCPCS S0191) and all associated services and supplies (HCPCS S0199) may be cost-shared when the pregnancy is the result of an act of rape or incest.

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5.0 BILLING PROCEDURES

5.1 G7 Modifier

To receive TRICARE reimbursement for abortions performed due to rape, incest or when the life of the mother is endangered if the fetus were carried to term, all claims, i.e., the CMS 1450 UB-04 and the CMS 1500 shall include the G7 modifier. The G7 modifier is defined as "the pregnancy resulted from rape or incest, or pregnancy certified by physician as life threatening".

5.2 Condition Codes

To receive TRICARE reimbursement for abortions performed due to rape, incest or when the life of the mother is endangered if the fetus were carried to term, all claims, i.e., the CMS 1450 UB-04 and the CMS 1500 shall include one of the following condition codes:

- AA – Abortion performed due to rape,
- AB – Abortion performed due to incest,
- AD – Abortion performed due to life endangering physical condition.

5.3 Outpatient Billing (Hospital Outpatient Departments (HOPDs) and Freestanding Ambulatory Surgery centers (ASCs))

HOPDs and freestanding ASCs shall bill on the CMS 1450 UB-04 claim form. One of the condition codes in [paragraph 5.2](#) and the G7 modifier is required on the UB-04 claim form in addition to one of the following Current Procedural Terminology (CPT²) procedure codes: 59840, 59841, 59850-59852, 59855-59857, 59866.

5.4 Professional Billing

Individual professional providers shall bill on the CMS 1500 claim form. One of the condition codes in [paragraph 5.2](#) shall be listed in FL 10d and the G7 modifier in FL24D. The claim shall include one of the following CPT² procedure codes: 59840, 59841, 59850-59852, 59855-59857, 59866.

6.0 TRICARE ENCOUNTER DATA (TED)

All TED records submitted for covered abortions must include one of the following Special Processing Codes as appropriate:

- AE (abortion performed due to rape),
- AF (abortion performed due to incest); or
- AG (abortion performed due to life endangering physical condition).

7.0 EDUCATION REQUIREMENTS

The TRICARE Operations Manual (TOM), [Chapter 11, Section 1](#) provides the contractors' responsibility regarding education of providers and beneficiaries.

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Nervous System

Issue Date: August 29, 1985

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

1.0 CPT¹ PROCEDURE CODES

61000 - 61626, 61680 - 62264, 62268 - 62284, 62290 - 63048, 63055 - 64484, 64505 - 64595, 64600 - 64650, 64680 - 64999, 95961, 95962, 95970 - 95975, 95978, 95979

2.0 POLICY

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

2.2 Therapeutic embolization (CPT¹ 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).

- Cerebral Arteriovenous Malformations (AVMs).
- Vein of Galen Aneurysm.
- Inoperable or High-Risk Intracranial Aneurysms.
- Dural Arteriovenous Fistulas.
- Meningioma.
- Pulmonary Arteriovenous Malformations (PAVMs).

2.3 Implantation of depth electrodes is covered. Implantation of a U.S. Food and Drug Administration (FDA) approved vagus nerve stimulator, and battery replacement, may be covered for the following indications:

- 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.
- As therapy for children 12 years of age or younger who have a diagnosis of medically refractory Lennox-Gastaut Syndrome (LGS) (a rare disease).
- Effective July 27, 2012, as adjunctive therapy in reducing the frequency of seizures that are refractory to anti-epileptic medications in beneficiaries under the age of 12.

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

2.4.1 The accessories necessary for the effective functioning of the covered device.

2.4.2 Repair, adjustment, replacement and removal of the covered device and associated surgical costs.

2.5 The Guglielmi Detachable Coil (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:

2.5.1 Very high risk for management by traditional operative techniques; or

2.5.2 Inoperable; or

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

2.6 Thoracic epidural steroid injections for the treatment of pain due to symptomatic thoracic disc herniations may be considered for cost-sharing when a patient meets all of the following criteria:

- Pain is radicular; and
- Pain is unresponsive to conservative treatment.

