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TRICARE
MANAGEMENT ACTIVITY

PDB

CHANGE No: 27
OCHAMPUS 6010.47-M
June 3, 1998

PUBLICATIONS SYSTEM CHANGE TRANSMITTAL FOR TRICARE/CHAMPUS POLICY MANUAL

THE DIRECTOR, OCHAMPUS, HAS AUTHORIZED THE FOLLOWING ADDITION(S)/REVISION(S) TO THE TRICARE/CHAMPUS POLICY MANUAL

REVISION(S)

CHAPTER(S):	1	SECTION(S):	Table of Contents, 3.2, 10.1, 10.2, 12.7, 12.9.
CHAPTER(S):	4	SECTION(S):	Table of Contents, 1.4, 1.7.
CHAPTER(S):	12	SECTION(S):	8.1, 8.2.
CHAPTER(S):	13	SECTION(S):	1.5, 3.10, 6.8, 23.1.
			INDEX: Pages 17-20.

REMOVE PAGES(S): See pages 2-3 of this transmittal.

INSERT: ATTACHED ADDITIONAL/REPLACEMENT PAGE(S): See pages 2-3 of this transmittal.

SUMMARY OF ADDITIONS/REVISIONS: This change incorporates the new 1998 CPT codes, replaces the word dependents with family members, replaces the word OCHAMPUS with TRICARE or TMA, and replaces the word TSO with TRICARE. Also, a new policy (not a new benefit) is included that provides guidelines regarding echocardiograms for patients about to undergo a dental or invasive procedure who have taken Fenfluramine or Dexfenfulramine either alone or in combination with other drug products.

EFFECTIVE DATE AND IMPLEMENTATION: Implementation is upon direction of the Contracting Officer.

THIS CHANGE IS MADE IN CONJUNCTION WITH OPERATIONS MANUAL CHANGE NO. N/A, COM-FI CHANGE NO. N/A, AND ADP MANUAL CHANGE 68.

Sheila H. Sparkman
Director, Program Development and Evaluation

ATTACHMENTS: 46 PAGES
DISTRIBUTION: 6010.47-M

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

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CHAPTER 1 - MEDICAL SERVICES

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CHAPTER 1 - MEDICAL SERVICES

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Subject: HOME VISITS	Chapter: 1
	Section: 3.2
Authority: DoD 6010.8-R, Chapter 4, C.2.d.	Issue Date: March 3. 1992

PROCEDURE CODE RANGE

99341 - 99350

Effective January 1, 1992, the American Medical Association Current Procedural Terminology (CPT) evaluation and management service codes (i.e., visit codes) were revised. The former CPT 90000 series codes were replaced by a new CPT 99000 series. These new codes were adopted for TRICARE claims processing for claims submitted on or after January 1, 1992.

DESCRIPTION

Visits provided by an individual professional provider for beneficiaries who are homebound.

POLICY

A. Home visits are covered when provided by an individual professional provider for the diagnosis or treatment of a covered condition for beneficiaries who are homebound or whose condition is such that home visits are indicated. The level of services is based on the:

1. Approach and detail of the medical history;

2. Extent of the examination;

3. Complexity of the decision making process; and

4. Severity of the presenting problem.

B. Typical times have not yet been established for this category of service.

POLICY CONSIDERATIONS

If the patient has been determined to be receiving custodial care, home visits are covered only when provided by a visiting nurse for one hour per day for skilled nursing care (CPT procedure code 99347). Visits by a physician for care of the custodial condition may be extended for up to twelve per calendar year (not to exceed one per month). See Chapter 8, Section 5.2, "Private Duty Nursing Care Provided by LPN or LVN" and Section 6.1, entitled "Custodial Care."

- END -

Subject: TRICARE STANDARD - CLINICAL PREVENTIVE SERVICES	Chapter: 1
Authority: DoD 6010.8-R, Chapter 4, E.3.b. & G.37.	Section: 10.1
	Issue Date: April 19, 1983

PROCEDURE CODES

45300, 45330, 45355, 45378, 76092, 80061, 82270, 84153, 86580, 86585, 86762, 87340, 88141, 88150-88158, 90700-90747 (except 90714, 90717, 90725-90728, 90733, 90735), 99382-99386, and 99392-99396

BACKGROUND

The Defense Authorization Act for fiscal year 1996 (P.L. 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 (see Chapter 1, Section 10.4) 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, pap smears, and mammograms. The Defense Authorization Act for fiscal year 1997 (P.L. 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 additions to the pap smears, mammograms, and well-baby care up to the age of two, the only related services authorized under the TRICARE 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 TRICARE Uniform HMO Benefit (see DoD 6010.8-R, Chapter 18, B.2.), except for the application of appropriate cost-sharing and deductibles under the TRICARE Extra and Standard plans.

While immunizations are provided as a specific exception to the general preventive care exclusion under the Regulation (DoD 6010.8-R, Chapter 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 TRICARE 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 TRICARE-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 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.

TRICARE STANDARD - CLINICAL PREVENTIVE SERVICES	Chapter: 1
	Section: 10.1

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 codes 99382-99386 and 99392-99396) 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.

POLICY

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

A. Health Promotion and Disease Prevention Examinations. The following health 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. The contractor need not establish additional edits to identify claims within the age, sex, race, or clinical history parameters included below:

1. Cancer Screening Examinations and Services.

a. Breast Cancer:

(1) Physical Examination. For women under age 40, physicians may elect to perform clinical breast examination for those who are at high risk, especially those whose first-degree relatives have had breast cancer diagnosed before menopause. For women age 40 and older, annual clinical examinations should be performed.

(2) X-ray mammography. Mammography is recommended as a routine screening procedure (i.e., performed in the absence of any signs or symptoms of breast disease) when ordered by a physician, or upon self-referral as outlined below for:

(a) An asymptomatic woman 40 years of age for one baseline mammogram.

(b) An asymptomatic woman 40 years of age, but under 50 years of age, for one screening mammography every 24 months.

(c) An asymptomatic woman 50 years of age and older for one screening mammography every 12 months.

(d) An asymptomatic woman 35 years of age, but under 50 years of age, for a baseline mammogram at age 35 and one screening mammogram every 12 months thereafter if the woman is considered to be at high risk of developing breast caner. Acceptable indicators for high risk are:

1 A personal history of breast cancer;

2 A personal history of biopsy-proven benign breast disease;

3 A mother, sister, or daughter who has had breast cancer;

4 Not given birth prior to age 30; or

5 Other acceptable high risk factors as may be recommended by major authorities (e.g., the American Academy of Family Physicians, American Cancer Society, American College of Obstetricians and Gynecologists, American College of Physicians, and U.S. Preventive Services Task Force (USPSTF)).

NOTE: *Screening mammography procedures should be billed using procedure code 76072 except when performed in connection with other preventive services, in which case a comprehensive health promotion and disease prevention examination office visit code (CPT codes 99382-99386 and 99392-99396) should be used.*

(e) The effective date for cancer screening mammography is November 5, 1990.

b. Cancer of Female Reproductive Organs.

(1) Physical examination. Pelvic examination should be performed in conjunction with Pap smear testing for cervical neoplasms and premalignant lesions.

(2) Papanicolaou smears. Cancer screening Papanicolaou (PAP) tests should be performed for women who are at risk for sexually transmissible diseases, women who have or have had multiple sexual partners (or if their partner has or has had multiple sexual partners), women who smoke cigarettes, and women 18 years of age and older when provided under the terms and conditions contained in the guidelines adopted by the Deputy Assistant Secretary of Defense, Health Services Financing. The frequency of the PAP tests will be at the discretion of the patient and clinician but not less frequent then every three years.

