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TRICARE
MANAGEMENT ACTIVITY
MB&RB

CHANGE 87
6010.57-M
APRIL 4, 2013

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: **REIMBURSEMENT AND CODING UPDATES 13-001**

CONREQ: 16411

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): See page 3.

EFFECTIVE DATE: As indicated, otherwise 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. 79 and Feb 2008 TSM, Change No. 47.

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Chief, Medical Benefits and Reimbursement Branch

ATTACHMENT(S): **16 PAGE(S)**
DISTRIBUTION: **6010.57-M**

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

REMOVE PAGE(S)	INSERT PAGE(S)
CHAPTER 1	
Section 8.1, pages 1 and 2	Section 8.1, pages 1 and 2
CHAPTER 7	
Section 2.2, pages 5 and 6	Section 2.2, pages 5 and 6
Section 3.10, pages 1 through 3	Section 3.10, pages 1 through 3
Section 3.13, pages 1 through 3	Section 3.13, pages 1 through 4
Section 22.1, pages 1 through 5	Section 22.1, pages 1 through 5

SUMMARY OF CHANGES

CHAPTER 1

1. Section 8.1. This change updates codes affected by the 2013 updated Current Procedural Terminology (CPT)[1]/Healthcare Common Procedure Coding System (HCPCS) mental health codes published by the AMA.

CHAPTER 7

2. Section 2.2. The temporary codes for Computed Tomographic Colonography (CTC), Level III procedure code 0066T or 0067T, have changed to new CPT 74263.

3. Section 3.10. This change updates codes affected by the 2013 updated CPT/HCPCS mental health codes published by the American Medical Association (AMA), and corrects an error in the code range for the first eight outpatient mental health visits.

4. Section 3.13. This change updates codes affected by the 2013 updated CPT/HCPCS mental health codes published by the AMA.

5. Section 22.1. This change updates codes affected by the 2013 updated CPT/HCPCS mental health codes published by the AMA.

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Chapter 1 Section 8.1

Primary Care Managers (PCMs)

Issue Date: May 15, 1996
Authority: 32 CFR 199.17

1.0 POLICY

1.1 TRICARE Prime enrollees shall select or have assigned to them Primary Care Managers (PCMs) according to guidelines established by the Military Treatment Facility (MTF) Commander and Regional Director (RD).

1.1.1 A PCM may be a network provider, or an MTF PCM by name/supported by a team. If a group practice is listed as a network provider, all members of the group practice must be TRICARE-authorized providers.

1.1.2 The following types of individual professional providers are considered primary care providers and may be designated PCMs, consistent with governing State rules and regulations: internists, family practitioners, pediatricians, general practitioners (GPs), obstetricians/gynecologists (OB/GYNs), physician assistants (PAs), nurse practitioners (NPs), and certified nurse midwives (CNMs). PCMs who are PAs, NPs, and CNMs cannot "prescribe and supervise" those speech, physical, occupational, and other therapies provided by non-physician therapists that must be prescribed and supervised by a physician.

1.2 A TRICARE Prime enrollee must seek all his or her primary health care from the PCM with the exception of Clinical Preventive Services. If the PCM is unable to provide a primary care service, the PCM is responsible for referring the enrollee to another primary care provider. A TRICARE Prime enrollee must be referred by the PCM for specialty care or for inpatient care. Failure to obtain a PCM referral when one is required will result in the service being paid under Point of Service procedures with a deductible for outpatient services and cost-shares for in- and outpatient services.

1.3 The PCM is responsible for notifying the contractor that a referral is being made. The contractor will assist the Prime enrollee in locating an MTF or network provider to provide the specialty care and in scheduling an appointment. Additionally, the contractor will conduct a prospective review and authorize the service in accordance with the contractor's best practices.

