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TRICARE
MANAGEMENT ACTIVITY

MB&RB

CHANGE 154
6010.54-M
MARCH 15, 2012

PUBLICATIONS SYSTEM CHANGE TRANSMITTAL FOR TRICARE POLICY MANUAL (TPM), AUGUST 2002

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

CHANGE TITLE: **COMBINED CODING AND CLARIFICATION UPDATES - 2011**

CONREQ: 15442

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): See pages 3 and 4.

EFFECTIVE AND IMPLEMENTATION DATE: As indicated, otherwise upon direction of the Contracting Officer.

This change is made in conjunction with Aug 2002 TRM, Change No. 146.

Ann N. Fazzini

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Chief, Medical Benefits and Reimbursement Branch

ATTACHMENT(S): **23 PAGE(S)**
DISTRIBUTION: **6010.54-M**

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

CHANGE 154
6010.54-M
MARCH 15, 2012

REMOVE PAGE(S)	INSERT PAGE(S)
CHAPTER 1	
Section 1.1, pages 1 and 2	Section 1.1, pages 1 and 2
Section 17.1, pages 1 and 2	Section 17.1, pages 1 and 2
CHAPTER 5	
Section 1.1, pages 1, 2, 5, 6	Section 1.1, pages 1, 2, 5, 6
CHAPTER 7	
Section 2.1, pages 1 and 2	Section 2.1, pages 1 and 2
Section 2.2, pages 5 - 9	Section 2.2, pages 5 - 9
Section 2.5, pages 3 and 4	Section 2.5, pages 3 and 4
CHAPTER 8	
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CHAPTER 9	
Section 17.1, pages 1 and 2	Section 17.1, pages 1 and 2
Addendum A, page 1	Addendum A, page 1
CHAPTER 11	
Section 3.7, page 1	Section 3.7, page 1

SUMMARY OF CHANGES

CHAPTER 1

1. Section 1.1. Added services or supplies provided by a sponsor or beneficiary, member of the beneficiary's or sponsor's immediate family to the Exclusions list (cannot self-prescribe).

2. Section 17.1.

   a. Removes HCPCS Codes S3818, S3819, S3820, S3822, and S3823 as these are not reimbursable under TRICARE.

   b. Adds HCPCS Code S8999 for reimbursement of a resuscitation bag for use by the patient on artificial respiration during power failure or other catastrophic event.

CHAPTER 5

3. Section 1.1. Revised Radiology (Diagnostic Imaging) CPT procedure codes. Changed CPT procedure code range from 73000 - 76083, 76086 - 76394, 76400, 76496 - 76499 to 73000 - 76499. Added 77071 - 77084. Removed outdated codes 76070 - 76078, and added 77078 - 77084 to bone density studies.

CHAPTER 7

4. Section 2.1. Added HPV DNA procedure codes 87620 - 87622 to the CPT procedure code range.

5. Section 2.2.

   a. Corrects clerical errors in text under Colorectal Cancer.

   b. Adds CPT codes 92585 and 92586 and revised language under Hearing Screenings.

6. Section 2.5. Modifies language to be consistent with language in Chapter 7, Section 2.2, under Hearing Screenings.

CHAPTER 8

7. Section 7.1. Clarification to remove the phrase "which require enteral tube feedings." This change will reduce confusion about the nutrition policy to clarify that oral nutrition therapy is allowed when medically necessary and policy is met.

SUMMARY OF CHANGES (Continued)

CHAPTER 9

8. Section 17.1. Corrects titles to make consistent with the TRICARE Operations Manual.

9. Addendum A. Corrects the footnotes in the table, changing Santa Cruz to Santa Clara nad changing Massachusetts to Alaska.

CHAPTER 11

10. Section 3.7. Clarifies credentialing requirements for clinical psychologists to mirror those in 32 CFR 199.6(c)(3)(iii)(A).

CHAPTER 1
SECTION 1.1

EXCLUSIONS

ISSUE DATE: June 1, 1999
AUTHORITY: 32 CFR 199.4(g)

I. POLICY

A. In addition to any definitions, requirements, conditions, or limitations enumerated and described in other sections of this manual, the following specifically are excluded:

1. Services and supplies that are not medically or psychologically necessary for the diagnosis or treatment of a covered illness (including mental disorder) or injury or for the diagnosis and treatment of pregnancy or well-baby care.

