OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
HEALTH AFFAIRS
16401 EAST CENTRETECH PARKWAY
AURORA, CO 80011-9066

DEFENSE
HEALTH AGENCY

MB&RB

CHANGE 184
6010.57-M
JUNE 29, 2017

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

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

CHANGE TITLE: **REIMBURSEMENT & CODING UPDATES 17-002**

CONREQ: 18490

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): See page 3.

EFFECTIVE DATE: See page 3.

IMPLEMENTATION DATE: July 31, 2017.

This change is made in conjunction with Feb 2008 TRM, Change No. 145 and Feb 2008 TSM, Change No. 95.

FAZZINI.ANN.NOREEN.1199802271 Digitally signed by FAZZINI.ANN.NOREEN.1199802271 Date: 2017.06.26 10:49:05 -06'00'

Ann N. Fazzini
Team Chief, Medical Benefits & Reimbursement Branch (MB&RB)
Defense Health Agency (DHA)

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

REMOVE PAGE(S)	INSERT PAGE(S)
CHAPTER 1	
Section 13.1, pages 1 and 2	Section 13.1, pages 1 and 2
CHAPTER 4	
Section 6.1, pages 1 and 2	Section 6.1, pages 1 and 2
Section 21.1, pages 1 and 2	Section 21.1, pages 1 and 2
CHAPTER 6	
Section 4.1, pages 1 and 2	Section 4.1, pages 1 and 2
CHAPTER 7	
Section 2.1, pages 1 and 2	Section 2.1, pages 1 and 2

SUMMARY OF CHANGES

CHAPTER 1

1. Section 13.1. This change removes temporary S codes. EFFECTIVE DATE: 01/01/2016.

CHAPTER 4

2. Section 6.1. This change removes temporary S codes. EFFECTIVE DATE: 01/01/2016.

3. Section 21.1. This change, removes language which outlines coverage of the aqueous drainage device iStent. EFFECTIVE DATE: 10/07/2015.

CHAPTER 6

4. Section 4.1. This change updates the codes in this section due to CPT 2017 changes. EFFECTIVE DATE: 01/07/2017.

CHAPTER 7

5. Section 2.1. This change removes CPT codes 85013-85027 for Complete Blood Count (CBC) blood panels. EFFECTIVE DATE: As stated in issuance.

Chapter 1 Section 13.1

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

Issue Date: November 6, 2007
Authority:

1.0 HCPCS "C" AND "S" CODES

C1000 - C9999; S0000 - S9999

2.0 DESCRIPTION

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

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

3.0 POLICY

3.1 Upon implementation of TRICARE's Outpatient Prospective Payment System (OPPS), HCPCS "C" codes shall be paid according to OPPS guidelines as outlined in the TRICARE Reimbursement Manual (TRM), Chapter 13. For Hospital Outpatient Department (HOPD) services provided on or before May 1, 2009 (implementation of TRICARE's OPPS), and thereafter, for services by exempt OPPS hospitals, the contractor shall allow payment of HCPCS "C" codes consistent with current policy as stated in the TRM, Chapter 1, Section 24, paragraph 2.2.

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

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

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

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

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

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

3.2.5 S0189 for testosterone pellets as provided in Chapter 4, Section 5.1.

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

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

3.2.8 S0190, S0191, and S0199 as provided in Chapter 4, Section 18.3.

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

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

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

3.6 S9480 as described in Chapter 7, Section 3.4, paragraph 3.8 and Chapter 7, Section 3.5, paragraph 3.3.1.2.3.

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

4.0 EXCLUSIONS

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

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

- END -

[1] CPT only © 2006 American Medical Association (or such other date of publication of CPT). All Rights Reserved.

Musculoskeletal System

Issue Date: August 26, 1985
Authority: 32 CFR 199.4(c)(2) and (c)(3)

1.0 CPT[1] PROCEDURE CODES

20005 - 20551, 20555 - 22328, 22510 - 22515, 22532 - 22856, 22858, 22861, 22864 - 27138, 27146 - 27178, 27181 - 29861, 29870 - 29913, 29999

2.0 HCPCS CODES

S2118, S2325

3.0 DESCRIPTION

The musculoskeletal system pertains to or comprises the skeleton and the muscles.

4.0 POLICY

4.1 Services and supplies required in the diagnosis and treatment of illness or injury involving the musculoskeletal system are covered. U.S. Food and Drug Administration (FDA) approved surgically implanted devices are also covered.

4.2 Effective August 25, 1997, Autologous Chondrocyte Implantation (ACI) surgery for the repair of clinically significant, symptomatic, cartilaginous defects of the femoral condyle (medial, lateral or trochlear) caused by acute or repetitive trauma is a covered procedure. The autologous cultured chondrocytes must be approved by the FDA.