2.0 EXCEPTIONS

PCM referral is not required for the following services:

2.1 Services provided directly by the PCM.

2.2 Emergency care.

2.3 Services provided as part of the comprehensive clinical prevention program offered to Prime enrollees.

2.4 The first eight outpatient mental health visits per beneficiary in a fiscal year do not require PCM or Health Care Finder (HCF) referral and do not require preauthorization. Mental health visits exceeding eight in a fiscal year require authorization, but do not require a referral. The authorization of outpatient mental health care after the first eight visits (visits nine forward) shall be in accordance with the MCSC's best practices. This does not apply to mental health care received by active duty personnel. Mental health care for active duty personnel requires preauthorization. See Chapter 7, Section 3.10.

Note: Active Duty Service Members (ADSMs) require preauthorization before receiving mental health services. The contractor shall comply with the provisions of the TRICARE Operations Manual (TOM), Chapters 16 and 17 when processing requests for service for active duty personnel.

- END -

SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT PROCEDURE CODE
Colorectal Cancer (Continued):	**Optical (Conventional) Colonoscopy for Individuals at Average, Increased, or High Risk for Colon Cancer (Continued):** **Increased Risk (Individuals with a family history):** 1. Once every five years for individuals with a first degree relative diagnosed with sporadic colorectal cancer or an adenomatous polyp before the age of 60, or in two or more first degree relatives at any age. Optical colonoscopy should be performed beginning at age 40 or 10 years younger than the earliest affected relative, whichever is earlier. 2. Once every 10 years, beginning at age 40, for individuals with a first degree relative diagnosed with sporadic colorectal cancer or an adenomatous polyp at age 60 or older, or colorectal cancer diagnosed in two second degree relatives. **High Risk:** 1. Once every one to two years for individuals with a genetic or clinical diagnosis of Hereditary Non-Polyposis Colorectal Cancer (HNPCC) or individuals at increased risk for HNPCC. Optical colonoscopy should be performed beginning at age 20 to 25 or 10 years younger than the earliest age of diagnosis, whichever is earlier. 2. For individuals diagnosed with Inflammatory Bowel Disease (IBD), Chronic Ulcerative Colitis (CUC), or Crohn's disease, cancer risk begins to be significant eight years after the onset of pancolitis or 10 to 12 years after the onset of left-sided colitis. For individuals meeting these risk parameters, optical colonoscopy should be performed every one to two years with biopsies for dysplasia. The effective date for coverage of optical colonoscopy for individuals at **increased** or **high risk** is October 6, 1997.	
	Computed Tomographic Colonography (CTC) for Individuals in whom an Optical Colonoscopy is Medically Contraindicated or Incomplete: CTC is covered as a colorectal cancer screening ONLY when an optical colonoscopy is medically contraindicated OR cannot be completed due to a known colonic lesion, structural abnormality, or other technical difficulty is encountered that prevents adequate visualization of the entire colon. CTC is NOT covered as a colorectal cancer screening for any other indication or reason. The effective date for coverage of CTC for this indication is March 15, 2006. CTC is NOT covered as a colorectal cancer screening for any other indication or reason.	CPT code 74263.

