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TRICARE  
MANAGEMENT ACTIVITY

**MB&RB**

**CHANGE 71  
6010.57-M  
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FOR  
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The TRICARE Management Activity has authorized the following addition(s)/revision(s).

**CHANGE TITLE:** 2012 CLARIFICATIONS - HOME INFUSION, SKILLED NURSING FACILITY (SNF), PROSTHETICS, OSTEOPOROSIS, TRICARE/MEDICARE, THERAPEUTIC SHOES, ORTHOTICS, AND APPLIED BEHAVIORAL ANALYSIS (ABA)

**CONREQ:** 15911

**PAGE CHANGE(S):** See page 2.

**SUMMARY OF CHANGE(S):** See page 3.

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

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

**This change is made in conjunction with Feb 2008 TRM, Change No. 70.**

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Chief, Medical Benefits and  
Reimbursement Branch**

**ATTACHMENT(S): 26 PAGE(S)  
DISTRIBUTION: 6010.57-M**

**CHANGE 71  
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**REMOVE PAGE(S)**

**CHAPTER 5**

Section 1.1, pages 3 through 8  
Section 2.1, pages 1 and 2  
Section 4.1, pages 3 and 4

**CHAPTER 8**

Section 3.1, pages 1 and 2  
Section 4.1, pages 1 and 2  
Section 8.2, pages 1 and 2  
Section 20.1, pages 3 through 5

**CHAPTER 9**

Table of Contents, page 1  
Section 9.1, pages 1 and 2

**INDEX**

pages 1, 2, 5, and 6

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Section 3.1, pages 1 and 2  
Section 4.1, pages 1 and 2  
Section 8.2, pages 1 and 2  
Section 20.1, pages 3 through 5

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Section 9.1, pages 1 and 2

pages 1, 2, 5, and 6

## **SUMMARY OF CHANGES**

### **CHAPTER 5**

1. Section 1.1. Updates procedure code range 77078 - 77082 and removes specific risk factors associated with osteoporosis. The list is unnecessary as the reference to American College of Obstetricians and Gynecologist's (ACOG's) high risk factors is sufficient.
2. Section 2.1. Updates procedure codes and removes specific risk factors associated with osteoporosis. The list is unnecessary as the reference to ACOG's high risk factors is sufficient.
3. Section 4.1. Removes specific risk factors associated with osteoporosis. The list is unnecessary as the reference to ACOG's high risk factors is sufficient.

### **CHAPTER 8**

4. Section 3.1. Clarifies policy for orthopedic shoes and other supportive devices.
5. Section 4.1. Clarifies policy for prosthetics, prosthetic devices, and supplies, and myoelectric prostheses.
6. Section 8.2. Clarifies therapeutic shoes for diabetics policy.
7. Section 20.1. Clarifies the payment of drugs provided as part of Home Infusion therapy.

### **CHAPTER 9**

8. Section 9.1. Defines the scope and limits of the educational modality known as Applied Behavioral Analysis (ABA).

### **INDEX**

9. Updated Chapter 9, Section 9.1's references.



**4.4.2** Detection of CAD:

- Symptomatic--evaluation of intracardiac structures (use of Magnetic Resonance (MR) coronary angiography).
- Evaluation of suspected coronary anomalies.

**4.4.3** Risk assessment with prior test results (use of vasolidator perfusion CMR or dobutamine stress function CMR).

- Coronary angiography (catheterization or CT).
- Stenosis of unclear significance.

**4.4.4** Structure and Function. Evaluation of ventricular and valvular function. Procedures may include Left Ventricular (LV)/Right Ventricular (RV) mass and volumes, MRA, quantification of valvular disease, and delayed contrast enhancement.

**4.4.4.1** Assessment of complex congenital heart disease including anomalies of coronary circulation, great vessels, and cardiac chambers and valves.

**4.4.4.2** Evaluation of LV function following Myocardial Infarction (MI) OR in heart failure patients. Patients with technically limited images from echocardiogram.

**4.4.4.3** Quantification of LV function. Discordant information that is clinically significant from prior tests.

**4.4.4.4** Evaluation of specific cardiomyopathies (infiltrative [amyloid, sarcoid], Hypertrophic Cardiomyopathy (HCM), or due to cardiotoxic therapies.

