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TRICARE
MANAGEMENT ACTIVITY

MB&RB

**CHANGE 113
6010.54-M
DECEMBER 15, 2009**

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

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

CHANGE TITLE: EVOLVING PRACTICES - OCTOBER 2009

CONREQ: 14898

PAGE CHANGE(S): See page 2.

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

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

**John A. D'Alessandro
Chief, Medical Benefits and
Reimbursement Branch**

**ATTACHMENT(S): 41 PAGE(S)
DISTRIBUTION: 6010.54-M**

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CHAPTER 1

Section 1.1, page 7

Section 17.1, pages 1 and 2

CHAPTER 4

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CHAPTER 5

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SUMMARY OF CHANGES

CHAPTER 1

1. Section 1.1. Corrected a typographical error in the NOTE under paragraph 67.
2. Section 17.1. Added S1040 code in paragraph III. B. 2.

CHAPTER 4

3. Table of Contents. Added new Section 5.8.
4. Section 5.1.
 - a. Added language that allows the use of AlloDerm (acellular dermal allograft) when used in a covered breast reconstruction surgery, effective July 8, 2008.
 - b. Added coverage for Negative Pressure Wound Therapy (NPWT) when specific criteria are met, effective November 9, 2007.
5. Section 5.3. Added CPT code 58720. Effective January 1, 2006, added coverage for prophylactic oophorectomy for women meeting certain criteria and removed requirement for a positive BRCA genetic test.
6. Section 5.8. Added a new section for Negative Pressure Wound Therapy (NPWT). Added coverage for NNPWT when specific criteria are met, effective November 9, 2007.
7. Section 6.1. Relocated "botox" (paragraph V.F.) to new botulinum section, Chapter 7, Section 27.1.
8. Section 8.1. Uvulopalatopharyngoplasty (UPPP) for treatment of Upper Airway Resistance Syndrome (UARS) is unproven and was added as an exclusion.
9. Section 21.1, Paragraph F. Changed the status from unproven to proven for Intrastromal Corneal Ring Segments, and allows coverage for certain indications (keratoconus refractory to lens treatment and for beneficiaries for whom corneal transplant is the only remaining option), effective July 17, 2005.
10. Section 22.2. Deleted CPT codes 90669 and 90732, as these are vaccine codes and are addressed elsewhere.

SUMMARY OF CHANGES (Continued)

CHAPTER 5

11. Section 4.1. PET and PET/CT for the diagnosis, staging, restaging, and monitoring of the treatment of gastric cancer are unproven and were added as exclusions.

CHAPTER 7

12. Table of Contents. Added new Section 27.1.

13. Section 8.1. Uvulopalatopharyngoplasty (UPPP) for treatment of Upper Airway Resistance Syndrome (UARS) is unproven and was added as an exclusion.

14. Section 15.1. Relocated botulinum exclusions (paragraphs IV.B and IV.B.1 through IV.B.5) to Chapter 7, Section 27.1.

15. Section 27.1. This is a new section specifically for Botulinum Toxin A Injections. Consolidated all references to botulinum in this section.

CHAPTER 8

16. Table of Contents. Added new Section 5.3.

17. Section 3.1. Effective December 17, 2004, added coverage for Dynamic Orthotic Cranioplasty (DOC) Band Post-Op device for infants from three to eighteen months of age, meeting certain criteria.

18. Section 5.3. Added a new section for Continuous Glucose Monitoring System (CGMS) Devices. Effective December 1, 2008, these devices may be covered when specific criteria are met.

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19. Added Botulinum Toxin A Injections, Continuous Glucose Monitoring System (CGMS) Devices, and Negative Pressure Wound Therapy (NPWT).

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CHAPTER 1, SECTION 1.1

EXCLUSIONS

61. Housekeeping, homemaker, or attendant services, sitter or companion (for exceptions, see [32 CFR 199.4\(e\)\(19\)](#) regarding hospice care) (see the TRICARE Reimbursement Manual (TRM), [Chapter 11, Sections 1 and 4.](#)).