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SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT PROCEDURE CODE
Skin Cancer:	**Physical Examination**: Skin examination should be performed for individuals with a family or personal history of skin cancer, increased occupational or recreational exposure to sunlight, or clinical evidence of precursor lesions.	See appropriate level evaluation and management codes.
Oral Cavity and Pharyngeal Cancer:	**Physical Examination**: A complete oral cavity examination should be part of routine preventive care for adults at **high risk** due to exposure to tobacco or excessive amounts of alcohol. Oral examination should also be part of a recommended annual dental check-up.	See appropriate level evaluation and management codes.
Thyroid Cancer:	**Physical Examination**: Palpation for thyroid nodules should be performed in adults with a history of upper body irradiation.	See appropriate level evaluation and management codes.
Infectious Diseases:	**Tuberculosis (TB) Screening**: Screen annually, regardless of age, all individuals at **high risk** for tuberculosis (as defined by Centers for Disease Control and Prevention (CDC) using Mantoux tests.	CPT[1] codes 86580 and 86585.
	Rubella Antibodies: Test females, once, between the ages of 12 and 18, unless documented history of adequate rubella vaccination with at least one dose of rubella vaccine on or after the first birthday is documented.	CPT[1] code 86762.
	Hepatitis B Screening: Screen pregnant women for HBsAG during prenatal period.	CPT[1] code 87340.
Cardiovascular Diseases:	**Cholesterol Screening**: Age-specific, periodic lipid panel as recommended by the National Heart, Lung, and Blood Institute (NHLBI). Refer to the NHLBI web site (http://www.nhlbi.nih.gov/guidelines) for current recommendations.	CPT[1] code 80061.
	Blood Pressure Screening: For children: annually between three and six years of age, and every two years thereafter. For adults: a minimum frequency of every two years.	See appropriate level evaluation and management codes.
	Abdominal Aortic Aneurysm (AAA): One time AAA screening by ultrasonography for men, age 65 - 75, who have ever smoked.	CPT[1] code 76999.
Other:	**Body Measurement**: For children and adolescents: Height and weight typically is measured and Body Mass Index (BMI)-for-age calculated and plotted at each primary care visit using the CDC "Data Table of BMI-for-age Charts". Children/adolescents with a BMI value greater than the 85th percentile typically receive appropriate nutritional and physical activity counseling as part of the primary care visit. Head circumference typically is measured through age 24 months. For adults: Height and weight typically is measured and BMI calculated at each primary care visit. Individuals identified with a BMI of 25 or above typically receive appropriate nutritional and physical activity counseling as part of primary care visit.	See appropriate level evaluation and management codes.

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Chapter 7 Section 3.10

Treatment Of Mental Disorders

Issue Date: December 5, 1984
Authority: 32 CFR 199.4(c)(3)(ix)

1.0 CPT[1] PROCEDURE CODE RANGES

90801 - 90899 for care provided through December 31, 2012.
90785 - 90899 for care provided on or after January 1, 2013.

2.0 POLICY

Benefits are payable for services and supplies that are medically or psychologically necessary for the treatment of mental disorders when:

2.1 The services are rendered by persons who meet the criteria of 32 CFR 199.6 for their respective disciplines (whether the person is an individual professional provider or is employed by another authorized provider), and

2.2 The mental disorder is one of those listed in the current edition of the **Diagnostic and Statistical Manual of Mental Disorders** (DSM) and is of a severity not only to cause the patient distress but also to interfere with the patient's ability to carry out his or her usual activities.

3.0 POLICY CONSIDERATIONS

3.1 Professional and Institutional Providers of Mental Health Services

3.1.1 List of authorized providers. Only the types of providers listed below are considered qualified providers of mental health services. The person providing the care must meet the criteria of 32 CFR 199.6, whether that person is an individual, professional provider or is employed by another authorized provider.

- Psychiatrists and other physicians;
- Clinical psychologists;
- Certified psychiatric nurse specialists (CPNSs);
- Clinical social workers (CSWs);
- Certified marriage and family therapists;
- Pastoral counselors; and
- Mental health counselors

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3.1.2 Professional staff of institutions providing mental health services. For those types of institutional providers that are certified by TRICARE Management Activity (TMA), reviewers may assume that all professional staff meet regulatory criteria. Any evidence to the contrary is to be brought to the attention of TMA Special Contract Operations Office (SCOO), immediately. Contractors shall notify institutional providers within their jurisdictions that payment is authorized only for professional services provided by employees meeting the program requirements. In any situation where the contractor obtains evidence that an institution is billing for professional services of unqualified staff, the case is to be submitted to the TMA Office of Program Integrity (PI).

3.2 Review of Claims for Treatment of Mental Disorders

All claims for treatment of mental disorders are subject to review in accordance with claims processing procedures contained in the TRICARE Operations Manual (TOM).