4.3 Single or multilevel anterior cervical microdiskectomy with allogeneic or autogeneic iliac crest grafting and anterior plating is covered for the treatment of cervical spondylosis.

4.4 Percutaneous vertebroplasty (CPT[1] procedure codes 22510-22512) and balloon kyphoplasty (CPT[1] procedure codes 22513-22515) are covered for the treatment of painful osteolytic lesions and osteoporotic compression fractures refractory to conservative medical treatment.

4.5 Total Ankle Replacement (TAR) (CPT[1] procedure codes 27702 and 27703) surgery is covered if the device is FDA approved and the use is for an FDA approved indication. However, a medical necessity review is required in case of marked varus or valgus deformity.

[1] CPT only © 2006 American Medical Association (or such other date of publication of CPT). All Rights Reserved.

4.6 Core decompression of the femoral head (hip) for early (precollapse stage I or II) avascular necrosis may be considered for cost-sharing (Healthcare Common Procedure Coding System (HCPCS) code S2325).

4.7 Single-level, cervical Total Disc Replacement (cTDR) (CPT[2] procedure code 22856) and two-level cTDR (CPT[2] procedure code 22858) using an FDA approved cervical artificial intervertebral disc for the treatment of cervical DDD, intractable radiculopathy, and/or myelopathy is covered if the disc is used in accordance with its FDA labeled indications.

4.8 High Energy Extracorporeal Shock Wave Therapy (HE ESWT) for the treatment of plantar fasciitis is covered when all of the following conditions are met:

- Patients have chronic plantar fasciitis of at least six months duration;
- Patients have undergone and failed six months of appropriate conservative therapy; and
- HE ESWT is defined as Energy Flux Density (EFD) greater than 0.12 millijoules per square millimeter (mJ/mm2).

4.9 Meniscal allograft transplant of the knee is covered.

4.10 Hip resurfacing (CPT[2] procedure codes 27125 and 27130, and HCPCS S2118) with an FDA approved device is proven for the treatment of Degenerative Joint Disease (DJD) of the hip in patients who are less than 65 years old and who meet all of the following criteria:

- Have chronic, persistent pain and/or disability;
- Are otherwise healthy and active;
- Have normal proximal femoral bone geometry and bone quality; and
- Would otherwise receive a conventional Total Hip Replacement (THR), but are likely to outlive a conventional THR implant system's expected life.

4.11 Minimally Invasive Surgery (CPT[2] procedure code 27279) for treatment of sacroiliac joint pain is proven.

5.0 EXCLUSIONS

5.1 Ligament replacement with absorbable copolymer carbon fiber scaffold is unproven.

5.2 Prolotherapy, joint sclerotherapy and ligamentous injections with sclerosing agents (HCPCS procedure code M0076) are unproven.

5.3 Trigger point injection (CPT[2] procedure codes 20552 and 20553) for migraine headaches.

[2] CPT only © 2006 American Medical Association (or such other date of publication of CPT). All Rights Reserved.

Eye And Ocular Adnexa

Issue Date: August 26, 1985
Authority: 32 CFR 199.4(c)(2), (c)(3) and (g)(46)

1.0 CPT[1] PROCEDURE CODES

0191T, 0192T, 0204T, 0253T, 0308T, 0376T, 65091 - 65755, 65772 - 66175, 66180 - 68899, 77600 - 77615

2.0 HCPCS PROCEDURE CODES

C1783, L8612

3.0 DESCRIPTION

The eye is the organ of vision and the ocular adnexa are the appendages or adjunct parts; i.e., eyelids, lacrimal apparatus.

4.0 POLICY

4.1 Services and supplies required in the diagnosis and treatment of illness or injury involving the eye or ocular adnexa are covered.

4.2 Phototherapeutic Keratectomy (PTK) is covered for corneal dystrophies.

4.3 Strabismus. Surgical procedures and eye examinations to correct, treat, or diagnose strabismus are covered.

4.4 Corneal transplants. A corneal transplant (keratoplasty) is a covered surgical procedure. Relaxing keratotomy to relieve astigmatism following a corneal transplant is covered.

4.5 Transpupillary thermotherapy (laser hyperthermia, CPT[1] procedure codes 77600 - 77615), with chemotherapy, is covered for the treatment of retinoblastoma. See also Chapter 5, Section 5.1.

4.6 Intrastromal Corneal Ring Segments (Intacs®) is covered for U.S. Food and Drug Administration (FDA) approved indications for beneficiaries with keratoconus who meet all of the following criteria: (1) are unable to achieve adequate vision using lenses or spectacles; and (2) for whom corneal transplant is the only remaining option. Coverage allowed effective July 17, 2005.

[1] CPT only © 2006 American Medical Association (or such other date of publication of CPT). All Rights Reserved.