**4.4.4.5** Characterization of native and prosthetic cardiac valves--including planimetry of stenotic disease and quantification of regurgitant disease. Patients with technically limited images from echocardiogram or Transesophageal Echocardiography (TEE).

**4.4.4.6** Evaluation for Arrhythmogenic Right Ventricular Cardiomyopathy (ARVC). Patients presenting with syncope or ventricular arrhythmia.

**4.4.4.7** Evaluation of myocarditis or MI with normal coronary arteries. Positive cardiac enzymes without obstructive atherosclerosis on angiography.

**4.4.5** Structure and Function. Evaluation of intracardiac and extracardiac structures.

**4.4.5.1** Evaluation of cardiac mass (suspected tumor or thrombus). Use of contrast for perfusion and enhancement.

**4.4.5.2** Evaluation of pericardial conditions (pericardial mass, constrictive pericarditis).

**4.4.5.3** Evaluation for aortic dissection.

**4.4.5.4** Evaluation of pulmonary veins prior to radiofrequency ablation for atrial fibrillation. Left atrial and pulmonary venous anatomy including dimensions of veins for mapping purposes.

**4.4.6** Detection of Myocardial Scar and Viability. Evaluation of myocardial scar (use of late gadolinium enhancement).

**4.4.6.1** To determine the location and extent of myocardial necrosis including “no reflow” regions. Post acute MI.

**4.4.6.2** To determine viability prior to revascularization. Establish likelihood of recovery of function with revascularization (Percutaneous Coronary Intervention [PCI] or Coronary Artery Bypass Graft [CABG]) or medical therapy.

**4.4.6.3** To determine viability prior to revascularization. Viability assessment by Single Photon Emission Tomography (SPECT) or dobutamine echo has provided “equivocal or indeterminate” results.

**4.5** MRA is covered when medically necessary, appropriate and the standard of care. (CPT<sup>3</sup> procedure codes 70544 - 70549, 71555, 72159, 72198, 73225, 73725, and 74185.)

**4.6** 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>3</sup> procedure codes 70450 - 70498, 71250 - 71275, 72125 - 72133, 72191 - 72194, 73200 - 73206, 73700 - 73706, 74150 - 74175, 75635, and 76355 - 76380.)

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

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

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

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

**4.11** 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.

**4.12** Bone density studies (CPT<sup>3</sup> procedure codes 77078 - [77082](#)) are covered for the following:

**4.12.1** The diagnosis and monitoring of osteoporosis.

**4.12.2** The diagnosis and monitoring of osteopenia.

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**4.12.3** Patients must present with signs and symptoms of bone disease or be considered at high-risk for developing osteoporosis. High-risk factors for osteoporosis are those identified as the standard of care by the American College of Obstetricians and Gynecologists (ACOG).

**4.13** Radiological supervision and interpretation, percutaneous vertebroplasty or vertebral augmentation including cavity creation, per vertebral body; under fluoroscopic guidance (CPT<sup>4</sup> procedure code 72291) or under CT guidance (CPT<sup>4</sup> procedure code 72292) is covered.

**4.14** Multislice or multidetector row CT angiography (CT, heart) (CPT<sup>4</sup> codes 75571 - 75574) is covered for the following indications:

**4.14.1** Evaluation of heart failure of unknown origin when invasive coronary angiography +/- Percutaneous Coronary Intervention (PCI) is not planned, unable to be preformed or is equivocal.

**4.14.2** In an Emergency Department (ED) for patients with acute chest pain, but no other evidence of cardiac disease (low-pretest probability), when results would be used to determine the need for further testing or observation.

**4.14.3** Acute chest pain or unstable angina when invasive coronary angiography or a PCI cannot be performed or is equivocal.

**4.14.4** Chronic stable angina and chest pain of uncertain etiology or other cardiac findings prompting evaluation for CAD (for example: new or unexplained heart failure or new bundle branch block).