3.2.1 Psychotropic drugs. All patients receiving psychotropic drugs must be under the care of a qualified mental health provider authorized by state licensure to prescribe drugs. That provider need not be the attending provider, but there must be evidence in the treatment plan of coordination between the various providers.

3.2.2 Electroconvulsive treatment (CPT[2] procedure codes 90870 and 90871). Electroconvulsive treatment is covered when medically or psychologically appropriate and when rendered by qualified providers. However, the use of electric shock as negative reinforcement (aversion therapy) is excluded.

3.2.3 Ancillary therapies (no code, as separate reimbursement is not permitted). Includes art, music, dance, occupational, and other ancillary therapies, when included by the attending provider in an approved inpatient treatment plan and under the clinical supervision of a licensed doctoral level mental health professional. These ancillary therapies are not separately reimbursed professional services but are included within the institutional reimbursement.

3.2.4 Services by non-medical providers. With the exception of pastoral counselors, and mental health counselors, approved categories of non-medical providers may render covered services independent of physician referral and supervision. All providers, however, are expected to consult with, or refer patients to, a physician for evaluation and treatment of physical conditions that may co-exist with or contribute to a mental disorder. Failure to do so will result in denial of the non-physician provider's services on quality-of-care grounds. Questionable cases will be referred to peer review.

3.3 The first eight outpatient mental health visits per beneficiary in a fiscal year require no Primary Care Manager (PCM) or Health Care Finder (HCF) referral, nor is a preauthorization required (see Chapter 1, Section 8.1 and the TOM, Chapter 7, Section 2). This applies to outpatient mental health visits identified by CPT[2] codes 90801 - 90857 for services provided through December 31, 2012; and, CPT[2] codes 90791 - 90853 for services provided on or after January 1, 2013.

4.0 EXCLUSIONS

4.1 Sexual dysfunctions, paraphilias, and gender identity disorders.

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4.2 Drug maintenance programs when one addictive drug is substituted for another on a maintenance basis.

4.3 Specific developmental disorders.

4.4 Microcurrent Electrical Therapy (MET), Cranial Electrotherapy Stimulation (CES), or any therapy that uses the non-invasive application of low levels of microcurrent stimulation to the head by means of external electrodes for the treatment of anxiety, depression or insomnia, and electrical stimulation devices used to apply this therapy.

4.5 Transcranial Magnetic Stimulation (TMS) (also referred to as repetitive TMS (rTMS)) for the treatment of major depressive disorder (CPT[3] procedure codes 90867 and 90868), is unproven.

5.0 EFFECTIVE DATE

November 13, 1984.

- END -

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Chapter 7 Section 3.13

Psychotherapy

Issue Date: December 5, 1984
Authority: 32 CFR 199.4(c)(3)(ix)

1.0 CPT[1] PROCEDURE CODE RANGES

90804 - 90857 for care provided through December 31, 2012.
90832 - 90853 for care provided on or after January 1, 2013.

2.0 DESCRIPTION

Psychotherapy is the treatment for mental illness and behavioral disturbances in which the clinician establishes a professional contact with the patient and, through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development.

3.0 POLICY

3.1 Benefits are available for inpatient and outpatient psychotherapy that is medically or psychologically necessary to treat a covered mental disorder.

3.2 Individual psychotherapy for patients with a mental disorder (**Diagnostic and Statistical Manual of Mental Disorders** (DSM)) that coexists with an alcohol and other drug abuse disorder is a covered benefit.

3.3 Charges for outpatient psychotherapy are not covered when the patient is an inpatient in an institution. Claims for outpatient psychotherapy must be denied for the entire period during which the beneficiary is an inpatient in the institution.

3.4 Employees of institutional providers are not authorized to bill for services rendered as part of that employment. Such services billed by the employee must be denied.