4.7 Optonal ExPRESS Mini glaucoma Shunt (CPT[2] procedure code 0192T) to reduce Intraocular Pressure (IOP) in the treatment of glaucoma, that cannot be controlled effectively with medications.

4.8 Off-label use of Photodynamic Therapy (CPT[2] procedure code 67221) with Visudyne (HCPCS J3396) may be considered for cost-sharing for the treatment of retinal astrocytic hamartoma in Tuberous Sclerosis. The effective date is February 1, 2008.

4.9 Transpupillary thermotherapy (CPT[2] procedure code 67299) with Plaque Radiotherapy (Brachytherapy) is covered for the treatment of choroidal melanoma. See also Chapter 5, Section 3.2.

4.10 Photodynamic Therapy for the treatment of Central Serous Chorioretinopathy in accordance with the TRICARE provisions for the treatment of rare diseases.

4.11 Implantable Miniature Telescope (IMT) is covered for FDA approved indications for beneficiaries with end-stage age-related macular degeneration.

4.12 Canaloplasty for the treatment of primary open angle glaucoma (CPT[2] procedure codes 66174 and 66175) is covered.

4.13 Insertion of aqueous drainage device (iStent®) during cataract surgery to reduce IOP in the treatment of glaucoma, initial insertion (CPT[2] procedure codes 0191T, C1783, and L8612), and each additional insertion (CPT[2] procedure code 0376T).

4.14 Collagen Cross-linking for the treatment of corneal ectasia due to the rare disease Keratoconus is safe and effective and may be considered for cost-sharing.

5.0 EXCLUSIONS

5.1 Refractive corneal surgery except as noted in paragraph 4.4 (CPT[2] procedure codes 65760, 65765, 65767, 65770, 65771).

5.2 Eyeglasses, and contact lenses except as noted in Chapter 7, Section 6.2.

5.3 Orthokeratology.

5.4 Orthoptics, also known as visual training, vision therapy, eye exercises, eye therapy, is excluded by 32 CFR 199.4(g)(46) (CPT[2] procedure code 92065).

5.5 Epikeratophakia for treatment of aphakia and myopia is unproven.

5.6 Transpupillary thermotherapy (CPT[2] procedure code 67299) as primary treatment of choroidal melanoma is unproven.

5.7 Autologous serum eye drops for the treatment of dry eye syndrome, keratitis, or ocular hypertension is unproven.

[2] CPT only © 2006 American Medical Association (or such other date of publication of CPT). All Rights Reserved.

Drug Testing

Issue Date: August 19, 2015
Authority: 10 USC 1079(h)(1); 32 CFR 199.4(c); 32 CFR 199.14

1.0 CPT[1] PROCEDURE CODES

80150 - 80299

2.0 HCPCS PROCEDURE CODES

On or before December 31, 2015: G0431, G0434, G6030 - G6058
On or after January 1, 2016, and before January 1, 2017: G0477 - G0483
On or after January 1, 2017: 80305 - 80307, G0480 - G0483

3.0 DESCRIPTION

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

4.0 POLICY

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

4.2 Qualitative/presumptive drug testing (Healthcare Common Procedure Code System (HCPCS) procedure codes G0431 and G0434 on or before December 31, 2015; G0477-G0479 between January 1, 2016, and December 31, 2016; and 80305-80307 on or after January 1, 2017) may be cost-shared for patients with any of the following:

4.2.1 An unreliable history.

4.2.2 Multiple drug ingestion.

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

4.2.4 Severe or unexplained cardiovascular instability.

4.2.5 Unexplained metabolic or respiratory acidosis.

[1] HCPCS Level I/CPT only © 2006 American Medical Association (or such other date of publication of CPT). All Rights Reserved.

4.2.6 Seizures with an undetermined history.

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

4.2.8 For monitoring patient compliance during active treatment for substance abuse. (See paragraph 5.0 for exclusions for medico-legal purposes.)

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

4.3.1 TRICARE does not recognize Current Procedural Terminology (CPT)[2] procedure codes 80320-80377 for reimbursement at this time.

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

4.4 Drug screening to identify specific drugs, to indicate when antagonists may be used, or to provide quantitative information regarding specific drugs may be cost-shared. Definitive and quantitative drug testing (HCPCS procedure codes G6030-G6058 on or before December 31, 2015 and G0480-G0483 on or after January 1, 2016) is covered when all of the following indications are met:

4.4.1 To verify and further analyze initial drug testing;

4.4.2 When medically necessary and appropriate; and

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

4.5 Therapeutic drug assays (CPT[2] procedure codes 80150-80299), performed to monitor clinical response to a known, prescribed medication, are covered when medically necessary and appropriate.