**4.14.4.1** When invasive coronary angiography or PCI is not planned, unable to be performed, or is equivocal; AND

**4.14.4.2** Exercise stress test is unable to be performed or is equivocal; AND

**4.14.4.3** At least one of the following non-invasive tests were attempted and results could not be interpreted or where equivocal or none of the following tests could be performed:

**4.14.4.3.1** Exercise stress echocardiography.

**4.14.4.3.2** Exercise stress echo with dobutamine.

**4.14.4.3.3** Exercise myocardial perfusion (SPECT).

**4.14.4.3.4** Pharmacologic myocardial perfusion (SPECT).

**4.14.5** Evaluation of anomalous native coronary arteries in symptomatic patients when conventional angiography is unsuccessful or equivocal and when results would impact treatment.

**4.14.6** Evaluation of complex congenital anomaly of coronary circulation or of the great vessels.

**4.14.7** Presurgical evaluation prior to biventricular pacemaker placement.

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**4.14.8** Presurgical evaluation of coronary anatomy prior to non-coronary surgery (valve placement or repair; repair of aortic aneurysm or dissection).

**4.14.9** Presurgical cardiovascular evaluation for patients with equivocal stress study prior to kidney or liver transplantation.

**4.14.10** Presurgical evaluation prior to electrophysiologic procedure to isolate pulmonary veins for radiofrequency ablation of arrhythmia focus.

## **5.0 EXCLUSIONS**

**5.1** Bone density studies for the routine screening of osteoporosis.

**5.2** Ultrafast CT (electron beam CT (HCPCS code S8092)) to predict asymptomatic heart disease is preventive. Ultrafast CT (electron beam CT) is excluded for symptomatic patients and for screening asymptomatic patients for CAD.

**5.3** MRIs (CPT<sup>5</sup> procedure codes 77058 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.

**5.4** MRIs (CPT<sup>5</sup> procedure codes 76058 and 77059) to assess implant integrity or confirm implant rupture, if implants were not originally covered or coverable.

**5.5** 3D rendering (CPT<sup>5</sup> procedure codes 76376 and 76377) for monitoring coronary artery stenosis activity in patients with angiographically confirmed CAD is unproven.

**5.6** 3D rendering (CPT<sup>5</sup> procedure codes 76376 and 76377) for evaluating graft patency in individuals who have undergone revascularization procedures is unproven.

**5.7** 3D rendering (CPT<sup>5</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.

**5.8** CT angiography (CPT<sup>5</sup> procedure codes 76376 and 76377) for acute ischemic stroke is unproven.

**5.9** CT angiography (CPT<sup>5</sup> procedure codes 76376 and 76377) for intracerebral aneurysm and subarachnoid hemorrhage is unproven.

**5.10** CT, heart, without contrast material, with quantitative evaluation of coronary calcium (CPT<sup>5</sup> procedure code 75571) is excluded for patients with typical anginal chest pain with high suspicion of CAD; patients with acute MI; and for screening asymptomatic patients for CAD.

**5.11** CT, heart, without contrast material, for evaluation of cardiac structure and morphology (including 3D image postprocessing, assessment of cardiac function, and evaluation of venous

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structures, if performed) (CPT<sup>6</sup> procedure code 75572) is excluded for patients with typical anginal chest pain with high suspicion for CAD; patients with acute MI; and for screening asymptomatic patients for CAD.

**5.12** CT, heart, with contrast material, for evaluation of cardiac structure and morphology in the setting of congenital heart disease (including 3D image postprocessing, assessment of LV cardiac function, RV structure and function and evaluation of venous structures, if performed) (CPT<sup>6</sup> procedure code 75573) is excluded for patients with typical anginal chest pain with high suspicion for CAD; patients with acute MI; and for screening asymptomatic patients for CAD.

**5.13** Computed tomographic angiography heart, coronary arteries and bypass (when present), with contrast material, including 3D image postprocessing (including evaluation of cardiac structure and morphology, assessment of cardiac function, and evaluation of venous structures, if performed) (CPT<sup>6</sup> procedure code 75574) is excluded for patients with typical anginal chest pain with high suspicion for CAD; patients with acute MI; and for screening asymptomatic patients for CAD.

**5.14** Multislice or multidetector row CT angiography of less than 16 slices per sec and 1mm or less resolution is excluded.