3.5 Eye Movement Desensitization and Reprocessing (EMDR) is covered for the treatment of Post-Traumatic Stress Disorder (PTSD) in adults.

3.6 Psychotherapy is not a Health and Behavior Assessment/Intervention. See Section 16.2.

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4.0 POLICY CONSIDERATIONS

4.1 Maximum duration of psychotherapy sessions for care provided through December 31, 2012:

4.1.1 Inpatient or outpatient individual psychotherapy (CPT[2] procedure codes 90806, 90807, 90818, 90819) approximately 45 to 50 minutes; or (CPT[2] procedure codes 90804, 90805, 90816, 90817) approximately 20 to 30 minutes.

4.1.2 Inpatient or outpatient group, conjoint or family psychotherapy: 90 minutes (CPT[2] procedure codes):

90846 - FAMILY PSYTX W/O PATIENT
90847 - FAMILY PSYTX W/ PATIENT
90849 - MULTIPLE FAMILY GROUP PSYTX
90853 - GROUP PSYCHOTHERAPY

4.1.3 Crisis intervention (CPT[2] procedure codes):

90808 - PSYTX, OFFICE, 75-80 MIN
90809 - PSYTX, OFF, 75-80, W/E&M
90821 - PSYTX, HOSP, 75-80 MIN
90822 - PSYTX, HOSP, 75-80 MIN W/E&M

4.2 Maximum duration of psychotherapy sessions for care provided on or after January 1, 2013:

4.2.1 Inpatient or outpatient individual psychotherapy: 30 minutes (CPT[2] procedure codes 90832 and 90833); 45 minutes (CPT[2] procedure codes 90834 and 90836); or 60 minutes (CPT[2] procedure codes 90837 and 90838).

4.2.2 Inpatient or outpatient group, conjoint or family psychotherapy (CPT[2] procedure codes):

90846 - FAMILY PSYTX W/O PATIENT
90847 - FAMILY PSYTX W/ PATIENT
90849 - MULTIPLE FAMILY GROUP PSYTX
90853 - GROUP PSYCHOTHERAPY

4.2.3 Crisis intervention (CPT[2] procedure codes):

90839 - PSYTX FOR CRISIS, FIRST 60 MIN
90840 - PSYTX FOR CRISIS, EACH ADDL 30 MIN

4.3 Frequency of psychotherapy sessions.

Note: Beginning October 1, 1993, the mental health benefit year is changed from a calendar year to fiscal year. A patient is not automatically entitled to a designated number of sessions, and review can be more frequent when determined necessary.

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4.3.1 The frequency limitations on outpatient psychotherapy apply to any psychotherapy performed on an outpatient basis, whether by an individual professional provider or by staff members of an institutional provider.

4.3.2 Treatment sessions may not be combined, i.e., 30 minutes on one day added to 20 minutes on another day and counted as one session, to allow reimbursement and circumvent the frequency limitation criteria.

4.3.3 Multiple sessions the same day: If the multiple sessions are of the same type--two individual psychotherapy sessions or two group therapy sessions--payment may be made only if the circumstances represent crisis intervention and only according to the restrictions applicable to crisis intervention. A collateral session not involving the identified patient on the same day the patient receives a therapy session does not require review.

4.3.4 Collateral visits (CPT[3] procedure code 90887). Collateral visits are payable when medically or psychologically necessary for treatment of the identified patient. A collateral visit is considered to be a psychotherapy session for purposes of reviewing the duration or frequency of psychotherapy.

4.3.5 Psychoanalysis (CPT[3] procedure code 90845). Psychoanalysis is covered when provided by a graduate or candidate of a psychoanalytic training institution recognized by the American Psychoanalytic Association and when preauthorized by the contractor.

4.3.6 Play therapy. Play therapy is a form of individual psychotherapy which is utilized in the diagnosis and treatment of children with psychiatric disorders. Play therapy is a benefit, subject to the regular points of review and frequency limitations applicable to individual psychotherapy.