62. All services and supplies (including inpatient institutional costs) related to a noncovered condition or treatment, or provided by an unauthorized provider.

63. Personal, comfort, or convenience items, such as beauty and barber services, radio, television, and telephone (for exceptions, see [32 CFR 199.4\(e\)\(19\)](#) regarding hospice care).

NOTE: Admission kits are covered.

64. Megavitamin psychiatric therapy, orthomolecular psychiatric therapy.

65. All transportation except by ambulance, as specifically provided under [32 CFR 199.4\(d\)](#) and [\(e\)\(5\)](#).

NOTE: Transportation of an ECHO beneficiary to or from a facility or institution to receive authorized institutionalized ECHO services or items may be cost-shared under [32 CFR 199.5\(c\)\(6\)](#). Transportation of an accompanying medical attendant to ensure the safe transport of the ECHO beneficiary may also be cost-shared (see [Chapter 9, Section 11.1](#)).

66. All travel even though prescribed by a physician and even if its purpose is to obtain medical care, except as specified in [32 CFR 199.4\(a\)\(6\)](#).

NOTE: For the exception for certain Prime travel expenses and non-medical attendants, see [32 CFR 199.17\(n\)\(2\)\(vi\)](#) and the TRM, [Chapter 1, Section 30](#).

67. Services and supplies provided by other than a hospital, unless the institution has been approved specifically by TRICARE. Nursing homes, intermediate care facilities, halfway houses, homes for the aged, or institutions of similar purpose are excluded from consideration as approved facilities.

68. Service animals (Seeing Eye dogs, hearing/handicap assistance dogs, seizure and other detection animals, service monkeys, etc.) are excluded from coverage under the Basic or ECHO programs.

- END -

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

ISSUE DATE: November 6, 2007

AUTHORITY:

I. HCPCS "C" AND "S" CODES

C1000 - C9999; S0000 - S9999

II. DESCRIPTION

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

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

III. POLICY

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

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

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

2. S0812, S1030, S1031, **S1040**, S2066, S2067, S2068, S2075, S2076, S2077, S2083, S2202, S2235, S2360, S2361, S2401, S2402, S2403, S2405, S2411, S3620, S3818, S3819, S3820, S3822, S3823, S8030, S8185, S8265, S8270, and S9430 for all beneficiaries; and

3. S5108 for direct Educational Interventions for Autism Spectrum Disorders (EIA) services provided to TRICARE beneficiaries under the Department of Defense (DoD) Enhanced Access to Autism Services Demonstration. (See the TRICARE Operations Manual (TOM), [Chapter 20, Section 10](#)).

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CHAPTER 1, SECTION 17.1
HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS) "C" AND
"S" CODES

4. S2400 for prenatal surgical intervention of temporary tracheal occlusion of Congenital Diaphragmatic Hernia (CDH) for fetuses with prenatal diagnosis of CDH shall be determined on a case-by-case basis, based on the Rare Disease policy, effective October 1, 2009. Procedural guidelines for review of rare disease are contained in [Chapter 1, Section 3.1](#).

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

IV. EXCLUSIONS

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

- END -

SURGERY

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1.1	Complications (Unfortunate Sequelae) Resulting From Noncovered Surgery Or Treatment
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4.1	Assistant Surgeons
5.1	Integumentary System
5.2	Postmastectomy Reconstructive Breast Surgery
5.3	Prophylactic Mastectomy, Prophylactic Oophorectomy, And Prophylactic Hysterectomy
5.4	Reduction Mammoplasty For Macromastia
5.5	Silicone Or Saline Breast Implant Removal
5.6	Breast Reconstruction As A Result Of A Congenital Anomaly
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12.1	Mediastinum And Diaphragm