**5.15** Radiological supervision and interpretation of percutaneous vertebroplasty (CPT<sup>6</sup> procedure codes 72291 and 72292).

**5.16** Dual Energy X-Ray Absorptiometry (DXA) composition study (CPT<sup>6</sup> procedure code 0028T) is unproven.

**5.17** Computer-Aided Detection with breast MRI (CPT<sup>6</sup> 0159T) is unproven.

## **6.0 EFFECTIVE DATES**

**6.1** 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.

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

**6.3** March 31, 2006, for coverage of multislice or multidetector row CT angiography.

**6.4** January 1, 2007, for CPT<sup>6</sup> procedure codes 72291 and 72292.

**6.5** January 1, 2007, for coverage of multislice of multidetector row CT angiography performed for presurgical evaluation prior to electrophysiological procedure to isolate pulmonary veins for radiofrequency ablation of arrhythmia focus.

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**TRICARE Policy Manual 6010.57-M, February 1, 2008**

Chapter 5, Section 1.1

Diagnostic Radiology (Diagnostic Imaging)

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**6.6** October 1, 2008, for breast MRI for guidance of interventional procedures such as vacuum assisted biopsy and preoperative wire localization for lesions that are occult on mammography or sonography and are demonstrable only with MRI.

**6.7** October 3, 2006, for CMR.

- END -

## Chapter 5

## Section 2.1

# Diagnostic Ultrasound

Issue Date: November 1, 1983

Authority: 32 CFR 199.2, 32 CFR 199.4(a)(1), (b)(2)(vii), (b)(3)(v), (b)(4)(ii), and (g)(36)

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### 1.0 CPT<sup>1</sup> PROCEDURE CODE RANGES

Diagnostic Ultrasound: 76506 - 76776, 76800 - 76886

Ultrasonic Guidance: 76930 - 76965

Ultrasound Other: 76970 - 76999

### 2.0 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.

### 3.0 POLICY

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

**3.2** 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.

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

**3.3.1** The diagnosis and monitoring of osteoporosis.

**3.3.2** For the diagnosis and monitoring of osteopenia.

**3.3.3** Patients must present with signs and symptoms of bone disease or be considered at high-risk for developing osteoporosis. High-risk factors for osteoporosis are those identified as the standard of care by the American College of Obstetricians and Gynecologists (ACOG).

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**4.0 EXCLUSIONS**

**4.1** Ultrasound for routine screening for breast disease.

**4.2** Ultrasound performed solely to determine the sex of an unborn child for non-medical reasons.

**4.3** Bone density studies for routine screening for osteoporosis.

**4.4** 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 76881 and 76942).

**4.5** 3D and 4D rendering (CPT<sup>2</sup> procedure codes 76376 and 76377) with maternity ultrasound is unproven.

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**3.4.3** Patients must present with signs and symptoms of bone disease or be considered at high-risk for developing osteoporosis. High-risk factors for osteoporosis are those identified as the standard of care by the American College of Obstetricians and Gynecologists (ACOG).

#### **4.0 EXCLUSIONS**

**4.1** Bone density studies for the routine screening of osteoporosis.

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

**4.3** PET and PET/CT for the initial diagnosis of differentiated thyroid cancer and for medullary cell thyroid cancer.

**4.4** Ultrasound ablation (destruction of uterin fibroids) with Magnetic Resonance Imaging (MRI) guidance (CPT<sup>3</sup> procedure code 0071T) in the treatment of uterine leiomyomata is unproven.

**4.5** PET and PET/CT for the diagnosis, staging, restaging, and monitoring of treatment of gastric cancer is unproven.

**4.6** PET and PET/CT for the initial diagnosis, staging, and monitoring of treatment of ovarian cancer is unproven.

**4.7** PET and PET/CT for the initial diagnosis and monitoring of treatment of colorectal cancer is unproven.

**4.8** PET for the diagnosis of renal mass or possible Renal Cell Carcinoma (RCC) recurrence.

**4.9** Scintimammography (HCPCS code S8080), Breast-Specific Gamma Imaging (BSGI) (CPT<sup>3</sup> procedure codes 78800, 78801), and Molecular Breast Imaging (MBI) are unproven for all indications.