4.3.7 Marathon therapy. Marathon therapy is a form of group therapy in which the therapy sessions last for an extended period of time, usually one or more days. Marathon therapy is not covered since it is not medically necessary or appropriate.

4.3.8 Inpatient psychotherapy and medical care. The allowable charge for inpatient psychotherapy includes medical management of the patient. A separate charge for hospital visits rendered by the provider on the same day as he/she is rendering psychotherapy is not covered. Payment is authorized only for medically necessary hospital visits billed on a day that psychotherapy was not rendered. If the provider who is primarily responsible for treatment of the mental disorder is not a physician, charges for medical management services by a physician are coverable, but only if the physician is rendering services that the non-physician provider is prohibited from providing. Concurrent inpatient care by providers of the same or different disciplines is covered only if second or third level review determines that the patient's condition requires the skills of multiple providers.

4.3.9 Physical examination. A physical examination is an essential component of the work up of the psychiatric patient, and for all admissions should be performed either by the attending psychiatrist or by another physician. The examination may lead to confirmation of a known psychiatric diagnosis or consideration of other unsuspected psychiatric or medical illness. When not performed by the attending psychiatrist, payment may be made to another physician for

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performance of the initial physical examination. Any additional concurrent care provided by a physician other than the attending psychiatrist may be covered only if it meets the criteria under inpatient concurrent care.

5.0 EFFECTIVE DATES

5.1 November 13, 1984.

5.2 April 16, 2007, for EMDR for the treatment of PTSD in adults.

- END -

Chapter 7 Section 22.1

Telemental Health (TMH)/Telemedicine

Issue Date: April 17, 2003
Authority: 32 CFR 199.4 and 32 CFR 199.14

1.0 DESCRIPTION

1.1 Telemedicine and Telemental Health (TMH) utilize information and telecommunications technology to transfer medical information for diagnosis, therapy and education. The information may include medical images, live two-way audio and video (e.g., video-conferencing), electronic patient medical records, output data from medical devices and sound files. The telemedical interaction may involve two-way live audio and video visits between patients at the "originating site" and medical professionals at the "distant site." Telemental Health is not a substitute for face-to-face behavioral health care and should be considered as the service delivery mode of choice in those instances in which behavioral health care is difficult to access or where continuity of care is critical (for example, when face-to-face care is no longer possible and continuity with the provider is critical in ensuring health maintenance for the beneficiary).

1.2 Generally, two different kinds of technology are in use in telemedicine. One technology is a two-way interactive video. This technology is used, for example, when a consultation involving the patient and a specialist is necessary. The videoconferencing equipment or an interactive telecommunication system at two locations permits a "real-time" or "live" service or consultation to take place.

1.3 The other technology, called "store and forward," is used to transfer video images from one location to another. A camera or similar device records (stores) an image(s) that is then sent (forwarded) via telecommunications media to another location for later viewing. The sending of x-rays, computed tomography scans, or magnetic resonance images are common store-and forward applications. The original image may be recorded and/or forwarded in digital or analog format and may include video "clips" such as ultrasound examinations, where the series of images that are sent may show full motion when reviewed at the receiving location.

2.0 DEFINITIONS

2.1 Interactive Telecommunications System

Interactive telecommunications systems are defined as multimedia communications equipment that includes, at a minimum, audio-video equipment permitting two-way, real time service or consultation involving the patient and practitioner as appropriate to the medical needs of the patient. Telephone services excluded by 32 CFR 199.4(g)(52) do not meet the definition of interactive telecommunications systems.

2.2 Originating Site

The originating site is the site where the beneficiary is located and must be where an otherwise authorized TRICARE provider normally offers professional medical or psychological services, such as the office of a TRICARE authorized individual professional provider (e.g., physician's office), or a TRICARE authorized institutional provider. A patient's home is not an originating site.