(a) Reimbursement for screening pap smears shall not exceed the reimbursement for the intermediate office level visit except when performed in connection with other preventive services, in which case reimbursement will be allowed for the appropriate comprehensive health promotion and disease prevention examination office visit (CPT codes 99382-99386 and 99392-99396).

(b) Claims for screening pap smears which are coded at a level greater than the intermediate level office visit and for which no additional preventive services have been provided will be reimbursed at the allowable charge for either CPT code 99203 or 99213 using the EOB message: "Charge reimbursed at the intermediate office visit level." Separate charges for the preparation, handling, and collection of the screening cervical Pap test are considered to be an integral part of the routine office examination visit and will not be allowed.

(c) Reimbursement for the cytopathology laboratory procedure associated with screening Pap tests should be billed using procedure codes 88150 - 88158.

Reimbursement of these procedures is limited to the total CHAMPUS Maximum Allowable Charge (CMAC) and will only be paid once regardless of whether the attending physician or the laboratory bills for the services.

(d) Reimbursement of Resource Sharing claims for the office visit associated with the screening Pap test should follow the same guidelines as civilian providers. Cytopathology laboratory charges billed by a Resource Sharing provider will not be reimbursed, unless the Resource Sharing Agreement states otherwise.

(e) TRICARE Extra and Standard plans may cost-share services that are rendered during the same office visit of a screening Pap test as long as the services are considered medically necessary and are documented as such, and would not otherwise be considered integral to the office visit.

(f) The effective date for cancer screening for Pap smears is November 5, 1990.

c. Colorectal Cancer.

(1) Physical examination. Digital rectal examination should be included in the periodic examination of individuals 40 years of age and older.

(2) Fecal Occult Blood Testing. Annually 50 years of age and over if at increased risk for colorectal cancer as defined by the U.S. Preventive Services Task Force.

(3) Proctosigmoidoscopy or sigmoidoscopy. Once every 3-5 years beginning at age 50.

(4) Colonoscopy. Performed every five years beginning age 40 for individuals at increased risk for colon cancer, including first-degree relative with history of colon cancer.

(5) The effective date for colorectal cancer screening is October 6, 1997.

d. Prostate Cancer.

(1) Physical examination. Digital rectal examination should be performed annually for men 40 to 49 years of age who have a family history of prostate cancer, and for all men over 50.

(2) Prostate-Specific Antigen.

(a) Annual testing for the following categories of males:

1 All men aged 50 years and older.

2 Men aged 40 years and over who have a family history of prostate cancer.

3 Men who have had a vasectomy at least 20 years previously or who had their vasectomy at age 40 years or older.

(b) Discontinuation of screening at age 70.

(3) The effective date for prostate cancer screening is October 6, 1997.

2. Infectious Diseases.

a. Hepatitis B screening. The effective date for screening pregnant women for HBsAG during prenatal period was March 1, 1992 (see Chapter 3, Section 13.2, "Maternity Care").

b. Human immunodeficiency virus (HIV) testing.

(1) Effective July 7, 1995, TRICARE may share the cost of routine HIV screening tests for pregnant women (see Chapter 3, Section 13.2, "Maternity Care"), and

(2) TRICARE Extra and Standard plans may share the cost of HIV testing when medically necessary; i.e., when performed on individuals with verified exposure to HIV or who exhibit symptoms of HIV infection (persistent generalized lymphadenopathy). Claims for HIV testing must include documentation by the attending physician verifying medical necessity. Claims that meet the criteria for coverage are to be reimbursed following the reimbursement methodology applicable to the provider's geographic location.

c. Prophylaxis. The following preventive therapy may be provided to those who are at risk for developing active disease:

(1) Tetanus immune globulin (human) and tetanus toxoid administered following an injury.

(2) Services provided following an animal bite:

(a) TRICARE Extra and Standard plans may share the cost of the administration of anti-rabies serum or human rabies immune globulin and rabies vaccine.

NOTE: *Pre-exposure prophylaxis for persons with a high risk of exposure to rabies is not covered.*

(b) TRICARE Extra and Standard plans may also cost-share the laboratory examination of the brain of an animal suspected of having rabies if performed by a laboratory which is a TRICARE-authorized provider and if the laboratory customarily charges for such examinations. In order for the examination charges to be paid, the animal must have bitten a beneficiary, the charges for the examination must be submitted under the beneficiary's name, and the beneficiary must be responsible for the cost-share on the claim.

NOTE: *Charges by any source for boarding, observing, or destroying animals, or for the collection of brain specimens are not covered.*

(3) Rh immune globulin when administered to an Rh negative woman during pregnancy and following the birth of an Rh positive child or following a spontaneous or induced abortion. Prepayment development is not required unless there is a reason to question the claim.

(4) For treatment provided to individuals with verified exposure to a potentially life-threatening medical condition (i.e., hepatitis A, hepatitis B, meningococcal

meningitis, etc.), claims must include documentation by the attending physician verifying exposure.

(5) Isoniazid therapy for individuals at high risk for tuberculosis to include those:

(a) With a positive Mantoux test without active disease;

(b) Who have had close contact with an infectious case of TB in the past 3 months regardless of their skin test reaction; or

(c) Who are members of populations in which the prevalence of TB is greater than 10 percent regardless of their skin test reaction - including injection drug users, homeless individuals, migrant workers, and those born in Asia, Africa, or Latin America.

NOTE: *In general, isoniazid prophylaxis should be continued for at least 6 months up to a maximum of 12 months.*

(6) Immunizations. The administration of the appropriate vaccine for the following diseases according to current CDC recommendations: Tetanus, Diphtheria, Pertussis, Poliomyelitis, Mumps, Measles, Rubella, Influenza, Pneumococcal Disease, Haemophilus Influenza Type B, Hepatitis A, Hepatitis B, and Varicella. The effective date for immunizations is October 6, 1997.

3. Genetic Testing.

a. Genetic testing and counseling is covered during pregnancy under any of the following circumstances:

(1) The pregnant woman is 35 years of age or older;

(2) One of the parents of the fetus has had a previous child born with a congenital abnormality;

(3) One of the parents of the fetus has a history (personal or family) of congenital abnormality; or

(4) The pregnant woman contracted rubella during the first trimester of the pregnancy.

NOTE: *TRICARE Extra and Standard plans may not cost-share routine or demand genetic testing or genetic tests performed to establish the paternity or sex of an unborn child.*

b. Chromosome analysis (to include karyotyping and/or high resolution chromosome analysis) in cases of habitual abortion or infertility is considered a diagnostic service and is not subject to the genetic testing criteria.

c. Genetic testing for Marfan Syndrome and chromosome analysis (to include karyotyping and/or high resolution chromosome analysis) of children are considered diagnostic services and are not subject to the genetic testing criteria. Common indications

for chromosome analysis in children include ambiguity of external genitalia, small-for-gestational age infants, multiple anomalies and failure to thrive.

d. Other conditions not included on the above list may be considered for TRICARE coverage under POLICY (see also, Chapter 3, Section 13.3, "Amniocentesis" and Section 13.4, "Chorionic Villus Sampling").

4. Other.

a. Physical examinations and immunizations provided to the spouse and children of active duty service members in conjunction with official travel outside the United States. Claims must include a copy of the travel orders or other official documentation verifying the official travel requirement.

b. Routine chest x-rays and electrocardiograms required for admission when a patient is scheduled to receive general anesthesia on an inpatient or outpatient basis.