2. X-ray, laboratory, and pathological services and machine diagnostic tests not related to a specific illness or injury or a definitive set of symptoms except for cancer screening mammography, cancer screening papanicolaou (PAP) tests and other tests allowed under the Preventive Services policy. (See Chapter 7, Section 2.1; Chapter 7, Section 2.2; and Chapter 12, Section 8.1.)

3. Services and supplies related to inpatient stays in hospitals or other authorized institutions above the appropriate level required to provide necessary medical care.

4. Services and supplies related to an inpatient admission primarily to perform diagnostic tests, examinations, and procedures that could have been and are performed routinely on an outpatient basis.

NOTE: If it is determined that the diagnostic x-ray, laboratory, and pathological services and machine tests performed during such admission were medically necessary and would have been covered if performed on an outpatient basis, benefits may be extended for such diagnostic procedures only, but cost-sharing will be computed as if performed on an outpatient basis.

5. Postpartum inpatient stay of a mother for purposes of staying with the newborn infant (usually primarily for the purpose of breast feeding the infant) when the infant (but not the mother) requires the extended stay; or continued inpatient stay of a newborn infant primarily for purposes of remaining with the mother when the mother (but not the newborn infant) requires extended postpartum inpatient stay.

6. Therapeutic absences from an inpatient facility, except when such absences are specifically included in a treatment plan approved by TRICARE.

7. Custodial care. The term "custodial care", as defined in 32 CFR 199.2, means treatment or services, regardless of who recommends such treatment or services or where such treatment or services are provided, that (a) can be rendered safely and reasonably by a person who is not medically skilled; or (b) is or are designed mainly to help the patient with the activities of daily living, also known as "essentials of daily living" as defined in 32 CFR 199.2.

8. Domiciliary care. The term "domiciliary care", as defined in 32 CFR 199.2, means care provided to a patient in an institution or homelike environment because--(a) providing support for the activities of daily living in the home is not available or is unsuitable; or (b) members of the patient's family are unwilling to provide the care.

9. Inpatient stays primarily for rest or rest cures.

10. Costs of services and supplies to the extent amounts billed are over the allowed cost or charge.

11. Services or supplies for which the beneficiary or sponsor has no legal obligation to pay; or for which no charge would be made if the beneficiary or sponsor was not eligible under TRICARE; or whenever TRICARE is a secondary payer for claims subject to the DRG-based payment system, amounts, when combined with the primary payment, which would be in excess of charges (or the amount the provider is obligated to accept as payment in full, if it is less than the charges).

12. Services or supplies furnished without charge.

13. Services and supplies paid for, or eligible for payment, directly or indirectly by a local, state, or Federal Government, except as provided under TRICARE, or by government hospitals serving the general public, or medical care provided by a Uniformed Service medical care facility, or benefits provided under title XIX of the Social Security Act (Medicaid).

NOTE: This exclusion applies to services and items provided in accordance with beneficiary's Individualized Family Service Plan (IFSP) as required by Part C of the Individuals with Disabilities Education Act, and which are otherwise eligible under the TRICARE Basic Program or the Extended Care Health Option (ECHO) but determined not to be "medically or psychologically necessary" as that term is defined within 32 CFR 199.2.

14. Services and supplies provided as a part of or under a scientific or medical study, grant, or research program.

15. Unproven drugs, devices, and medical treatments or procedures (see Chapter 1, Section 2.1).

16. Services or supplies provided or prescribed by a sponsor or beneficiary, member of the beneficiary's or sponsor's immediate family, or person living in the beneficiary's or sponsor's household.

CHAPTER 1
SECTION 17.1

HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS) "C" AND "S" CODES

ISSUE DATE: November 6, 2007
AUTHORITY:

I. HCPCS "C" AND "S" CODES

C1000 - C9999; S0000 - S9999

II. DESCRIPTION

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

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

III. POLICY

A. 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 II.B.

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

1. S9122, S9123, and S9124 for the ECHO respite care benefit and the ECHO Home Health Care (EHHC) benefit; and

2. S0812, S1030, S1031, S1040, S2066, S2067, S2068, S2075, S2076, S2077, S2083, S2202, S2235, S2325, S2360, S2361, S2401, S2402, S2403, S2405, S2411, S3620, S8030, S8185, S8265, S8270, and S9430 for all beneficiaries; and

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 20, Section 9).

