# TRICARE Maternity Ultrasound Policy Revised Effective April 1, 2006

TRICARE has changed the way it administers the maternity ultrasound benefit. In the past, maternity ultrasounds, other than those with a high-risk diagnosis, were considered to be included within the maternity global fee. Effective April 1, 2006, medically necessary fetal ultrasounds are covered outside the maternity global fee as follows.

**TRICARE Maternity-Related Ultrasound**

The professional and technical components of medically necessary fetal ultrasounds are covered outside the maternity global fee. The medically necessary indications include (but are not limited to) **clinical circumstances** that require obstetric ultrasounds to: estimate gestational age, evaluate fetal growth, conduct a biophysical evaluation for fetal well being, evaluate a suspected ectopic pregnancy, define the cause of vaginal bleeding, diagnose or evaluate multiple gestations, confirm cardiac activity, evaluate maternal pelvic masses or uterine abnormalities, evaluate suspected hydatidiform mole, and evaluate the fetus' condition in late registrants for prenatal care.

Per American College of Obstetricians and Gynecologists (ACOG) guidelines, ultrasonography should be performed only when there is a valid medical indication. A physician is not obligated to perfom ultrasonography in a patient who is at low risk and has no medical indications.

Some providers offer all patients routine ultrasound screening as part of the scope of care after 16-20 weeks of gestation. *TRICARE **does not cover** routine ultrasound screening*. Only maternity ultrasound with a valid medical indication that constitutes medical necessity is covered by TRICARE.

**Important Note:** For rendering providers billing with a diagnosis of supervision of normal pregnancy, a secondary diagnosis is required to establish medical necessity of a diagnostic fetal ultrasound performed during a normal pregnancy. Otherwise, the claim will not be reimbursed. Those Primary Prenatal Care Providers referring patients out to receive an ultrasound need to provide the diagnosis (medical indications) to the rendering provider in order to justify medical necessity.

**Non-Medically Necessary Maternity Ultrasounds**

If the beneficiary or provider is considering an ultrasound that does not have a valid medical indication, the ultrasound is not covered by TRICARE and payment may be the beneficiary's responsibility. For example, determining gender is not considered to be medically necessary. Please refer to "Billing the Beneficiary for Ultrasounds" below for additional information.

**Billing the Beneficiary for Ultrasounds**
If the beneficiary and the rendering ultrasound provider agree to perform an ultrasound that does not have a valid medical indication, the ultrasound provider may only bill the beneficiary directly under the following circumstances:

Network Providers: Network providers must have the beneficiary complete a Request for Non-Covered Services form, or equivalent, prior to the service being rendered. This form identifies that the beneficiary has agreed to pay in full for the ultrasound. The general release of liability forms used by most provider offices do not relieve the provider of responsibility under TRICARE; therefore use of the Request For Non-Covered Services Form is strongly recommended. The provider should retain this form with the beneficiary's file and refer to it if necessary for beneficiary billing purposes. If this form is not completed in advance of the ultrasound, the beneficiary is "held harmless," and the provider cannot bill the beneficiary.

Network providers can choose to use a different legal signed waiver release form rather than the Request for Non-Covered Services form, to identify the beneficiary's agreement to pay for the non-covered service. However, the general release of liability forms used by most provider offices do not relieve the provider of responsibility under TRICARE; therefore use of the Request for Non-Covered Services form is strongly recommended.

Non-Network Providers: Although a TRICARE-specific form is not required to document the payment agreement, it is important that you inform the beneficiary that she will be responsible for paying for the ultrasound. A written document identifying this agreement is recommended. Non-network providers can use the Request for Non-Covered Services form to document the payment agreement in writing prior to the service. Otherwise, TRICARE prohibits billing beneficiaries for care that is not medically necessary unless the beneficiary knew before treatment that the care would not be covered.

As a reminder, global maternity care requires a prior authorization from Health Net for TRICARE Prime beneficiaries, TRICARE Prime Remote for Active Duty Family Members beneficiaries or active duty service members receiving care from a network or non-network provider.If you have additional questions about ultrasounds or maternity benefits, you may find additional information on this Web site or by calling Health Net at 1-877-TRICARE (1-877-874-2273).