NOTE: *TRICARE Extra and Standard plans may not cost-share routine chest x-rays or electrocardiograms for admissions not involving services that require general anesthesia.*

B. Health Promotion and Disease Prevention Services Covered in Connection with Immunizations, Pap Smears, Mammograms, or Examinations for Colon and Prostate Cancer. The following health prevention services are only covered in connection with immunizations, pap smears, mammograms, or screening examinations for colon and prostate cancer; i.e., preventive services provided during the same comprehensive preventative office visit as the associated immunization, pap smear, mammogram, or colon and prostate examination or preventive services provided as a result of a referral made during that same office visit. The contractor shall apply all appropriate claims processing and rebundling edits before determining if the following preventive services are individually reimbursable. The contractor need not establish additional edits to identify claims within the age, sex, race, or clinical history parameters included below, or research claims history to ensure that an association exists between the following preventive services and an immunization, pap smear, mammogram, or colon and prostate cancer examination:

1. Cancer Screening Examinations.

a. Testicular Cancer. Physical examination annually for males age 13-39 with history of cryptorchidism, orchipexy, or testicular atrophy.

b. Skin Cancer. Physical skin examination should be performed for individuals with family or personal history of skin cancer, increased occupational or recreational exposure to sunlight, or clinical evidence of precursor lesions.

c. Oral Cavity and Pharyngeal Cancer. 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.

d. Thyroid Cancer. Palpation for thyroid nodules should be performed in adults with a history of upper body irradiation.

2. Infectious Diseases.

a. Tuberculosis screening. Screening annually, regardless of age, all individuals at high risk for tuberculosis (as defined by CDC) using Mantoux tests.

b. Rubella antibodies. Females, once during age 12-18, unless documented history of adequate rubella vaccination with at least one dose of rubella vaccine on or after the first birthday.

3. Cardiovascular Disease.

a. Cholesterol. Non-fasting total blood cholesterol at least once every five years, beginning age 18.

b. Blood pressure screening. Blood pressure screening at least every 2 years after age 6.

4. Body Measurements. Height and weight should be measured periodically. The optimal frequency is a matter of clinical discretion. Those individuals who are 20 percent or more above desirable weight should receive appropriate nutritional and exercise counseling.

5. Vision Screening. Vision screening continues to be excluded from coverage under the TRICARE Extra and Standard plans except for the one routine eye examination per calendar year per person for family members of active duty members and vision screening allowed under the well-child benefit. (See Chapter 1, Section 10.4 and Section 16.1.)

6. Audiology Screening. Preventive hearing examinations are only allowed under the well-child care benefit. (See Chapter 1, Section 10.4.)

7. Counseling Services.

a. Patient and parent education counseling for:

(1) Dietary assessment and nutrition;

(2) Physical activity and exercise;

(3) Cancer surveillance;

(4) Safe sexual practices;

(5) Tobacco, alcohol and substance abuse;

(6) Promoting dental health;

(7) Accident and injury prevention; and

(8) Stress, bereavement and suicide risk assessment.

b. These are expected components of good clinical practice that are integrated into the appropriate office visit at no additional charge.

8. The effective date of health promotion and disease prevention services covered in connection with immunizations, Pap smears, mammograms, or examinations for colon and prostate cancer is October 6, 1997.

- END -

Subject: PAPANICOLAOU (PAP) TESTS	Chapter: 1
	Section: 10.2
Authority: DoD 6010.8-R, Chapter 4, G.1. G.2. and G.37.h.	Issue Date: February 23, 1994

PROCEDURE CODES

88141, 88150 - 88158
99201 - 99215 or 99301 - 99313

DESCRIPTION

Papanicolaou (Pap) test is an exfoliative cytological staining procedure for the detection and diagnosis of various conditions, particularly malignant and premalignant conditions of the female genital tract. Pap tests are performed as either a diagnostic or screening test. For TRICARE purposes diagnostic Pap tests are tests performed on symptomatic females presenting with signs or symptoms of malignant or premalignant disease or pregnancy; screening Pap tests are performed on asymptomatic females who do not present with signs or symptoms of cervical or medical disease.

POLICY

A. Cervical Pap tests are covered on either a diagnostic or screening basis subject to the circumstances and guidelines discussed in the following paragraphs.

1. Diagnostic Pap tests may be cost-shared under the following circumstances:

a. Previous cancer of the cervix, uterus, or vagina

b. Previous abnormal Pap test

c. Irritation or inflammation of the cervix

d. Abnormal vaginal bleeding

e. Abnormal vaginal discharge

f. Intrauterine exposure to diethylstilbestrol

g. As part of the prenatal laboratory workup for a new maternity patient

h. As part of the care for women undergoing estrogen replacement therapy

2. The policy for screening Pap smears is outlined in Section 10.1 of this chapter.

- END -

Subject: PSYCHOTHERAPY	Chapter: 1
Authority: DoD 6010.8-R, Chapter 4, C.3.i.	Section: 12.7
	Issue Date: December 5, 1984

PROCEDURE CODE RANGE

90804-90857

POLICY

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

POLICY CONSIDERATIONS

A. Maximum duration of psychotherapy sessions:

1. Inpatient or outpatient individual psychotherapy (90806, 90807, 90818, 90819): approximately 45 to 50 minutes; or (90804, 90805, 90816, 90817): approximately 20 to 30 minutes.

2. Inpatient or outpatient group, conjoint or family psychotherapy: 90 minutes

90846 - family medical psychotherapy - (without the patient present)

90847 - family medical psychotherapy - (conjoint psychotherapy)

90849 - multiple-family group medical psychotherapy

90853 - group psychotherapy (other than of a multiple-family group)

3. Crisis intervention:

90808, 90809, 90821, 90822- individual medical psychotherapy, approximately 75 to 80 minutes.

4. Cross-walk of 1998 CPT psychotherapy codes:

Old Codes	New Codes
90842	90808, 90809, 90821, 90822
90843	90804, 90805, 90816, 90817
90844	90806, 90807, 90818, 90819

B. Frequency of psychotherapy sessions. 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.

PSYCHOTHERAPY	Chapter: 1
	Section: 12.7

1. Inpatient psychotherapy: more than five sessions per calendar week (Sunday through Saturday) of any type of psychotherapy requires certification of the overall treatment plan for necessity and appropriateness.

2. Outpatient psychotherapy: more than two sessions per calendar week (Sunday through Saturday) of any type of psychotherapy, and more than 23 sessions in a fiscal year requires certification of the overall treatment plan for necessity and appropriateness. (Note: Please reference TRICARE Chapter 12 of the manual for the outpatient preauthorization requirements for TRICARE Prime enrollees.)

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.*

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. Collateral visits (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. See Chapter 1, Section 12.10.

5. Psychoanalysis (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 Director, TMA, or a designee.

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 under TRICARE, subject to the regular points of review and frequency limitations applicable to individual psychotherapy.

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 under TRICARE since it is not medically necessary or appropriate.

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.

9. Physical examination. A physical examination is an essential component of the workup 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 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 in Chapter 1, Section 4.4.

This policy does not preclude the attending psychiatrist from performing and billing for CPT codes 99221, 99222, or 99223. It also does not preclude billing for other relevant and medically necessary CPT-coded care concurrent with performance of, and billing for, the code 90801 and 90802.

10. Related issuances.

a. COM-FI Part Two, Chapter 17, Section III.D.2.g.

b. OPM Part Two, Chapter 17, Section II.D.2.2.

EFFECTIVE DATE November 13, 1984

- END -

Subject: CHEMOTHERAPY MANAGEMENT	Chapter: 1
Authority: DoD 6010.8-R, Chapter 4, C.3.i.	Section: 12.9
	Issue Date: December 5, 1984

PROCEDURE CODE

90862

DESCRIPTION

Professional services of a physician provided in connection with psychotropic drugs, including prescription use, and review of medication with no more than minimal psychotherapy.

POLICY

A. Chemotherapy management is covered when provided as an independent procedure.

B. Charges for chemotherapy management are not covered if the provider billing for such services is not qualified by state licensure to prescribe psychotropic drugs.