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

5. S0189 for testerone pellets as provided in Chapter 4, Section 5.1.

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

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

IV. EXCLUSIONS

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

- END -

CHAPTER 5
SECTION 1.1

DIAGNOSTIC RADIOLOGY (DIAGNOSTIC IMAGING)

ISSUE DATE: March 7, 1986
AUTHORITY: 32 CFR 199.4(a), (b), (c), and (e)(14) and 32 CFR 199.6(d)(2)

I. CPT[1] PROCEDURE CODES

70010 - 72292, 73000 - 76499, 77071 - 77084, 95965 - 95967

II. HCPCS PROCEDURE CODES

G0204, G0206

III. DESCRIPTION

Radiology is the science that deals with the use of radiant energy, such as X-rays, radium, and radioactive isotopes, in the diagnosis and treatment of disease. Radiology is an important diagnostic tool useful for the evaluation. The techniques used for diagnostic radiology are as follows:

A. Magnetic Resonance Imaging (MRI), formerly also referred to as Nuclear Magnetic Resonance (NMR), is a non-invasive method of graphically representing the distribution of water and other hydrogen-rich molecules in the human body. MRI uses radio frequency radiation in the presence of a carefully controlled magnetic field to produce high quality cross-sectional images of the head and body in any plane. These tomographic images represent the tissue being analyzed and the environment surrounding it. MRI has become a useful diagnostic imaging modality that is capable of demonstrating a wide variety of soft-tissue lesions with contrast resolution equal or superior to Computerized Tomography (CT) scanning in various parts of the body. Among the advantages of MRI are the absence of ionizing radiation and the ability to achieve high levels of tissue contrast resolution without injected iodinated contrast agents.

B. Magnetic Resonance Angiography (MRA) techniques generate contrast between flowing blood and surrounding tissue, and provide anatomic images that can be provided in a format similar to that of conventional x-ray angiography, and can also provide physiologic information.

C. A Computerized Tomography (CT)/Computerized Axial Tomography (CAT) scan is interchangeably referred to as either a CT or CAT scan. This diagnostic test uses x-ray

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technology to create three-dimensional, computerized images of internal organs. However, unlike a traditional x-ray, CT/CAT scans are able to distinguish between obscured and overlapping parts of the body. CAT scans are also capable of producing images of several different internal components, including soft tissue, blood vessels and bones.

IV. POLICY

A. MRI and MRI with contrast media are covered when medically necessary, appropriate, and the standard of care. (CPT[2] procedure codes 70336, 70540-70543, 70551-70553, 71550-71552, 72141-72158, 72195-72197, 73218-73223, 73718-73723, 74181-74183, 75552-75556, and 76400.)

B. Breast MRI (CPT[2] procedure codes 77058 and 77059) is covered for the following indications. This list of indications is not all inclusive. Other indications may be covered when documented by reliable evidence as safe, effective, and comparable to conventional technology (proven):

1. To detect breast implant rupture (the implantation of the breast implants must have been covered by TRICARE).

2. For detection of occult breast cancer in the setting of axillary nodal adenocarcinoma with negative physical exam and negative mammography.

3. For presurgical planning for locally advanced breast cancer before and after completion of neoadjuvant chemotherapy, to permit tumor localization and characterization.

4. For presurgical planning to evaluate the presence of multicentric disease in patients with localized or advanced breast cancer who are candidates for breast conservation treatment.

5. Evaluation of suspected cancer recurrence.

6. To determine the presence of pectoralis major muscle/chest wall invasion in patients with posteriorly located tumor.

7. For guidance of interventional procedures such a vacuum assisted biopsy and preoperative wire localization for lesions that are occult on mammography or sonography and are demonstrable only with MRI.

NOTE: For policy on breast MRI to screen for breast cancer in high risk women, see Chapter 7, Sections 2.1 and 2.2.

C. Open MRI and Open MRI with contrast media are covered when medically necessary, appropriate, and the standard of care.

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J. Diagnostic mammography (CPT[5] procedure codes 76090-76092/HCPCS codes G0204-G0207) to further define breast abnormalities or other problems is covered.