2.3 Distant Site

The term "distant site" means the site where the physician or practitioner, providing the professional service, is located at the time the service is provided via a telecommunications system.

2.4 Telepresenter

2.4.1 Telemedicine. An individual with a clinical background (e.g., Licensed Practical Nurse (LPN), Registered Nurse (RN), etc.) trained in the use of the equipment who is available at the originating site to "present" the patient, manage the cameras and perform any "hands-on" activities to successfully complete the exam. For example, a neurological diagnostic exam usually requires a nurse capable of testing a patient's reflexes and other manipulative activities.

2.4.2 TMH. Most behavioral health encounters do not require a physical examination by a provider. Therefore, for the provision of TMH, an individual with or without a clinical background (e.g., TRICARE authorized medical or behavioral health provider) who is trained in the use of the equipment and who is available at the originating site to "present" the patient, manage the equipment and perform any "hands-on" activities to successfully complete the clinical encounter, may be utilized. The need for a telepresenter with a clinical background is determined by the provider referring the beneficiary to TMH (for an initial TMH encounter) or by the provider delivering TMH care. When TMH care is provided without prior referral or authorization, the TMH provider will determine during the initial encounter whether the individual is appropriate for TMH care and if a telepresenter with a clinical background is necessary.

3.0 POLICY

3.1 TMH

3.1.1 Scope of Coverage. The use of interactive audio/video technology may be used to provide clinical consultation, office visits, individual psychotherapy, psychiatric diagnostic interview examination, and pharmacologic management when appropriate and medically necessary. These services and corresponding Current Procedure Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes are listed below:

3.1.1.1 For care provided through December 31, 2012:

- Individual psychotherapy (CPT[1] procedure codes 90804 - 90809)
- Psychiatric diagnostic interview examination (CPT[1] procedure code 90801)
- Pharmacologic management (CPT[1] procedure code 90862)

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3.1.1.2 For care provided on or after January 1, 2013:

- Individual psychotherapy (CPT[2] procedure codes 90832 - 90838)
- Psychiatric diagnostic examination (CPT[2] procedure codes 90791 and 90792)
- Pharmacologic management (add-on CPT[2] procedure code 90863)

3.1.2 Technical Requirements. A provider of TMH services shall have video technology components meeting or exceeding American Telemedicine Association (ATA) Standards as outlined in their most current applicable consensus standards and guidelines for TMH, but at a minimum as follows:

3.1.2.1 A minimum bandwidth of 384 kbps (H.263), 256 kbps (H.264), or technical equivalent.

3.1.2.2 A monitor with a:

- Minimum net display of 16 inches diagonally; and
- Non-anamorphic video picture display.

3.1.2.3 A minimum video resolution of one Common Intermediate Format (CIF), or one Source Input Format (SIF).

3.1.2.4 Security. All internet protocol sessions shall be encrypted unless they are conducted entirely on a protected network, or using a virtual private network connection.

3.1.2.5 No later than July 1, 2010, originating sites with more than 50 visits per calendar year shall have cameras with pan, tilt, and zoom capabilities that can be remotely controlled from the distant site.

3.1.3 Current TRICARE rules regarding mental health (e.g., preauthorizations) shall apply to TMH services.

3.2 Telemedicine Procedures

The use of interactive audio/video technology may be used to provide clinical consultations and office visits when appropriate and medically necessary. These services and corresponding CPT or HCPCS codes are listed below:

- Consultations (CPT[2] procedure codes 99241 - 99255)
- Office or other outpatient visits (CPT[2] procedure codes 99201 - 99215)
- End Stage Renal Disease (ESRD) related services (HCPCS codes G0308, G0309, G0311, G0312, G0314, G0315, G0317, and G0318)

3.3 TMH and Telemedicine

3.3.1 Requirements

Requirements, criteria, and limitations applicable to medical and psychological services

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shall also apply to services involving TMH/telemedicine health.