2.7 Non-pulsed Radiofrequency (RF) denervation (CPT² procedure codes **64633-64636**) for the treatment of chronic cervical and lumbar facet pain is covered when the following criteria are met:

2.7.1 No prior spinal fusion surgery in the vertebral level being treated, and

2.7.2 Low back (lumbosacral) or neck (cervical) pain, suggestive of facet joint origin as evidenced by absence of nerve root compression as documented in the medical record on history, physical and radiographic evaluations; and the pain is not radicular, and

2.7.3 Pain has failed to respond to three months of conservative management which may consist of therapies such as nonsteroidal anti-inflammatory medications, acetaminophen, manipulation, physical therapy, and a home exercise program, and

2.7.4 A trial of controlled diagnostic medial branch blocks under fluoroscopic guidance has resulted in at least a 50% reduction in pain; and

2.7.5 If there has been a prior successful RF denervation, a minimum time of six months has elapsed since prior RF treatment (per side, per anatomical level of the spine).

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2.8 Endoscopic laminotomy (CPT³ procedure code 63030) is covered for the treatment of lumbar spinal stenosis. The endoscopic spinal system used in the procedure must be FDA approved.

2.9 Sacral Nerve Stimulation (SNS) for the treatment of chronic fecal incontinence is covered for patients who have failed or are not candidates for more conservative treatment, and who have a weak but structurally intact anal sphincter refractory to conservative measures. See [Section 14.1](#) for coverage policy for the urinary system and the Sacral Nerve Root Stimulation (SNS).

3.0 EXCLUSIONS

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

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

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

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

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

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

3.7 Dorsal Root Entry Zone (DREZ) thermocoagulation or microcoagulation neurosurgical procedure is unproven.

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

3.9 Neuromuscular Electrical Stimulation (NMES) for the treatment of denervated muscles is unproven.

3.10 Stereotactic cingulotomy is unproven.

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

3.12 Balloon angioplasty, intracranial, percutaneous (CPT³ procedure code 61630) is unproven.

3.13 Transcatheter placement of intravascular stent(s) intracranial (e.g., atherosclerotic or venous sinus stenosis) including angioplasty, if performed (CPT³ procedure code 61635) is unproven. See [Chapter 1, Section 3.1](#) for coverage policy regarding treatment of pseudotumor cerebri.

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

3.15 Endoscopic thoracic sympathectomy.

3.16 Trigger point injection for migraine headaches.

3.17 Sphenopalatine ganglion block (CPT⁴ procedure code 64505) for the treatment of chronic migraine headaches and neck pain is unproven.

3.18 RF denervation (CPT⁴ procedure codes 64633, 64634) for the treatment of thoracic facet pain is unproven. Pulsed Radiofrequency Ablation (RFA) for spinal pain is unproven.

3.19 Implantation of Occipital Nerve Stimulator for the treatment of chronic intractable migraine headache is unproven.

3.20 Cryoablation of Occipital Nerve (CPT⁴ procedure code 64640) for the treatment of chronic intractable headache is unproven.

3.21 Spinal cord and deep brain neurostimulation in the treatment of chronic intractable headache or migraine pain is unproven.

3.22 Thermal Intradiscal Procedures (TIPs) (CPT⁴ procedure codes 22526, 22527, 62287, and Healthcare Common Procedure Coding System (HCPCS) code S2348) are unproven. TIPs are also known as: Intradiscal Electrothermal Annuloplasty (IEA), Intradiscal Electrothermal Therapy (IDET), Intradiscal Thermal Annuloplasty (IDTA), Percutaneous Intradiscal Radiofrequency Thermocoagulation (PIRFT), Coblation Percutaneous Disc Decompression, Nucleoplasty (also known as Percutaneous RF thermomodulation or Percutaneous Plasma Diskectomy), Radiofrequency Annuloplasty (RA), Intradiscal Biacuplasty (IDB), Percutaneous (or Plasma) Disc Decompression (PDD), Targeted Disc Decompression (TDD), Cervical Intradiscal RF Lesioning.

3.23 Laser ablation of paravertebral facet joint nerves (CPT⁴ procedure codes 64622 and 64623) is unproven. **(This applies only to laser ablation and should not be applied to RFA.)**

3.24 Minimally Invasive Lumbar Decompression (mild®) for the treatment of Degenerative Disc Disease (DDD) and/or spinal stenosis is unproven.

4.0 EFFECTIVE DATES

4.1 January 1, 1989, for PAVM.

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

4.3 July 14, 1997, for GDC.

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

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Chapter 7

Section 7.1

Speech Services

Issue Date: April 19, 1983

Authority: [32 CFR 199.6\(c\)](#) and 10 USC 1079(e)

1.0 CPT¹ PROCEDURE CODES

92507, 92508, 92521 - 92524, 92630 - 92633

2.0 DESCRIPTION

Speech-language pathology services that provide evaluation, treatment, habilitation, and rehabilitation of communication disorders resulting from congenital anomalies, disease, injury, hearing loss, pervasive developmental disorders or a therapeutic process, or other condition, such as pragmatic language impairment, that prevents or diminishes an individual's ability to communicate.