EFFECTIVE DATE November 13, 1984

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CHAPTER 4 - RADIOLOGY

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Subject: POSITRON EMISSION TOMOGRAPHY (PET)	Chapter: 4
Authority: DoD 6010.8-R, Chapter 4, B.2.j. and C.2.h.	Section: 1.4
	Issue Date: June 30, 1993

PROCEDURE CODES

78459, 78491, 78492, 78608

DESCRIPTION

Positron emission tomography (PET) is a nuclear imaging procedure that uses short-lived radiopharmaceuticals to detect and quantify the metabolic abnormalities of disease processes.

POLICY

A. Following medical review, PET scans may be cost-shared by TRICARE when performed to localize epileptogenic foci in patients with complex partial seizure disorders who are being considered for neurosurgical resection of the focus.

1. The patient's seizures are intractable to medical therapy;

2. Prior diagnostic studies suggest, but do not confirm, the presence of a localized seizure focus; and

3. The seizure focus is located in an area of the brain amenable to surgical resection.

B. Following medical review, PET scans may be covered for evaluation of ischemic heart disease when:

1. The imaging agent used is Rubidium 82 (Rb 82); and

2. PET is used in place of, but not in addition to, single photon emission computed tomography (SPECT); or

3. A SPECT was inconclusive (test results are equivocal, technically uninterpretable, or discordant with a patient's other clinical data).

EXCLUSIONS

PET is considered investigational and is not covered for the following (see Chapter 8, Section 14.1):

A. The differential diagnosis of symptomatic intracranial masses.

B. The differentiation of low-grade and high-grade brain tumors.

C. The guidance of stereotactic biopsy or biopsies of documented intracranial mass.

D. The differentiation of recurrent brain tumor from radionecrosis.

POSITRON EMISSION TOMOGRAPHY (PET)	Chapter: 4
	Section: 1.4

E. The monitoring of response to treatment in patients with brain tumors.

F. The assessment of cerebrovascular disease, including ischemic disease, hemorrhagic disease, and arteriovenous malformations.

G. PET with deoxy-2-Fluro-D-glucose (FDG). (Rb82 is the only PET radiopharmaceutical approved by the FDA for cardiac application.)

EFFECTIVE DATE January 1, 1995, for PET for ischemic heart disease.

- END -

Subject: ECHOCARDIOGRAM FOR DENTAL AND INVASIVE PROCEDURES	Chapter: 4
Authority: 32 CFR 199.4(e)(10)	Section: 1.7
	Issue Date: May 4, 1998

PROCEDURE CODE RANGE

93303 - 93350

DESCRIPTION

An echocardiogram is a non-invasive diagnostic test performed to evaluate the heart's function. It is able to monitor the performance of the valves. It can help to diagnose structural abnormalities in the heart wall, valves, and blood vessels. It can detect tumors, clots or pericardial effusions (abnormal fluid collection around the heart). It is sometimes used after a heart attack to evaluate the cardiac wall motion and function. The most frequent use of an echocardiogram is for diagnosing or monitoring congenital heart disease, cardiomyopathies or aneurysms.

POLICY

A. An echocardiogram is a covered procedure to evaluate the valves and chambers of the heart, to aid the diagnosis of cardiomyopathies, to detect atrial tumors or pericardial effusions or to evaluate cardiac wall motion and function after a heart attack.

B. An echocardiogram is a covered diagnostic procedure for cardiac valvulopathy associated with ingestion of Pondimin and Redux (Phen-Fen):

1. After a thorough medical history and cardiovascular physical examination reveals a new murmur or symptoms (shortness of breath) of cardiac problems.

or

2. Before dental procedures in patients who have been found to have clinically significant valvular abnormalities. Abnormalities that create the risk for developing endocarditis include, but are not limited to:

a. Implanted heart valves as a replacement for their own heart valve.

b. Abnormal native heart valves (leakage, blockage).

c. Any congenital heart defect (VSD, ASD, PDA, complex anomaly).

d. Dacron or Teflon vascular grafts or patches over cardiac defects.

e. Mitral valve prolapse - only if there is significant valve leakage.

f. Pacemakers.

- END -

Subject: TRICARE PRIME - CLINICAL PREVENTIVE SERVICES	Chapter: 12
	Section: 8.1
Authority: DoD 6010.8-R, Chapter 17	Issue Date: May 15, 1996

BACKGROUND

The following are clinical preventive services expected of good comprehensive clinical practice in which every patient encounter should be used as an opportunity for preventive care. These preventive services are either (1) screening procedures to detect disease or (2) primary or secondary prevention interventions to protect or restore health. These services may be provided during acute and chronic care visits or during preventive care visits for asymptomatic individuals to maintain and promote good health.

Routine history and physical examination are no longer recommended for health promotion and disease prevention in individuals who are not being monitored as a part of a therapeutic plan for chronic disease. Instead, the U.S. Preventive Services Task Force and other major authorities recommend that every patient encounter be used as an opportunity for preventive care and that a variety of age and sex specific services be combined into these encounters and periodic health promotion disease prevention surveillance examinations.

POLICY

A. There is no preauthorization required for the following services, however, the beneficiary must use a network provider or, if a network provider is not available within the access standards of the contract, a non-network provider to whom the beneficiary is referred by the contractor. The contractor shall clearly and completely explain this requirement in all beneficiary and provider education materials. Payment will not be made under the Point of Service option for clinical preventive services that are not otherwise covered under TRICARE Standard.

B. There shall be no co-payments associated with the individually TRICARE reimbursable services listed below. The contractor shall apply all appropriate claims processing and rebundling edits before determining if the below listed CPT procedure code is individually reimbursable. The contractor need not establish additional edits to identify claims within the age, sex, race or clinical history perimeters included below:

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SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT CPT CODE
SCREENING EXAMINATIONS:		
COMPREHENSIVE HEALTH PROMOTION AND DISEASE PREVENTION EXAMINATIONS	**For ages 24 months or older**: One comprehensive disease prevention clinical evaluation and follow up during age intervals: 2-4; 5-11; 12-17; 18-39; 40-64.	99382-99386 99392-99396

TRICARE PRIME - CLINICAL PREVENTIVE SERVICES	Chapter: 12
	Section: 8.1

SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT CPT CODE
TARGETED HEALTH PROMOTION AND DISEASE PREVENTION EXAMINATIONS	The following screening examinations may be performed during either the above periodic comprehensive health promotion examination or as part of other patient encounters. The intent is to maximize preventive care.	
Breast Cancer:	**Physical Examination**: For women under age 40, physicians may elect to perform clinical breast examination for those who are at high risk, especially those whose first-degree relatives have had breast cancer diagnosed before menopause. For women age 40 and older, annual clinical examinations should be performed.	See codes for comprehensive health promotion and disease prevention exams.
	Mammography: Baseline mammogram age 40; every two years age 40-50, annually age 50 and over; For high risk women (family history of breast cancer in a first degree relative), baseline mammogram age 35, then annually.	76092
Cancer of Female Reproductive Organs:	**Physical Examination:** Pelvic examination should be performed in conjunction with Pap smear testing for cervical neoplasms and premalignant lesions.	See codes for comprehensive health promotion and disease prevention exams.
	Papanicolaou smears: Annually starting at age 18 (or younger, if sexually active) until three consecutive satisfactory normal annual examinations. Frequency may then be less often at the discretion of the patient and clinician but not less frequently than every three years.	88141, 88150 - 88158.
Testicular Cancer:	**Physical Examination:** Clinical testicular exam annually for males age 13-39 with a history of cryptorchidism, orchiopexy, or testicular atrophy.	See codes for comprehensive health promotion and disease prevention exams.
Colorectal Cancer:	**Physical Examination:** Digital rectal examination should be included in the periodic health examination of individuals 40 years of age and older.	See codes for comprehensive health promotion and disease prevention exams.

SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT CPT CODE
Colorectal Cancer: (Continued)	**Fecal occult blood testing**: Annually 50 and over if at increased risk for colorectal cancer as defined by the U.S. Preventive Services Task Force.	82270
	Proctosigmoidoscopy or Sigmoidoscopy: Once every 3-5 years beginning at age 50.	45300 and 45330.
	Colonoscopy: Performed every five years beginning age 40 for individuals at increased risk for colon cancer with first degree relative with a history of colon cancer.	45355 and 45378.
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 codes for comprehensive health promotion and disease prevention exams.
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 codes for comprehensive health promotion and disease prevention exams.
Thyroid Cancer:	**Physical Examination**: Palpation for thyroid nodules should be performed in adults with a history of upper body irradiation.	See codes for comprehensive health promotion and disease prevention exams.
Infectious Diseases:	**Tuberculosis screening**: Screen annually, regardless of age, all individuals at high risk for tuberculosis (as defined by CDC) using Mantoux tests.	86580 and 86585
	Rubella antibodies: females, once, age 12-18, unless documented history of adequate rubella vaccination with at least one dose of rubella vaccine on or after the first birthday.	86762
	Hepatitis B screening: Screen pregnant women for HBsAG during prenatal period.	87340

TRICARE PRIME - CLINICAL PREVENTIVE SERVICES	Chapter: 12
	Section: 8.1

SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT CPT CODE
Cardiovascular Diseases:	**Cholesterol**: Non-fasting total blood cholesterol: At least once every five years, beginning age 18.	80061
	Blood pressure screening: For children: annually between 3 and 6 years of age, and every 2 years thereafter. For adults: a minimum frequency of every two years.	See codes for comprehensive health promotion and disease prevention exams.
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 codes for comprehensive health promotion and disease prevention exams.
	Vision Screening: For children: eye and vision screening by primary care provider during routine examinations at birth, approximately 6 months, 3 years and 5 years of age. Additionally, age 3-6: comprehensive eye examination for amblyopia and strabismus. For adults: comprehensive eye examination, including screening for visual acuity and glaucoma, every 3 to 5 years in African Americans aged 20 to 39 years, and regardless of race, every 2 to 4 years in individuals aged 40 to 64 years. Diabetic patients, at any age, should have comprehensive eye examinations at least yearly.	92002, 92004, 92012, 92014, and 92015.

Subject: TRICARE OVERSEAS PROGRAM PRIME - CLINICAL PREVENTIVE SERVICES	Chapter: 12
	Section: 8.2
Authority: DoD 6010.8-R, Chapter 17	Issue Date: September 20, 1996

BACKGROUND

The following are clinical preventive services expected of good comprehensive clinical practice in which every patient encounter should be used as an opportunity for preventive care. These preventive services are either (1) screening procedures to detect disease or (2) primary or secondary prevention interventions to protect or restore health. These services may be provided during acute and chronic care visits or during preventive care visits for asymptomatic individuals to maintain and promote good health.

Routine history and physical examination are no longer recommended for health promotion and disease prevention in individuals who are not being monitored as a part of a therapeutic plan for chronic disease. Instead, the U.S. Preventive Services Task Force and other major authorities recommend that every patient encounter be used as an opportunity for preventive care and that a variety of age and sex specific services be combined into these encounters and periodic health promotion disease prevention surveillance examinations.

POLICY

A. There is no preauthorization or referral required for the following services. Verification of codes is not required for payment of enhanced services under the TRICARE Overseas Program.

B. There shall be no co-payments associated with the individually CHAMPUS reimbursable services listed below. The contractor need not establish additional edits to identify claims within the age, sex, race or clinical history perimeters included below:

SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT CPT CODE
SCREENING EXAMINATIONS:		
COMPREHENSIVE HEALTH PROMOTION AND DISEASE PREVENTION EXAMINATIONS	**For ages 24 months or older**: One comprehensive disease prevention clinical evaluation and follow up during age intervals: 2-4; 5-11; 12-17; 18-39; 40-64.	99382-99386 99392-99396

SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT CPT CODE
TARGETED HEALTH PROMOTION AND DISEASE PREVENTION EXAMINATIONS	The following screening examinations may be performed during either the above periodic comprehensive health promotion examination or as part of other patient encounters. The intent is to maximize preventive care.	
Breast Cancer:	**Physical Examination**: For women under age 40, physicians may elect to perform clinical breast examination for those who are at high risk, especially those whose first-degree relatives have had breast cancer diagnosed before menopause. For women age 40 and older, annual clinical examinations should be performed.	See codes for comprehensive health promotion and disease prevention exam.
	Mammography: Baseline mammogram age 40; every two years age 40-50, annually age 50 and over; For high risk women (family history of breast cancer in a first degree relative), baseline mammogram age 35, then annually.	76092
Cancer of Female Reproductive Organs:	**Physical Examination**: Pelvic examination should be performed in conjunction with Pap smear testing for cervical neoplasms and premalignant lesions.	See codes for comprehensive health promotion and disease prevention exams.
	Papanicolaou smears: Annually starting at age 18 (or younger, if sexually active) until three consecutive satisfactory normal annual examinations. Frequency may then be less often at the discretion of the patient and clinician but not less frequently than every three years.	88141, 88150, 88155, and 88156.
Testicular Cancer:	**Physical Examination**: Clinical testicular exam annually for males age 13-39 with a history of cryptorchidism, orchiopexy, or testicular atrophy.	See codes for comprehensive health promotion and disease prevention exams.
Colorectal Cancer:	**Physical Examination**: Digital rectal examination should be included in the periodic health examination of individuals 40 years of age and older.	See codes for comprehensive health promotion and disease prevention exams.

SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT CPT CODE
Colorectal Cancer: (Continued)	**Fecal occult blood testing**: Annually 50 and over if at increased risk for colorectal cancer.	82270
	Proctosigmoidoscopy or Sigmoidoscopy: Once every 3-5 years beginning at age 50.	45300 and 45330.
	Colonoscopy: Performed every five years beginning age 40 for individuals at increased risk for colon cancer with first degree relative with a history of colon cancer.	45355 and 45378.
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 codes for comprehensive health promotion and disease prevention exams.
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 codes for comprehensive health promotion and disease prevention exams.
Thyroid Cancer:	**Physical Examination**: Palpation for thyroid nodules should be performed in adults with a history of upper body irradiation.	See codes for comprehensive health promotion and disease prevention exams.
Infectious Diseases:	**Tuberculosis screening**: Screen annually, regardless of age, all individuals at high risk for tuberculosis.	86580 and 86585
	Rubella antibodies: females, once, age 12-18, unless documented history of adequate rubella vaccination with at least one dose of rubella vaccine on or after the first birthday.	86762
	Hepatitis B screening: Screen pregnant women for HBsAG during prenatal period.	87340

TRICARE OVERSEAS PROGRAM PRIME - CLINICAL PREVENTIVE SERVICES	Chapter: 12
	Section: 8.2

SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT CPT CODE
Cardiovascular Diseases:	**Cholesterol**: Non-fasting total blood cholesterol: At least once every five years, beginning age 18.	80061
	Blood pressure screening: **For children:** Annually between 3 and 6 years of age, and every 2 years thereafter. **For adults**: A minimum frequency of every two years.	See codes for comprehensive health promotion and disease prevention exams.
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 codes for comprehensive health promotion and disease prevention exams.
	Vision Screening: **For children**: Eye and vision screening by primary care provider during routine examinations at birth, approximately 6 months, 3 years and 5 years of age. Additionally, age 3-6: comprehensive eye examination for amblyopia and strabismus. **For adults**: Comprehensive eye examination, including screening for visual acuity and glaucoma, every 3 to 5 years in African Americans aged 20 to 39 years, and regardless of race, every 2 to 4 years in individuals aged 40 to 64 years. Diabetic patients, at any age, should have comprehensive eye examinations at least yearly.	92002, 92004, 92012, 92014, and 92015.