3.3.2 Providers

3.3.2.1 TRICARE authorized providers rendering TMH/telemedicine services are required to be practicing within the scope and jurisdiction of their license or certifications. Otherwise authorized TRICARE providers must be licensed under all applicable licensing requirements of the state(s) in which services are provided and or received.

3.3.2.2 The provider is responsible for ensuring correct TMH/telemedicine licensure. Violation of state licensure laws may have serious consequences for both the consulting health care providers, as well as the referring provider.

3.3.2.3 Providers shall ensure that appropriate staff are available to meet patient needs before, during, and after TMH encounters.

3.3.3 Conditions of Payment

3.3.3.1 For TRICARE payment to occur, interactive audio and video telecommunications must be used, permitting real-time communication between the TRICARE authorized provider distant site and the TRICARE beneficiary.

3.3.3.2 As a condition of payment, the patient must be present and participating in the TMH/telemedicine visit.

Note: A TMH/telemedicine service originating from a patient's home is not covered.

3.3.4 "Store and Forward" Technology

TRICARE allows payment for those telemedicine applications (such as teleradiology or telepathology) in which, under conventional health care delivery, the medical service does not require face-to-face "hands-on" contact between patient and physician. For example, TRICARE permits coverage of teleradiology, which is the most widely used and reimbursed form of telemedicine, as well as physician interpretation of electrocardiogram and electroencephalogram readings that are transmitted electronically.

3.3.5 ATA Guidelines

In addition to requirements in this Section, TMH shall be delivered according to the requirements as directed in documents representing the most current applicable consensus standards and guidelines for TMH published by the ATA. It is the provider's responsibility to ensure compliance with the ATA guidelines. The policy stated in this section of the TPM has priority over any standard stated in the ATA guidelines. In the event of conflict between the two, the TPM shall be followed.

3.3.6 Reimbursement for TMH/Telemedicine

3.3.6.1 Distant Site

3.3.6.1.1 The payment amount for the professional service provided via a telecommunication system by a TRICARE authorized provider at the distant site is the lower of the CHAMPUS Maximum Allowable Charge (CMAC), the billed charge, or the negotiated rate, for the service provided. Payment for an office visit, consultation, individual psychotherapy or pharmacologic management via a telecommunications system should be made at the same amount as when these services are furnished without the use of a telecommunications system.

3.3.6.1.2 For TRICARE payment to occur, the provider must be a TRICARE authorized provider and the service must be within a provider's scope of practice under all applicable state(s) law(s) in which services are provided and or received.

3.3.6.1.3 The beneficiary is responsible for any applicable copay or cost-sharing. The copayment amount shall be the same as if the service was without the use of a telecommunications system.

3.3.6.2 Originating Site Facility

3.3.6.2.1 For covered TMH/telemedicine services delivered via a telecommunications system, the payment for the originating site facility fee (Q3014) will be the lesser of the originating site fee or the actual charge. The facility fee for the originating site for 2009 is $23.72. It will be updated annually by the Medicare Economic Index (MEI). Annual updates of the originating site facility fee (Q3014) will be included in the annual updates of the CMAC file and TRICARE contractors will implement these updates in accordance with the annual CMAC updates.

3.3.6.2.2 Outpatient cost-share rules will apply to this fee.

3.3.6.2.3 For reporting TMH/telemedicine services, contractors will use CPT or HCPCS codes with a **GT** modifier for distant site and Q3014 for originating site to distinguish telemedicine services. By coding and billing the **GT** modifier with a covered telemedicine procedure code, the distant site provider certifies that the beneficiary was present at an eligible originating site when the TMH/telemedicine service was furnished.

3.3.6.2.4 Payment is made only when the originating site is an otherwise authorized TRICARE provider normally offers professional medical or psychological services. No payment shall be made when the originating site does not satisfy this requirement (e.g., no payment shall be made when the originating site is the beneficiary's home).

3.4 EFFECTIVE DATE

August 1, 2003.

- END -