3.0 POLICY

3.1 Speech-language pathology services prescribed and supervised by a physician, certified Physician Assistant (PA) working under the supervision of a physician, or certified Nurse Practitioner (NP) may be cost-shared.

3.2 Speech-language pathology services to improve, restore, or maintain function, or to minimize or prevent deterioration of function of a patient when prescribed by a physician, certified PA working under the supervision of a physician, or certified NP is covered in accordance with the rehabilitative therapy provisions found in [Section 18.1](#).

4.0 EXCLUSIONS

4.1 Services provided to address speech, language, or communication disorders resulting from occupational or educational deficits.

4.2 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.

4.3 For beneficiaries ages three to 21 who are receiving special education services from a public educational agency, cost-sharing of outpatient speech services that are required by the IDEA and

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Speech Services

which are indicated in the beneficiary's 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.

4.4 Myofunctional or tongue thrust therapy.

4.5 Maintenance therapy that does not require a skilled level after a therapy program has been designed (see [Section 18.1](#)).

4.6 Videofluoroscopy evaluation in speech pathology is unproven.

4.7 Speech therapists (speech pathologists) are not authorized to bill using Evaluation and Management (E&M) codes listed in the Physicians' CPT.

- END -

Electronystagmography (ENG)

Issue Date: July 8, 1998

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

1.0 CPT¹ PROCEDURE CODE RANGE

92541 - 92547

2.0 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.

3.0 POLICY

3.1 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.

3.2 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).]

- Meniere's disease/Endolymphatic hydrops
- Vestibular neuritis
- Labyrinthine concussion
- Recurrent vestibulopathy
- Migraine-associated dizziness, benign paroxysmal vertigo of childhood
- Labyrinthine ischemia
- Chemical-induced vestibulotoxicity

4.0 EXCLUSIONS

4.1 Dynamic Posturography (CPT¹ procedure code 92548) is unproven.

4.2 Vestibular rehabilitation therapy (HCPCS code S9476) for the treatment of benign paroxysmal positional vertigo is unproven.

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5.0 EFFECTIVE DATE

June 1, 1996.

- END -

Chapter 8

Section 2.2

Infantile Apnea Cardiorespiratory Monitor

Issue Date: December 4, 1987

Authority: [32 CFR 199.4\(d\)\(3\)\(ii\)](#), 10 United States Code (USC) Section 1079(a)(15)

1.0 HCPCS PROCEDURE CODE

Level II Code [E0618](#) and [E0619](#)

2.0 DEFINITION

Apnea refers to abnormal cessation of air exchange. Infantile apnea is thought to be one of the pediatric disorders of respiratory control. Abnormalities that have been identified in infants with idiopathic apnea include prolonged episodes of apnea during sleep, often associated with bradycardia; an increased incidence of upper airway obstruction; a high density of short apneic episodes during sleep; excessive periodic breathing during sleep and diminished arousal and ventilatory responses to induced hypercapnia and hypoxemia.

3.0 POLICY

3.1 Use of a cardiorespiratory monitor, with or without a trend-event recorder, may be covered for in-home diagnostic data-collection or in-home clinical management of a condition or suspected condition, which places the beneficiary at extraordinary risk of life threatening cardiorespiratory complications for which 24-hour per day observation would otherwise be clinically indicated.

3.2 Associated services and items are covered in conjunction with a covered cardiorespiratory monitor.

3.3 Other applicable policy. Equipment cost-share is subject to the provisions of the Durable Medical Equipment (DME)/Durable Equipment (DE) Basic Program.

4.0 EXCLUSIONS

4.1 Screening Pneumogram. A 12- to 24-hour pneumogram (recordings of heart rate and thoracic impedance) accomplished solely as a predictive test for Sudden Infant Death Syndrome (SIDS) risk or life-threatening apnea risk.

4.2 A back-up electrical system or any alteration to the beneficiary's living space.

4.3 Any separate charge for the availability of medical, technical, or counseling assistance.

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Infantile Apnea Cardiorespiratory Monitor

4.4 Equipment which monitors only respiration or cardiac function.

- END -