5.0 EXCLUSIONS

5.1 Drug screening using blood and urine simultaneously.

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

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

---

[2] HCPCS Level I/CPT only © 2006 American Medical Association (or such other date of publication of CPT). All Rights Reserved.

Clinical Preventive Services - TRICARE Standard

Issue Date: April 19, 1983
Authority: 32 CFR 199.4(e)(28) and (f)(12), 10 USC 1079(a), Public Law 110-471, Section 711

1.0 CPT[1] PROCEDURE CODES

45300 - 45305, 45308 - 45315, 45320, 45321, 45330, 45331, 45333, 45338, 45346, 45378, 45380, 45384, 45385, 45388, 74263, 76977, 77052, 77057 - 77059, 77078 - 77081, 80061, 81528, 82270, 82274, 82465, 82947 - 82952, 83036, 83718 - 83721, 84152 - 84154, 84478, 86480, 86481, 86580, 86592, 86593, 86631, 86632, 86689, 86701 - 86706, 86762, 86780, 86803, 86804, 87110, 87270, 87320, 87340, 87341, 87389 - 87391, 87490 - 87492, 87534 - 87536, 87590 - 87592, 87623 - 87625, 87800, 87801, 87806, 87810, 87850, 88141 - 88155, 88160 - 88162, 88164 - 88167, 88174, 88175, 92002, 92004, 92012, 92014, 92015, 99172, 99173, 99383 - 99387, 99393 - 99397, 99401 - 99404

2.0 HCPCS PROCEDURE CODES

Level II Codes G0101 - G0105, G0121, G0123, G0124, G0130, G0141 - G0148, G0202, G0328, G0445, G0472, G6022, G6024

3.0 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 National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2009 (Public Law 110-417, Section 711) waived cost-share requirements for certain preventive services rendered on or after October 14, 2008. (See the TRICARE Reimbursement Manual (TRM), Chapter 2, Section 1, paragraph 1.3.3.10 and 1.4.3 for services for which cost-shares were eliminated.)

Effective January 1, 2017, cost-shares are also eliminated for the services listed in paragraphs 3.1.1.1.2 and 3.1.5.

Covered services as identified in this policy are based on recommendations from the United States Department of Health and Human Services (HHS). This includes recommendations from the United States Preventive Services Task Force, the Health Resources and Services Administration, etc.

The services identified in this policy are applicable to beneficiaries age six years and older. For beneficiaries under age six, covered preventive services are identified in the TRICARE well-child

[1] CPT only © 2006 American Medical Association (or such other date of publication of CPT). All Rights Reserved.

care policy. (See Section 2.5.)

A 30 day administrative tolerance will be allowed for any time interval requirements imposed on services covered by this policy; e.g., if an asymptomatic woman 40 years of age or older received a screening mammography on September 15, coverage for another screening mammography would be allowed on or after August 17 of the following year.

3.1 Covered Services Exempt from Cost-Share Requirements

The following preventive services are covered and exempt from cost-share requirements under Standard and Extra plans:

3.1.1 Cancer Screening Examinations and Services

3.1.1.1 Breast Cancer

3.1.1.1.1 Clinical Breast Examination (CBE)

A CBE may be performed during a covered Health Promotion and Disease Prevention examination.

3.1.1.1.2 BRCA1 Or BRCA2 Genetic Counseling And Testing

3.1.1.1.2.1 Genetic counseling rendered by a TRICARE-authorized provider that precedes BRCA1 or BRCA2 gene testing is covered for women who are identified as high risk for breast cancer by their primary care clinician.

3.1.1.1.2.2 BRCA1 or BRCA2 gene testing is covered for women who meet the coverage guidelines outlined in the TRICARE Operations Manual (TOM), Chapter 18, Section 17, Figure 18.17-1.

3.1.1.1.3 Screening Mammography

3.1.1.1.3.1 Screening mammography is covered annually for all women beginning at age 40.

3.1.1.1.3.2 Screening mammography is covered annually beginning at age 30, for women who have a 15% or greater lifetime risk of breast cancer (according to risk assessment tools based on family history such as the Gail model, the Claus model, and the Tyrer-Cuzick model), or who have any of the following risk factors:

3.1.1.1.3.2.1 History of breast cancer, Ductal Carcinoma In Situ (DCIS), Lobular Carcinoma In Situ (LCIS), Atypical Ductal Hyperplasia (ADH), or Atypical Lobular Hyperplasia (ALH);

3.1.1.1.3.2.2 Extremely dense breasts when viewed by mammogram;

3.1.1.1.3.2.3 Known BRCA1 or BRCA2 gene mutation;

3.1.1.1.3.2.4 First-degree relative (parent, child, sibling) with a BRCA1 or BRCA2 gene mutation, and have not had genetic testing themselves;