K. 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.

L. Bone density studies (CPT[5] procedure codes 77078 - 77084) are covered for the following:

1. The diagnosis and monitoring of osteoporosis.

2. The diagnosis and monitoring of osteopenia.

3. Patients must present with signs and symptoms of bone disease or be considered at high-risk for developing osteoporosis. High-risk factors which have been identified as the standard of care by the American College of Obstetricians and Gynecologists (ACOG) include:

a. Women who are estrogen-deficient and at clinical risk for osteoporosis. Naturally or surgically post-menopausal women who have not been on **long-term** Hormone Replacement Therapy (HRT). However, **current** use of HRT does not preclude estrogen deficiency.

b. Individuals who have vertebral abnormalities.

c. Individuals receiving long-term glucocorticoid (steroid) therapy.

d. Individuals with primary hyperparathyroidism.

e. Individuals with positive family history of osteoporosis.

f. Any other high-risk factor identified by ACOG as the standard of care.

M. Radiological supervision and interpretation, percutaneous vertebroplasty or vertebral augmentation including cavity creation, per vertebral body; under fluoroscopic guidance (CPT[5] procedure code 72291) or under CT guidance (CPT[5] procedure code 72292) is covered.

N. Multislice or multidetector row CT angiography (CT, heart) (CPT[5] codes 75571 - 75574) is covered for the following indications:

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.

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.

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

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).

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

b. Exercise stress test is unable to be performed or is equivocal; AND

c. 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:

(1) Exercise stress echocardiography.

(2) Exercise stress echo with dobutamine.

(3) Exercise myocardial perfusion (SPECT).

(4) Pharmacologic myocardial perfusion (SPECT).

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

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

7. Presurgical evaluation prior to biventricular pacemaker placement.

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

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

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

V. EXCLUSIONS

A. Bone density studies for the routine screening of osteoporosis.

CHAPTER 7
SECTION 2.1

CLINICAL PREVENTIVE SERVICES - TRICARE STANDARD

ISSUE DATE: April 19, 1983
AUTHORITY: 32 CFR 199.4(e)(3)(ii) and (g)(37)

I. CPT[1] PROCEDURE CODES

45300 - 45339, 45355 - 45385, 77052, 77057 - 77059, 80061, 82270, 82274, 84153, 86580, 86762, 87340, 87620 - 87622, 88141 - 88155, 88160 - 88162, 88164 - 88167, 88174, 88175, 90281 - 90396, 99172, 99173, 99201 - 99215, 99381 - 99387, 99391 - 99397

II. HCPCS AND TEMPORARY PROCEDURE CODES

A. Level II Codes G0008 - G0010, G0101 - G0105, G0121, G0202

B. Level III Codes 0066T, 0067T - Specific criteria must be met for coverage of these codes. See paragraph IV.A.1.c.(5) for coverage criteria.

III. BACKGROUND

A. The National Defense Authorization Act for Fiscal Year (NDAA FY) 1996 (Public Law 104-106, Section 701) signed into effect on February 10, 1996, expands well-baby visits and immunizations to family members under the age of six and establishes immunizations and comprehensive preventive benefits for family members age six and above to include health promotion and disease preventive visits provided in connection with immunizations, Papanicolaou (Pap) smears, and mammograms. The NDAA FY 1997 (Public Law 104-201, Section 701) signed into effect on September 23, 1996, further expands health care preventive services for colon and prostate cancer examinations. Periodic health examinations that include risk assessment, physical examination, laboratory tests, x-rays, and risk specific counseling will allow for the prevention, early detection and treatment of diseases before they manifest themselves as major health problems. Prior to these Acts, preventive services were quite limited. In addition to Pap smears, mammograms, and well-baby care up to the age of two, the only related services authorized under Extra and Standard plans in the absence of symptoms were immunizations for family members accompanying an active duty member on overseas duty. The expanded preventive services will generally be reflective of those currently being offered to Prime enrollees under the Uniform Health Maintenance Organization (HMO) Benefit (see 32 CFR 199.18(b)(2)). The NDAA FY 2009 (Public Law 110-417, Section 711) signed into effect October 14, 2008, waives copayment requirements for certain TRICARE beneficiaries for those preventive services as described in the TRICARE

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Reimbursement (TRM), Chapter 2, Section 1, paragraph I.C.3.j. and paragraph I.D.3. Appropriate cost-sharing and deductibles will apply for all other preventive services under Extra and Standard plans.