#### **5.0 EFFECTIVE DATES**

**5.1** January 1, 1995, for PET for ischemic heart disease.

**5.2** December 1, 1996, for PET for lung cancer.

**5.3** October 14, 1990, for SPECT for myocardial perfusion imaging.

**5.4** January 1, 1991, for SPECT for brain imaging.

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

**5.6** June 1, 1994, for Octreoscan Scintigraphy.

**5.7** May 26, 1994, for bone density studies.

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**TRICARE Policy Manual 6010.57-M, February 1, 2008**

Chapter 5, Section 4.1

Nuclear Medicine

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- 5.8** January 1, 2006, for PET and PET/CT for pancreatic cancer.
- 5.9** February 16, 2006, for PET and PET/CT for thyroid cancer.
- 5.10** December 1, 2008, for PET and PET/CT for ruling out recurrence of ovarian cancer.
- 5.11** May 1, 2007, for PET and PET/CT for staging, restaging, and detection of recurrence of colorectal cancer.
- 5.12** January 1, 2010, for PET/CT for metastatic bladder cancer.
- 5.13** January 1, 2007, for PET and PET/CT for lymphoma.

- END -

## Chapter 8

## Section 3.1

# Orthotics

Issue Date: September 20, 1990  
Authority: [32 CFR 199.4\(d\)\(3\)\(viii\)](#)

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### 1.0 DESCRIPTION

**1.1** Orthotics is the field of knowledge relating to the making of an appliance or apparatus used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body.

**1.2** Orthopedic shoes and other supportive devices (e.g., orthotic inserts), which are specially designed to correct a specific deformity of the foot, are generally not covered. However, this exclusion does not apply to such shoes if it is an integral part of a covered brace, and its expense is included as part of the cost of the brace.

### 2.0 POLICY

**2.1** Orthotic devices are covered.

**2.2** For individuals with diabetes, see [Chapter 8, Section 8.2](#).

**2.3** Orthopedic braces including shoes, inserts, and heel/sole replacements are covered only when the shoes are an integral part of the brace and medically necessary for the proper functioning of the brace. Neither the shoe nor the brace is usable separately.

**2.4** The Dynamic Orthotic Cranioplasty (DOC) Band Post-Op device is covered for adjunctive use for infants from three to eighteen months of age whose synostosis has been surgically corrected, but who still have moderate to severe cranial deformities including plagiocephalic-, brachycephalic-, and scaphocephalic-shaped heads (Healthcare Common Procedure Coding System (HCPCS) code S1040).

### 3.0 EXCLUSIONS

The following types of orthoses are excluded from TRICARE coverage:

**3.1** Orthopedic shoes, unless one or both shoes are an integral part of a covered brace.

**3.2** Arch supports and shoe inserts designed to effect conformational changes in the foot or foot alignment.

**3.3** Over-The-Counter (OTC) custom-made or built-up shoes.

**TRICARE Policy Manual 6010.57-M, February 1, 2008**

Chapter 8, Section 3.1

Orthotics

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**3.4** Other supportive devices of the feet, such as, wedges, specialized fillers, heels straps, pads, shanks, etc., **except where otherwise covered.**

**3.5** Cranial orthosis (DOC Band) and cranial molding helmets are not covered for the treatment of nonsynostotic positional plagiocephaly (deformational plagiocephaly, plagiocephaly without synostosis) or for the treatment of craniosynostosis before surgery.

- END -

## Chapter 8

## Section 4.1

# Prosthetic Devices And Supplies

Issue Date: September 19, 1990

Authority: [32 CFR 199.4\(d\)\(3\)\(vii\)](#) and 10 USC 1077(a)

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### 1.0 HCPCS PROCEDURE CODES

Level II Codes L5000 - L9900, V2623 - V2629

### 2.0 DESCRIPTION

**2.1** Prosthetic. A prosthetic or prosthetic device (prosthesis) determined to be necessary because of significant conditions resulting from trauma, congenital anomalies, or diseases.