Data Type	Columns	
State abbreviation	1-2	alphabetic
State FIPS code	3-4	numeric
Zip code	5-9	numeric
Locality	10-12	numeric

For example, the first two columns will be the State code, the third and fourth columns will be the State FIPS code, the fifth through ninth columns will be 5-digit zip code, and the 10th-12th columns will be the Medicare locality code. The most current locality for the zip code would always be in columns 10-12. Previous years localities would be in the columns next to columns 10-12 by year in descending order, newest to oldest. Eliminated zip codes shall be zero filled. The file is in ASCII format and will be provided on a 3.5" diskette.

4. TSO/TSO CMAC support contractor shall also provide quarterly updates (replacement file/cartridge) to the contractors on new zip codes and their Medicare locality. The contractors are to have the updates on the zip code file implemented and available for claims received on and after the first day of the second month in the quarter, e.g., August 1.

5. TSO/TSO CMAC support contractor shall also provide a quarterly updated pricing file (replacement file/tape) to the contractors. Both zip code replacement file and the pricing replacement file will be provided on the tenth day of the start of each quarter, e.g., July 10. Both of these files will be accumulative. The updated pricing file will contain the Medicare locality and the CMAC for each procedure code within each given Medicare locality. The main purpose of the update tapes is to provide the contractors with any changes that have been made to the CMACs and the zip codes. The contractors are to inform TSO (PAA) of any missing CMAC price, locality, or zip code so that it can be included in the next update. The contractors are to have the updates on the CMAC tape implemented and available for claims received on and after the first day of the second month in the quarter, e.g., August 1. Each quarterly update tape will have an effective date given with the specific procedure code and CMAC correction. The effective date is defined as the date the CMAC was originally effective. The correction date is defined as the date on which the correct CMAC will be used for claims and adjustments processed on and after that correction date. For audit trail purposes, both the originally calculated CMAC and the corrected CMAC will be on the quarterly CMAC update tape. Interim updates, not annual or quarterly, are to be entered on the contractor's system no later than ten (10) work days after receipt by the contractor. The most recent update (change record) is to be added above the old one(s). When new records are added above the old ones, the first record that would be found in the file for a given CPT-4 code would be the most current information. All variables shall be zero-filled and right-adjusted. CMAC variables will have two implied decimal places.

6. TMA will provide the contractors with national conversion factors (CF) for most professional services (medical and surgical), adjusted to each Medicare locality. Separate CFs will be provided for medical, surgical, radiology, and pathology services for each of the Medicare localities and for each of the four classes of providers. The national CFs will be used by the contractors in pricing "by report" and "unlisted" procedures. The contractors' medical consultants are to use the Medicare RVUs as published in the Federal Register, in

estimating an RVU when they apply the national conversion factors. See Chapter 13, Section 1.5, Addendum 1.

NOTE: *The national conversion factors are not to be applied to anesthesiology, lab, DME, routine dental, Program for Persons with Disabilities, and other non-professional services such as drugs, supplies, facility charges, or ambulance services.*

National conversion factors will be provided in a separate pricing file. The layout for this file is as follows:

Variable	Columns	Data Type Comments
CHAMPUS Locality No.	1-3	range 001-225
Class 01 CF - Medical	4-8	
Class 01 CF - Surgical	9-13	
Class 01 CF - Radiology	14-18	
Class 01 CF - Pathology	19-23	
Class 04 CF - Medical	24-28	
Class 04 CF - Surgical	29-33	
Class 04 CF - Radiology	34-38	
Class 04 CF - Pathology	39-43	
Class 02 CF - Medical	44-48	
Class 03 CF - Medical	49-53	

The file shall be on a 3.5" diskette in ASCII character data. All variables shall be zero-filled and right-adjusted. All conversion factor variables will have two implied decimal places.

D. Categories of care not subject to the National Allowable Charge System.

1. Pricing for certain categories of health care shall remain the responsibility of the contractor (see Chapter 13, Section 1.5, Addendum 1). The following categories will continue to be priced under current contractor procedures:

Durable Medical Equipment (DME)

Routine Dental (ADA codes)

Anesthesiology

Lab (as designated in Chapter 13, Section 1.5, Addendum 1)

Ambulance

Special purpose procedural codes included in the ADP Manual, Chapter 2,

Addendum F. (See Chapter 13, Section 1.5, Addendum 1 for specific designation of pricing responsibility.)

2. The contractors shall continue paying claims for new procedures following current policy as described in the COM-FI Part Two, Chapter 4 and OPM Part Two, Chapter 4. However, a new set of locally-adjusted prevailing charges shall be provided to each contractor annually, and these update files shall include new codes for which sufficient claims data exist to calculate locally-adjusted prevailing charges.

3. Low volume procedures are now defined as those procedures with less than eight claims nationally per year. In the past, low-volume was designate on the state level. Under the new system, there shall be fewer low-volume codes because there shall typically be enough claims on a national level to create locally-adjusted prevailing charges. For cases where there are fewer than eight claims nationally and the contractor has not been provided with a locally-adjusted prevailing, the contractors shall follow current policies as described in the COM-FI and Operations Manual.

NOTE: *The definition of a low volume procedure as less than fifty (50) claims began with the first CMAC file update occurring after April 1, 1994. For CMAC file changes on or before April 1, 1994, a low volume procedure was less than eight claims.*

E. The following procedures which may have been separately reimbursed in the past are no longer eligible for separate TRICARE cost-sharing. Payment for these services is included in the payment for other services.

15850	Remove sutures under anes., same surgeon
20930	Allograft, morselized
20936	Autograft, same incision
22841	Internal spinal fixation
78890	Generation of automated data <= 30 min.
78891	Generation of automated data > 30 min.
90885	Psych. eval. of records, reports, tests
92340-92342	Fitting of spectacles
92352-92358	Special services for aphakia
92370-92371	Repair and refit spectacles
92531-92534	Vestibular function tests
94150	Vital Capacity, Total (Separate Procedure)
97010	Hot or cold packs
99024	Post-op follow-up visit incl. in global service
99025	Initial patient visit when minor surg. done
99050	Visit after normal office hours
99052	Visit 10pm-8am
99054	Visit on Sunday/holiday

99056	Visit outside office due to patient request
99058	Office services on emergency basis
99288	Physician direction of EMS/ALS
99358, 99359	Prolonged E&M services before/after visit
99376	Care plan oversight > 60 min

F. The CHAMPUS Maximum Allowable Charge applies to all fifty states and Puerto Rico. Guam and the Virgin Islands are to still be paid as other foreign countries as billed for professional services.

G. The Appropriations Act of Fiscal Year 1993, Public Law 102-396, Section 9011 had several provisions which affects the TRICARE allowable charge payment methodology.

1. Reductions in maximum allowable payments.

a. This act authorizes reductions in maximum allowable payments to physicians and other individual professional providers (including clinical laboratories) for overpriced procedures. These are the procedures for which the prior year's national CHAMPUS Maximum Allowable Charge (CMAC) exceeds the Medicare fee. In such comparisons, reduction will be the lesser of the percentage by which the CMAC exceeds the Medicare fee or fifteen (15) percent.

b. The appropriate reductions are reflected in the CMACs for services rendered and paid on or after November 1, 1993.