B. While immunizations are provided as a specific exception to the general preventive care exclusion under the Regulation (32 CFR 199.4(g)(37)) and can be provided independently of other preventive services for those age six and older, the other expanded services (i.e., preventive services reflective of those currently being offered to Prime enrollees under Uniform HMO Benefit) must be provided in connection with immunizations, Pap smears, mammograms, and other cancer screening authorized by 10 U.S.C. 1079. For example, if a eligible female goes in for a routine Pap smear, she is also eligible to receive a wide variety of other preventive services such as Tuberculosis (TB) screening, rubella antibody screening, blood pressure screening, cholesterol screening test and preventive counseling services, to name a few. However, the same coverage will not be extended if she simply makes an appointment for a routine health promotion visit, where one or more of the associated preventive services (i.e., Pap smear, mammogram, immunization and/or other cancer screening authorized by 10 U.S.C. 1079) are not performed.

C. Preventive physical examinations (for example, oral cavity examinations for pharyngeal cancer, palpation for thyroid nodules, skin cancer screening, and examinations for testicular cancer) are paid under the same comprehensive health promotion and disease prevention examination office visit code (CPT[2] procedure codes 99381-99387 and 99391-99397) as the associated Pap smear, mammogram, immunization or other cancer screening examination authorized by 10 U.S.C. 1079. In other words, these additional physical examinations are being performed during the same office visit as required to perform the associated Pap smear, mammogram, immunization or other cancer screening authorized by 10 U.S.C. 1079.

IV. POLICY

Preventive care is not directly related to specific illness, injury, a definitive set of symptoms, or obstetrical care, but rather is performed as a periodic health screening, health assessment, or periodic health maintenance. The following services may be provided during acute and chronic care visits or during preventive care visits for asymptomatic individuals to maintain and promote good health:

A. Health Promotion and Disease Prevention Examinations. The following prevention services are specific exceptions to the general preventive care exclusion under the Regulation. The contractor shall apply all appropriate claims processing and rebundling edits before determining if the following preventive services are individually reimbursable.

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SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT PROCEDURE CODE
Colorectal Cancer (Continued):	**Proctosigmoidoscopy or Flexible Sigmoidoscopy for Individuals at Average Risk for Colon Cancer:** Once every three to five years beginning at age 50. **Proctosigmoidoscopy or Flexible Sigmoidoscopy for Individuals at Increased or High Risk for Colon Cancer:** **Increased Risk** (Individuals with a family history): Once every five years, beginning at age 40, for individuals with a first-degree relative diagnosed with a colorectal cancer or an adenomatous polyp at age 60 or older, or two second-degree relatives diagnosed with colorectal cancer. **High Risk:** Annual flexible sigmoidoscopy, beginning at age 10 through 12, for individuals with known or suspected Familial Adenomatous Polyposis (FAP). The effective date for coverage of proctosigmoidocopy or flexible sigmoidoscopy, regardless of risk, is October 6, 1997.	CPT[1] codes 45300-45321, 45327, and 45330-45339. HCPCS code G0104.
	Optical (Conventional) Colonoscopy for Individuals at Average, Increased, or High Risk for Colon Cancer: **Average Risk**: Once every 10 years for individuals age 50 or above. The effective date for coverage of optical colonoscopy for individuals at **average risk** is March 15, 2006. **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.	

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):** **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.	CPT[1] codes 45355 and 45378-45385. HCPCS codes G0105 and G0121.
	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.	CPT[1] Level III codes 0066T or 0067T.
Skin Cancer:	**Skin Examination**: Examination of the skin 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.

SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT PROCEDURE CODE
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 CDC) using Mantoux tests.	CPT[1] codes 86580 and 86585.
	Rubella Antibodies: Test females once between the ages of 12 and 18, unless 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**: A lipid panel at least once every five years, beginning at age 18.	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: Height and weight should be measured regularly throughout infancy and childhood. Head circumference should be measured through age 24 months. For adults: Height and weight should be measured periodically. The optimal frequency is a matter of clinical discretion. Those individuals who are 20% or more above desirable weight should receive appropriate nutritional and exercise counseling.	See appropriate level evaluation and management codes.

SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT PROCEDURE CODE
Other (Continued):	**Vision Care:** Pediatric vision screening at birth and approximately six months of age to include determination of vision on visual acuity, ocular alignment and red reflex, along with external examination of ocular abnormalities. Routine eye examination once every two years for all TRICARE Prime enrollees age three and older. Diabetic patients, at any age, should have routine eye examinations at least yearly.	CPT[1] codes 92002, 92004, 92012, 92014, 92015, 99172, and 99173.
	NOTE: Routine eye examinations are meant to be more than the standard visual acuity screening test conducted by the member's primary care physician through the use of a standard Snellen wall chart. Self-referral will be allowed for routine eye examinations since PCMs are incapable of providing this service (i.e., a Prime beneficiary will be allowed to set up his or her own appointment for a routine eye examination with any network optometrist or ophthalmologist).	
	Hearing Screening: According to the American Academy of Pediatrics (AAP) and the Joint Committee on Infant Hearing (JCIH) all newborns should undergo hearing screening using evoked Otoacoustic Emissions (OAE) testing or automatic Auditory Brainstem Response (ABR) testing before one month of age; preferably, before leaving the hospital. An infant who does not pass the hearing screening should undergo appropriate audiological and medical evaluations to confirm the presence of a hearing loss at no later than three months of age. A hearing evaluation should be a part of routine examinations for all children, and those with possible hearing impairment should be referred for appropriate testing.	CPT[1] codes 92551 and 92585 - 92588.
	Pediatric Blood Lead: Assessment of risk for lead exposure by structured questionnaire based on Centers for Disease Control and Prevention (CDC) Preventing Lead Poisoning in Young Children (October 1991) during each well child visit from age six months through six years. Screening by blood lead level determination for all children at **high risk** for lead exposure per CDC guidelines.	CPT[1] code 83655.

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SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT PROCEDURE CODE
Other (Continued):	**Patient & Parent Education Counseling:** Dietary Assessment & Nutrition; Physical Activity & Exercise; Cancer Surveillance; Safe Sexual Practices; Tobacco, Alcohol and Substance Abuse; Accident & Injury Prevention; Promoting Dental Health; Stress, Bereavement, & Suicide Risk Assessment.	These are expected components of good clinical practice that are integrated into the appropriate office visit at no additional charge.
	Immunizations: Age appropriate dose of vaccines that have been recommended and adopted by the Advisory Committee on Immunization Practices (ACIP) and accepted by the Director of the CDC and the Secretary of Health and Human Services (HHS) and published in a CDC *Morbidity and Mortality Weekly Report* (MMWR). Refer to the CDC's home page (http://www.cdc.gov) for current schedule of CDC recommended vaccines for use in the United States. The effective date of coverage for immunizations recommended by the CDC is the date that the ACIP recommendations for a particular vaccine or immunization are published in CDC MMWR or October 6, 1997, whichever is later. Immunizations recommended specifically for travel outside the United States are NOT covered, EXCEPT for those required by dependents of active duty military personnel who are traveling outside the United States as a result of an active duty member's duty assignment, and such travel is being performed under orders issued by a Uniformed Service.	

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- END -

c. Sensory screening: vision, hearing (by history).

(1) Eye and vision screening by primary care provider during routine examination at birth, and approximately six months of age.

(2) According to the AAP and the Joint Committee on Infant Hearing (JCIH), all newborns should undergo hearing screening using evoked Otoacoustic Emissions (OAE) testing or automated Auditory Brainstem Response (ABR) testing before one month of age; preferably, before leaving the hospital. An infant who does not pass the hearing screening should undergo appropriate audiological and medical evaluations to confirm the presence of a hearing loss at no later lan three months of age.

(3) All children should undergo hearing screening (by history) at each well-child visit, and children with possible hearing impairments should be referred for appropriate testing.

d. Dental screenings.

e. Discussion with parents, anticipatory guidance.

G. The following specific services are covered in a program of well-child care:

1. Immunizations as indicated in paragraph IV.C.

2. Heredity and metabolic screening:

a. Two screening tests for PKU, one prior to discharge from the hospital nursery and the other within one to two weeks after hospital discharge.

b. All neonates should be screened for congenital hypothyroidism prior to discharge from the hospital nursery but not later than day six of life.

c. Screening for hemoglobinophies should be done for those in high-risk ethnic groups.