**2.2** Prosthetic supplies. Supplies that are necessary for the effective use of a prosthetic or prosthetic device.

### 3.0 POLICY

**3.1** Prosthetics, prosthetic devices, and prosthetic supplies **medically** necessary because of significant conditions resulting from trauma, congenital anomalies, or disease are covered.

**3.2** Duplicate or similar items are not covered. Therefore, only one permanent prosthesis at a time is covered unless a beneficiary requires bilateral prostheses.

**3.3** Prosthetics, prosthetic devices, and supplies shall be consistent with the beneficiary's symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary's needs.

**3.4** Additionally, the following are covered:

**3.4.1** Any accessory or item of supply that is used in conjunction with the device for the purpose of achieving therapeutic benefit and proper functioning;

**3.4.2** Services necessary to train the recipient of the device in the use of the device;

**3.4.3** Repair of the device for normal wear and tear or damage;

**3.4.4** Customization of the prosthetic is covered when provided by an otherwise authorized provider.

**TRICARE Policy Manual 6010.57-M, February 1, 2008**

Chapter 8, Section 4.1

Prosthetic Devices And Supplies

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**3.5** Replacement. Replacement of a prosthetic is covered when:

**3.5.1** Required due to growth or a change in the patient's condition; or

**3.5.2** The device is lost or irreparably damaged or the cost of repair would exceed 60% of the cost of replacement. Effective September 1, 2005.

**3.6** Surgical implants that are approved for use in humans by the U.S. Food and Drug Administration (FDA) are covered as an essential and integral part of an otherwise covered surgical procedure.

**3.7** As of May 20, 1999, the purchase of prosthetic devices is expanded to include, but not limited to, ears, noses, and fingers, as determined by the Secretary of Defense, to be necessary because of significant conditions resulting from trauma, congenital anomalies, or disease.

**3.8** Prosthetic devices with an FDA approved Investigational Device Exemption (IDE) categorized by the FDA as non-experimental/investigational (FDA Category B) will be considered for coverage. Coverage is dependent on the device meeting all other requirements of the law and rules governing TRICARE and upon the beneficiary involved meeting FDA approved IDE study protocols.

**3.9** Coverage for prosthetic devices includes myoelectric prosthetic devices. As an example, a myoelectrical prosthesis with a hand is an acceptable alternative to conventional prosthesis with a hook.

**4.0 EXCLUSIONS**

**4.1** Prosthetic devices categorized by the FDA as experimental/investigational (FDA Category A) IDEs.

**4.2** Prosthetic devices intended for sports related purposes, exercise equipment, physiotherapy, personal comfort, and convenience.

- END -

## Chapter 8

## Section 8.2

# Therapeutic Shoes For Diabetics

Issue Date: February 27, 1996

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

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### 1.0 HCPCS PROCEDURE CODES

A5500 - A5513

### 2.0 DESCRIPTION

Therapeutic shoes (also referred to as extra depth or diabetic shoes) including inserts and modifications are designed for diabetics with conditions of impaired peripheral sensation and/or altered peripheral circulation (e.g., diabetic neuropathy and peripheral vascular disease), foot deformity, and pre-ulcerative callus formation. The primary goal of therapeutic shoes is to prevent complications, such as strain, ulcers, calluses, or even amputations for patients with diabetes and poor circulation.

### 3.0 POLICY

**3.1** Therapeutic shoes, extra-depth shoes with inserts or custom molded shoes with inserts, for individuals with diabetes are covered.

**3.2** Separate shoes inserts shall be covered when dispensed as a separate item for an otherwise covered therapeutic/diabetic shoe.

### 4.0 COVERAGE LIMITATION

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

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

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

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

- Rigid rocker bottoms
- Roller bottoms

**TRICARE Policy Manual 6010.57-M, February 1, 2008**

Chapter 8, Section 8.2

Therapeutic Shoes For Diabetics

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- Metatarsal bars
- Wedges
- Offset heels

**4.2** The physician who is managing the beneficiary's systemic diabetic condition must:

**4.2.1** Document that the patient has diabetes.

**4.2.2** Document that the patient has one or more of the following conditions:

- Previous amputation of the foot or part of the foot;
- History of previous foot ulceration; or
- Pre-ulcerative callus formation, or peripheral neuropathy with a history of callus formation, foot deformity, or poor circulation.