2. Balance billing limitation.

a. Nonparticipating providers may not balance bill a beneficiary an amount which exceeds the applicable balance billing limit. This limit is 115 percent of the TRICARE allowable charge.

b. Failure by a provider to comply with this requirement is a basis for exclusion from the TRICARE program.

c. Effective November 1, 1993. See COM-FI Part Two, Chapter 4 and OPM Part Two, Chapter 4 for specific application of this date.

H. National Defense Authorization Act for Fiscal Year 1992, 10 U.S.C. Section 1106 had several provisions which affect the TRICARE allowable charge payment methodology.

1. Change in the claims filing deadline.

a. All (including beneficiary) claims must be filed with the appropriate contractor no later than one year after the services are provided. For inpatient admissions, facility charges (not professional charges) must be filed with the appropriate contractor no later than one year after the date of discharge.

b. Effective January 1, 1993. See COM-FI Part Two, Chapter 1 and OPM Part Two, Chapter 1 for specific application of this date.

2. Filing of claims by providers.

a. Providers are required to file claims on behalf of TRICARE beneficiaries. The provider is prohibited from imposing any administrative charge related to the filing requirement.

b. Providers who fail to comply with the requirement or who fail to obtain a waiver will have the TRICARE allowable charge reduced by ten (10) percent. The reduction shall not be balance billed to the beneficiary.

c. See COM-FI Part Two, Chapter 1, and OPM Part Two, Chapter 1 for specific application of this requirement.

I. The Appropriations Act for Fiscal Year 1994, Public Law 103-139, Section 8010, enacted November 11, 1993, had several provisions which affect the TRICARE allowable charge payment methodology.

1. Reduction in maximum allowable payments.

a. This Act authorizes reductions in maximum allowable payments to physicians and other individual professional providers (including clinical laboratories) for overpriced procedures. These are the procedures for which the prior year's national CHAMPUS Maximum Allowable Charge (CMAC) exceeds the Medicare fee. In such comparisons, reduction will be the lesser of the percentage by which the CMAC exceeds the Medicare fee, ratio level of 1.0, or fifteen (15) percent (except that the reduction may be waived if determined to impair adequate access to health care services for beneficiaries).

b. The appropriate reductions are reflected in the CMACs for services rendered and paid on or after April 1, 1994.

2. This Act authorizes an increase when justified by economic circumstances. The CHAMPUS maximum allowable charge may be increased in accordance with Medicare's economic index. Such increases are reflected in the CMACs for services rendered and paid on or after April 1, 1994.

POLICY CONSIDERATIONS

A. A charge that exceeds the allowable charge may be determined to be allowable only when unusual circumstances or medical complications justify the higher charge (see the Chapter 13, Section 4.1 and Section 4.3). The allowable charge may not exceed the billed charge under any circumstances.

B. The allowable charge for physician assistant services other than assistant-at-surgery may not exceed 85 percent of the allowable charge for a comparable service rendered by a physician performing the service in a similar location. For cases in which the physician assistant and the physician perform component services of a procedure other than assistant-at-surgery (e.g., home, office, or hospital visit), the combined allowable charge for the procedure may not exceed the allowable charge for the procedure rendered by a physician alone. The allowable charge for physician assistant services performed as an assistant-at-surgery may not exceed 65 percent of the allowable charge for a physician serving as an assistant surgeon when authorized as TRICARE benefits. Physician assistant

services must be billed through the employing physician who must be an authorized TRICARE provider. (See Chapter 13, Section 2.5.)

EFFECTIVE DATE May 1, 1992, except as stated above.

- END -

Subject: SKILLED NURSING SERVICES	Chapter: 13
Authority: DoD 6010.8-R, Chapter 2 and DoD 6010.8-R, Chapter 4, C.	Section: 3.10
	Issue Date: September 27, 1995

ISSUE

How are claims to be reimbursed for skilled nursing services provided in the home?

DEFINITION

A skilled nursing service is a service that can only be furnished by a registered nurse (R.N.), licensed practical nurse (L.P.N.), or licensed vocational nurse (L.V.N.), and is required to be performed under the supervision of a physician to ensure the safety of the patient and achieve the medically desired result. Skilled nursing services are other than those that could be performed by a layman adult with minimum instruction or supervision. (For example, the pre-filling of insulin syringes can be safely done by a nonmedical person without direct nursing supervision. Therefore, teaching how to pre-fill the syringe would be skilled, but pre-filling the syringes on an ongoing basis would not be skilled.) A service is not considered a skilled nursing service merely because it is performed by or under the direct supervision of a licensed nurse.

POLICY

A. The skilled nursing service must be medically necessary and appropriate to the diagnosis and treatment of the beneficiary's illness or injury within the context of the beneficiary's unique medical condition. To be considered medically necessary and appropriate for the diagnosis or treatment of the beneficiary's illness or injury, the services must be consistent with the nature and severity of the illness or injury, his or her particular medical needs, and accepted standards of medical and nursing practice. A beneficiary's overall medical condition is a valid factor in deciding whether skilled services are needed. A beneficiary's diagnosis should never be the sole factor in deciding that a service the beneficiary needs is either skilled or not skilled.

B. Skilled nursing services may be cost-shared under CHAMPUS provided all of the following conditions are met:

1. The services are ordered by and included in the plan of treatment established by the physician; and

2. The services are required on an intermittent or part-time basis; or are received under cas management in those areas where case management is available, if for more than four hours per day; and

3. The services must require the skills of an R.N., or the services of and L.P.N. or L.V.N., under the supervision of a registered nurse or a physician; and

4. The services are medically necessary and appropriate to the treatment of an illness or injury.

SKILLED NURSING SERVICES	Chapter: 13
	Section: 3.10

POLICY CONSIDERATIONS

A. The determination of whether the skilled nursing services are medically necessary and appropriate should be made in consideration that a physician has determined that the skilled nursing services ordered are medically necessary and appropriate. The services must, therefore, follow the plan of treatment established by the physician. Comprehensive nursing progress notes must document the skilled nursing services provided, the patient's condition, and the patient's response to treatment.

B. Intermittent skilled nursing services means any number of visits per week, up to and including 21 hours per week, for three hours or less per day.

C. Part-time skilled nursing services means any number of visits per week, up to and including 28 hours per week, for four hours per day.

D. Any case requiring or requesting more than four hours per day of skilled nursing services shall be referred to case management (where available). (Reference COM-FI Part Two, Chapter 20 and OPM Part Two, Chapter 20.)

E. Reimbursement for skilled nursing services.

1. Current CPT procedure code 99347 (home visit) is to be used to price and report one hour of skilled nursing care under the custodial care benefit. (See Chapter 8, Section 6.1.)

2. An in-home intermittent skilled nursing visit is an all-inclusive unit of service that is three hours or less in duration and is reimbursed on a per visit basis. Current CPT procedure code 99348 (home visits) is to be used to price and report an in-home intermittent skilled nursing visit.

3. An in-home part-time skilled nursing visit is four hours in duration and is reimbursed on an hourly basis. Current CPT procedure code 99347 (home visits) is to be used to price and report a part-time skilled nursing visit (four hours per day) by multiplying the CMAC amount by four.

a. The contractors are expected to verify the medical necessity and appropriateness of the skilled nursing service charges as supported in the comprehensive nursing progress notes on all cases under basic home health care. Where time records of home health visits are unavailable or found to be inaccurate, the reimbursement rate is based on the intermittent visit rather than actual hours of services rendered. Nurses are required to maintain detailed daily nursing notes and benefits will be available only for that time actually required to perform medically necessary skilled nursing services (e.g., if skilled nurse is assigned a four hour shift, but only 30 minutes of skilled nursing services is performed every two hours, then only one hour (30 minutes x 2) will be reimbursed for the four hour shift. If a nurse came every two hours (meets intermittent definition) to perform 60 minutes of skilled nursing services for a total of two hours per day, TRICARE would reimburse at the intermittent visit rate (CPT code 99348) for the two hours.