3. Tuberculin test: at 12 months of age and once during second year of age.

4. Hemoglobin or hematocrit testing: once during first year of age, once during second year of age.

5. Urinalysis: once during first year of age, once during second year of age.

6. Annual blood pressure screening for children between three and six years of age.

7. Blood lead test: (CPT[2] procedure code 83655): Assessment of risk for lead exposure by structured questionnaire based on CDC's Preventing Lead Poisoning in Young (October 1991) during each well-child visit from age six months to under six years of age.

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8. Health guidance and counseling, including breast feeding and nutrition counseling.

9. One routine eye examination by an ophthalmologist or optometrist every two years beginning at age three. The routine eye exams offered between the ages of three and six should include screening for amblyopia and strabismus.

10. Additional services or visits required because of specific findings or because the particular circumstances of the individual case are covered if medically necessary and otherwise authorized for benefits.

- END -

CHAPTER 8
SECTION 7.1

NUTRITIONAL THERAPY

ISSUE DATE: April 19, 1983
AUTHORITY: 32 CFR 199.4(a)(1)(i), (d)(3)(iii), (g)(57), and 32 CFR 199.5(c)

I. HCPCS PROCEDURE CODES

B4034 - B9999

II. DESCRIPTION

Nutritional therapy provides medically necessary nutrient intake for individuals with:

- Inborn errors of metabolism;
- Medical conditions of malabsorption;
- Pathologies of the alimentary or gastrointestinal tract; and/or
- Neurological or physiological conditions which require enteral tube feedings.

III. POLICY

A. When used as the primary source of nutrition, TRICARE may cost-share medically necessary supplies and nutritional products for:

1. Enteral nutritional therapy.

2. Parenteral nutritional therapy.

3. Oral nutritional therapy.

4. Medically necessary vitamins and minerals added to the nutritional solution.

5. Intraperitoneal Nutrition (IPN) therapy when determined to be medically necessary treatment for individuals suffering from malnutrition as a result of end stage renal disease.

6. Ketogenic diet if it is part of a medically necessary admission for epilepsy. Services and supplies will be reimbursed under the DRG payment methodology.

B. Medically necessary nutritional products which are provided under paragraph III.A. and which are on the "Enteral Nutrition Product Classification List" are eligible for TRICARE

cost-sharing. The list is maintained by Noridian Administrative Services and is currently available online at: http://www.dmepdac.com/dmecsapp/do/search.

C. Medical supplies and equipment required to provide the therapy are covered.

D. Nutritional therapy may be provided in the inpatient or outpatient setting.

IV. EXCLUSIONS

A. Food and food substitutes.

B. Vitamins or mineral preparations, except as provided in paragraph III. or by Chapter 8, Section 9.1.

C. Nutritional supplements administered solely to boost protein or caloric intake or in the absence of a medical condition for which the accepted treatment consists of or includes administration of nutritional supplements.

D. The above exclusions apply also to prenatal care.

E. For children less than one year of age who require enteral nutritional therapy, usual and customary infant formulas are excluded.

F. Except as provided in paragraph III.A.6., services and supplies related to a ketogenic diet, including nutritional counseling, calculation of a ketogenic formula, and food substitutes.

- END -

CHAPTER 9
SECTION 17.1

PROVIDERS

ISSUE DATE: August 4, 1988
AUTHORITY: 32 CFR 199.6(e)

I. POLICY

A. Services and items cost-shared through the ECHO must be rendered by TRICARE authorized providers.

B. ECHO inpatient care providers: Inpatient care providers under the ECHO must:

1. Be a not-for-profit organization which primarily provides services to the disabled, OR

2. Be a facility operated by the state or under state contract, AND

3. Meet all applicable licensing or certification requirements that are extant in the state, county, municipality, or other political jurisdiction in which the provider is located.

C. ECHO outpatient care providers. A provider of ECHO outpatient, ambulatory, or in-home services shall be:

1. An authorized provider of services as defined in 32 CFR 199.6, OR

2. An individual, corporation, foundation, or public entity that predominantly renders services of a type uniquely allowable as a ECHO benefit and not otherwise allowable as a benefit of 32 CFR 199.4, that meets all applicable licensing or other regulatory requirements that are extant in the state, county, municipality, or other political jurisdiction in which the ECHO service is rendered.