**4.2.3** Certify that the patient is being treated under a comprehensive plan of care for his diabetes and needs therapeutic shoes.

**5.0 EFFECTIVE DATE**

May 1, 1993.

- END -

do so when a physician or other authorized individual professional provider certifies that self-administration is medically appropriate. Physician or other authorized individual professional provider certification that self-administration is medically appropriate will be noted in the patient's POC described in the TRM, [Chapter 12](#) or in the medical record.

**5.1.3** The MCSC shall be responsible for beneficiary and provider education on cost-share requirements associated with infusion therapy provided in the home and cost-sharing advantages of self-administration, if self-administration is medically appropriate. See TRM, [Chapter 2, Addendum A](#) for beneficiary cost-shares for HHC services. See TRM, [Chapter 2, Addendum B](#) for beneficiary cost-shares for TPharm Benefits Program.

## **5.2 Non-Homebound Beneficiaries**

MCSC shall provide preauthorization for non-homebound beneficiaries to receive infusion therapy in the home when:

**5.2.1** Long-term infusion therapy services are needed (more than five sequential infusions). The MCSC shall preauthorize infusion therapy in the home when all of the following criteria are met:

### **5.2.1.1 Individual Professional Provider Certification**

The attending physician certifies that the non-homebound beneficiary (or caregiver, such as a spouse) is capable and willing to learn to self-administer the infusion drug, and that self-administration in the home is medically appropriate; and

### **5.2.1.2 Skilled Nursing**

The MCSC shall preauthorize up to five sequential skilled nursing visits (CPT<sup>2</sup> procedures codes 99601 and 99602) by a TRICARE authorized provider to administer and instruct the non-homebound beneficiary or caregiver to self-administer the drug. Additional visits may be authorized when medically necessary and appropriate (i.e., a change in condition requires additional visits). Claims for skilled nursing are the responsibility of the MCSC; and

### **5.2.1.3 Drug and Compounding Services**

The MCSC shall coordinate and provide a referral to the TPharm for the drug and compounding services. If the drug is available from the TPharm, it must be provided through the TPharm Benefits Program. In the case that the drug is not available through the TPharm, the MCSC shall coordinate provision of the drug through an appropriate TRICARE authorized provider or direct the non-homebound beneficiary to care in an alternative setting; and

### **5.2.1.4 Medical Supplies and DME**

The MCSC is responsible for ensuring the beneficiary has a referral to all medically necessary and appropriate services and supplies for infusion therapy in the home, including medical supplies and DME. Claims for medical supplies and DME are the responsibility of the MCSC;

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and

#### 5.2.1.5 Coordination of Services

The MCSC shall coordinate delivery of infusion therapy in the home between the referring individual professional provider, the beneficiary, and necessary TRICARE authorized providers to meet the requirement of this policy of delivering care in the most medically appropriate and economical manner.

**Note:** See TRM, [Chapter 2, Addendum A](#) for information on beneficiary cost-shares for services of individual professional providers. See TRM, [Chapter 2, Addendum B](#) for beneficiary cost-shares for TPharm Benefits Program.

**5.2.2** Short-term (five or fewer) therapy services are needed. If a non-homebound beneficiary requires five or fewer sequential infusions, the MCSC shall preauthorize up to five sequential skilled nursing visits (CPT<sup>3</sup> procedure codes 99601 and 99602) to administer the drug. The beneficiary is not required to learn to self-administer. The MCSC will coordinate and provide a referral for the infusion drug, DME and medical supplies in accordance with [paragraphs 5.2.1.3, 5.2.1.4, and 5.2.1.5](#).

**5.3** See [Section 6.1](#) for coverage and policy related to medical supplies, [Section 2.1](#) for coverage and policy related to DME, and [Section 5.1](#) for coverage and policy related to medical devices.

**5.4** In cases where the drug is not available from TPharm, or the beneficiary is not required to use TPharm to obtain the drug, see the TRM, [Chapter 3, Section 7](#) for information on the processing and payment of home infusion claims for home-based services provided by Corporate Service Providers (CSPs), and the TRM, [Chapter 1, Section 15](#) for information on legend drugs and insulin reimbursement.