Subject: SUBSTANCE USE DISORDER REHABILITATION FACILITIES REIMBURSEMENT	Chapter: 13
	Section: 6.8
Authority: DoD 6010.8-R, Chapter 14, A.1.b.(5) and A.2.i.(1)	Issue Date: June 26, 1995

ISSUE

Reimbursement of Substance Use Disorder Rehabilitation Facilities (SUDRF). This includes reimbursement for both inpatient and partial hospitalization for the treatment of substance use disorder rehabilitation care.

POLICY

A. Inpatient Substance Use Disorder Facilities. Effective with admissions on or after July 1, 1995, authorized substance use disorder facilities are subject to the DRG-based payment system. (See Chapter 13, Section 6.1D.)

B. Partial hospitalization for the treatment of substance use disorders. Substance use disorder rehabilitation partial hospitalization services are reimbursed on the basis of prospectively determined all-inclusive per diem rates. The per diem payment amount must be accepted as payment in full for all institutional services provided, including board, routine nursing services, ancillary services (includes art, music, dance, occupational and other such therapies), psychological testing and assessments, overhead and any other services for the customary practice among similar providers is included as part of the institutional charges. (See Chapter 13, Section 6.7)

C. Outpatient services will be reimbursed using billed charges for OCHAMPUS Level III HCPCS Code 90834. Payment is not to exceed the allowable amount for CPT Code 90853.

D. Family therapy provided on an inpatient or outpatient basis will be reimbursed under the CMAC for the procedure code(s) billed.

E. Cost-sharing. Effective for care on or after October 1, 1995, the cost-share for active duty dependents for inpatient substance use disorder services is $20 per day for each day of the inpatient admission. The $20.00 cost-share amount also applies to substance use disorder rehabilitation care provided in a partial hospitalization setting. The inpatient cost-share applies to the associated services billed separately by the individual professional providers. For care prior to October 1, 1995, the cost-share will be the daily rate or $25.00, whichever is greater. For retirees and their dependents, the cost-share is 25 percent of the allowed amount. Since inpatient cost-sharing is being applied, no deductible is to be taken for partial hospitalization regardless of sponsor status. The cost-share for active duty dependents is to be taken from the partial hospitalization facility claim.

F. Related Issuances.

1. Chapter 1, Section 12.1F, PREAUTHORIZATION REQUIREMENTS FOR SUBSTANCE USE DISORDER DETOXIFICATION AND REHABILITATION.

2. Chapter 8, Section 21.1, ALCOHOLISM - PRIOR TO OCTOBER 1, 1995.

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3. Chapter 13, Section 6.1D, HOSPITAL REIMBURSEMENT - CHAMPUS DRG-BASED PAYMENT SYSTEM (APPLICABILITY OF THE DRG SYSTEM).

4. Chapter 13, Section 6.7, PSYCHIATRIC PARTIAL HOSPITALIZATION PROGRAM REIMBURSEMENT.

5. Chapter 11, Section 11.7, SUBSTANCE USE DISORDER REHABILITATION FACILITIES CERTIFICATION PROCESS.

- END -

(a) General Requirements -- Hospitals report HCPCS codes for all radiology services and other diagnostic procedures. Most related HCPCS codes are in Level I, but some are in Level II in the M (Cardiology) and R (Radiology) series.

(b) Aborted Procedure -- When a procedure is not completed, hospitals bill an unlisted code showing the actual charges for radiology services and for other diagnostic procedures. See paragraph A.6.c.(1)(g), below, for an explanation of unlisted codes.

(c) Combined Procedures (Radiology) -- There are no separate codes covering certain combined procedures, (e.g., a hand and forearm included in a single X-ray). In this case, the hospital may use the code for the more expensive procedure. Charges must be for the combined procedure, not two procedures.

(d) Radiation Treatment Delivery -- The hospital should not bill weekly treatment management services (codes 77419 - 77499). Instead, they should bill for radiation treatment deliver (codes 77401 - 77404, 77406 - 77409, 77411 - 77414, and 77416). The hospital should enter the number of services in the units field.

(e) High Osmolar Contrast Material (HOCM) (Radiology) -- When a hospital provides a radiology procedure with HOCM, the HCPCS code that indicates "with" contrast material is billed. If HCPCS does not have codes that distinguish between "with" and "without" contrast material, the hospital uses the closest available code to the service. In such cases, the hospital may bill HOCM separately in addition to the radiology procedure, or it may include the HOCM as part of the amount for the radiology procedure. If billed separately, revenue code 255 is used.

(f) Low osmolar Contrast Material (LOCM) Radiology -- The applicable Level I HCPCS codes for intrathecal injections are:

70010, 70015, 72240, 72255, 72265, 72270, 72285, 72295

Level II codes for contrast material are:

A4644 - Supply of low osmolar contrast material (100-199 mgs of iodine);

A4645 - Supply of low osmolar contrast material (200-299 mgs of iodine); or

A4646 - Supply of low osmolar contrast material (300-399 mgs of iodine).

(g) Radiology or Other Diagnostic Unlisted Service or Procedure -- Hospitals may find radiology and other diagnostic services for which a corresponding code in HCPCS may not be found. This is because these are typically services that are rarely provided, unusual, or new. The hospital should assign the appropriate "unlisted procedure" code found in the CPT.

(2) Other Diagnostic and Medical Services. The following instructions apply to reporting medical and additional diagnostic services other than lab, radiology or other

diagnostic tests. These reporting requirements apply to hospital services provided in clinics, emergency departments, and other outpatient departments.

(a) Level I codes do not always reflect the technical component of a service furnished by the hospital. Therefore, the hospital should ignore any wording that indicates that the service must be performed by a physician. In cases where there are separate codes for the technical component, professional component and/or complete procedure, the hospital should use the code that represents the technical component. If there is no technical component code for the service, the hospital should use the code that represents the complete procedure.

(b) Codes used to report clinic and emergency room visits are designed primarily for professional services, but are to be used by a hospital to report facility charges because of the absence of specific facility charges. Related charges reported are for the facility charge only. Separate billing is appropriate on the HCFA form 1500 for professional services.

(c) Chemotherapy - The hospital should use Level I codes for chemotherapy administration, and show the number of visits for units. The hospital should code the drugs administered during chemotherapy using Level II HCPCS codes in the J series; and Q series where temporary codes are applicable. Other outpatient hospital drugs are not coded in HCPCS but may be billed under appropriate revenue codes without HCPCS.

(3) Non-Reportable HCPCS Codes -- Hospitals do not use the following list of HCPCS codes to report diagnostic and medical services. These codes are for professional services and should be billed on a HCFA form 1500, but may be billed separately from the institutional services by the hospital on a UB-92 when sufficient information is submitted to process the claim as professional services.

99341 - 99350	Home Services
99221 - 99233	Hospital Inpatient Services
99499	Unlisted Evaluation and Management Services

(4) Outpatient Surgery -- A hospital should use Level I codes to report significant outpatient surgical procedures.

(a) Definition of Surgery -- surgery is defined as incision, excision, amputation, introduction, repair, destruction, endoscopy, suture or manipulation. The codes for surgery are in the Level I portion of HCPCS beginning with 10000 and ending at 69979. The claim includes the hospital's charges for the surgery as well as all other services provided on the day the procedure was performed. Usually only one surgical procedure is entered on a claim. However, upon occasion, more than one outpatient surgical procedure might be furnished at the same session. In such cases, all significant surgical procedures are reported.

(b) Unlisted Service or Procedure -- There may be surgical procedures performed that are not found in any level of HCPCS. These are typically services that are rarely provided, unusual, variable, or unlisted procedures. When an unlisted procedure

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