D. Individual professional providers authorized by 32 CFR 199.6 for the Basic Program are also authorized providers for the ECHO. Individual professional providers who can be authorized only under the ECHO must meet all applicable licensing and other regulatory requirements that are extant in that state, county, municipality, or other political jurisdiction in which the ECHO service is rendered, or, in the absence of such licensing or regulatory requirements, as determined by the Director, TRICARE Management Activity or designee.

E. For the purpose of services rendered in conjunction with Applied Behavioral Analysis (ABA) under the ECHO Special Education benefit (see Chapter 9, Section 9.1), TRICARE-authorized providers are those that:

1. Have a current State license to provide ABA services; or

2. Are currently State-certified as an Applied Behavioral Analyst; or

3. Where such State license or certification is not available, are certified by the Behavioral Analyst Certification Board (BACB) as either a Board Certified Behavior Analyst (BCBA) or a Board Certified Assistant Behavior Analyst (BCaBA); and

4. Otherwise meet all applicable requirements of TRICARE-authorized providers.

F. ECHO vendor. A provider of an allowable ECHO item, supply, equipment, orthotic, or device shall be deemed to be an authorized vendor for the provision of the specific item, supply, equipment, orthotic, or device when the vendor supplies such information as the Managed Care Support Contractor (MCSC) or Director, TRICARE Area Office (TAO) determines necessary to adjudicate a specific claim.

G. Provider requirements for the Department of Defense (DoD) Enhanced Access to Autism Services Demonstration are indicated in the TRICARE Operations Manual (TOM), Chapter 20, Section 9.

II. EFFECTIVE DATE September 1, 2005.

- END -

CHAPTER 9
ADDENDUM A

ECHO HOME HEALTH CARE (EHHC) BENEFIT

The following example illustrates the process of calculating the maximum fiscal year benefit for EHHC as described in Chapter 9, Section 15.1, paragraph VI.H.

This example is based on the Fiscal Year (FY) 2012 rates for the Medicare Program; Prospective Payment System (PPS) and Consolidated Billing for Skilled Nursing Facilities (SNFs) for FY 2012; Notice published by the Centers for Medicare and Medicaid Services (CMS) in the **Federal Register** on August 8, 2011 (76 FR 48486).

STEP	DESCRIPTION	URBAN[1]	RURAL[2]
1	Tables 6 and 7 Highest RUG-IV Category	RUX	RUX
2	Tables 6 and 7 Labor Component of RUX	506.32	518.02
3	Tables A and B Wage Index	1.6878	1.3962
4	Adjusted Labor Component (Step 2 x Step 3)	854.57	723.26
5	Tables 6 and 7 Non-Labor Component	230.76	236.09
6	Total RUX Daily Rate (Step 4 + Step 5)	1,085.33	959.35
7	Total FY EHHC Benefit (Step 6 x 365)[3]	396,145.45	350.162.75

[1] Beneficiary resides in Santa Clara, CA (Core Based Statistical Area (CBSA) Code 41940).
[2] Beneficiary resides in rural Alaska (State Code 22).
[3] 366 in Leap Year.

- END -

CHAPTER 11
SECTION 3.7

CLINICAL PSYCHOLOGIST

ISSUE DATE: December 5, 1984
AUTHORITY: 32 CFR 199.6(c)(3)(iii)(A)

I. ISSUE

Clinical Psychologist.

II. POLICY

A. To be certified as an authorized clinical psychologist, an individual must be licensed or certified by the state for the independent practice of psychology; **and**:

1. Posses a doctoral degree in psychology from a regionally accredited university; **and**

2. Have two years of supervised clinical experience in psychological health services of which at least one year is post-doctoral and one year (may be the post-doctoral year) is in an organized psychological health service training program; **or**

3. As an alternative to paragraph II.A.1. and 2.., be listed in the National Register of Health Service Providers in Psychology.

B. A provider has fulfilled the degree requirement if the provider holds a doctorate from a regionally accredited institution and if the doctorate (or doctorate combined with additional coursework) fulfills the licensing/certifying/registering jurisdiction's educational requirements to become a licensed/certified/registered psychologist at the independent practice level.

C. A provider who does not qualify as an authorized clinical psychologist is to be offered the alternative of applying for provider status under another mental health provider category or of applying for listing in the National Register of Health Service Providers in Psychology.

- END -