**5.5** See [Section 9.1](#) for information on the Pharmacy Benefits Program.

**5.6** Provider payments are reduced for the failure to comply with the preauthorization requirements in this section. See TRM, [Chapter 1, Section 28](#).

## 6.0 EXCEPTIONS

In the event that a non-homebound beneficiary:

**6.1** Is unable or unwilling to learn to self-administer and requires skilled services to administer the infusion drug;

**6.2** Requires long-term infusion therapy; and

**6.3** Infusion therapy in the home is requested and is medically appropriate, the MCSC shall preauthorize infusion therapy in the home when it is determined that infusion in the home setting, provided in the same manner as described in [paragraph 5.2.2](#) without the limit of five visits, is less costly to the government than infusion in an alternative setting.

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Chapter 8, Section 20.1

Infusion Drug Therapy Delivered In The Home

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**7.0 EXCLUSIONS**

**7.1** "S" codes, except those described in [Chapter 1, Section 13.1](#).

**7.2** Long-term infusion therapy in the home for non-homebound beneficiaries who are unwilling to learn to self-administer.

**7.3** TRICARE dual eligible beneficiaries are not subject to the requirements in this policy.

**7.4** TRICARE Overseas Program (TOP) beneficiaries are not subject to the requirements of this policy.

**7.5** Beneficiaries with Other Health Insurance (OHI), where TRICARE is not the primary payor, are not subject to the requirements of this policy.

- END -



## Chapter 9

### Extended Care Health Option (ECHO)

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| 15.1             | ECHO Home Health Care (EHC)                                     |
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| 17.1             | Providers   |
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| A                | ECHO Home Health Care (EHC) Benefit                             |



## Special Education **And Other Educational Services**

Issue Date: July 3, 1997

Authority: [32 CFR 199.5\(c\)\(3\)](#) and [\(c\)\(4\)](#)

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### 1.0 CPT<sup>1</sup> PROCEDURE CODES

99199, 99600

### 2.0 POLICY

**2.1** 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 Extended Care Health Option (ECHO) requirements, and in particular, the requirement that other public programs and facilities be used to the extent available and adequate.

**2.2** 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.

**2.3** Applied Behavioral Analysis (ABA) **services are** included as a benefit under this issuance **in accordance with the Director, TRICARE Management Activity (TMA) coverage decision memorandum of October 19, 2010. The "Medical Benefit Determinations-Applied Behavior Analysis for the Treatment of Autism Spectrum Disorders" determined that ABA is no longer considered special education for TRICARE program purposes and concludes that ABA is considered a part of an integrated set of services and supplies designed to assist in the reduction of the disabling effects of Autism Spectrum Disorder (ASD) for an ECHO-registered beneficiary with a qualifying condition. Therefore, ABA may be covered under ECHO as an "other service" for those eligible Active Duty Family Members (ADFM)s with an ASD diagnosis only when provided by a TRICARE-authorized provider in accordance with the scope of their license or when provided in accordance with the Department of Defense (DoD) Enhanced Access to Autism Services Demonstration.** Payable services include periodic evaluation of the beneficiary, development of a treatment plan, and training of immediate family members 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 cannot pay for such services when provided by family members, trainers or other individuals who are not TRICARE-authorized providers (see [Section 17.1](#)) and for children less than three and included in the Individualized Family Service Plan (IFSP).

**2.4** 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

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Chapter 9, Section 9.1

Special Education **And Other Educational Services**

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beneficiary's natural environment. This includes at home, at school, or other location that is suitable for the type of services being rendered.

**2.5** See the TRICARE Operations Manual (TOM), [Chapter 18, Section 8](#) for information about the DoD Enhanced Access to Autism Services Demonstration.

**3.0 EXCLUSION**

Special education services are generally unavailable under the TRICARE Basic Program except as authorized under Section 1079(a)(g) of Title 10 United States Code (USC), and when authorized are not eligible to be cost-shared under ECHO.

**4.0 EFFECTIVE DATE**

September 1, 2005.

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