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18.1	Maternity Care
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19.1	Endocrine System
20.1	Nervous System
20.2	Stereotactic Radiofrequency Pallidotomy With Microelectrode Mapping For Treatment Of Parkinson's Disease
20.3	Stereotactic Radiofrequency Thalamotomy
21.1	Eye And Ocular Adnexa
22.1	Auditory System
22.2	Cochlear Implantation
23.1	High Dose Chemotherapy And Stem Cell Transplantation
24.1	Heart-Lung And Lung Transplantation
24.2	Heart Transplantation
24.3	Combined Heart-Kidney Transplantation (CHKT)
24.4	Small Intestine, Combined Small Intestine-Liver, And Multivisceral Transplantation
24.5	Liver Transplantation
24.6	Combined Liver-Kidney Transplantation
24.7	Simultaneous Pancreas-Kidney, Pancreas-After-Kidney, And Pancreas-Transplant-Alone, And Pancreatic Islet Cell Transplantation
24.8	Kidney Transplantation
24.9	Donor Costs

INTEGUMENTARY SYSTEM

ISSUE DATE: August 26, 1985

AUTHORITY: 32 CFR 199.4(c)(2) and (c)(3)

I. CPT¹ PROCEDURE CODES

10021, 10022, 10040 - 11977, 11981 - 11983, 12001 - 15366, 15400 - 15431, 15570 - 15776, 15840 - 15845, 15851 - 19499, 97601, and 97602

II. DESCRIPTION

Integumentary system pertains to the skin, subcutaneous tissue and areolar tissue.

III. POLICY

A. Services and supplies required in the diagnosis and treatment of illness or injury involving the integumentary system are covered.

B. Topical Treatment of Skin Ulcers Caused by Venous Insufficiency. Topical application of Alpigraf by a physician for the treatment of skin ulcers caused by venous insufficiency is a covered benefit. Effective May 26, 1998.

C. Tropical Treatment of Diabetic Foot Ulcers. Application of tissue cultured skin grafts for diabetic foot ulcers is a covered benefit. Effective May 8, 2000.

D. Topical Treatment of Diabetic Foot Ulcers. Application of Becaplermine Gel (Regranex) is a covered treatment of lower extremity diabetic neuropathic foot ulcers that extend into the subcutaneous tissue or beyond. Effective December 16, 1997.

E. AlloDerm (an acellular allograft) is a covered benefit, effective July 8, 2008, when used in a covered breast reconstruction surgery (see Section 5.2) for women who have any of the following indications:

1. Have insufficient tissue expander or implant coverage by the pectoralis major muscle and additional coverage is required; or

2. There is viable, but compromised or thin post-mastectomy skin flaps that are at risk of dehiscence or necrosis; or

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3. The infra-mammary fold and lateral mammary folds have been undermined during mastectomy and re-establishment of these landmarks are needed.

F. Negative Pressure Wound Therapy (NPWT) may be covered effective November 9, 2007 when certain criteria are met. See Section 5.8.

IV. EXCLUSIONS

A. Removal of corns or calluses or trimming of toenails and other routine podiatry services, except those required as a result of diagnosed systemic medical disease affecting the lower limbs, such as severe diabetes.

B. Services performed for cosmetic purposes.

C. Subcutaneous hormone (estradiol and/or testosterone) pellet implantation (CPT² procedure code 11980) is unproven. Estradiol pellets are not U.S. Food and Drug Administration (FDA) approved for general use in humans.

- END -

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PROPHYLACTIC MASTECTOMY, PROPHYLACTIC OOPHORECTOMY, AND PROPHYLACTIC HYSTERECTOMY

ISSUE DATE: October 25, 1993

AUTHORITY: [32 CFR 199.4\(c\)\(2\)](#)

I. CPT¹ PROCEDURE CODES

19300 - 19307, 58150 - 58294, 58541 - 58554, 58661, **58720**, 58940 - 58956

II. DESCRIPTION

A. Prophylactic mastectomy is an extirpative procedure (usually simple or total mastectomy) which removes all breast tissue which would be otherwise subject to breast carcinoma. Carefully selected indications have been developed for prophylactic mastectomy and are included in this policy.

B. Prophylactic oophorectomy is removal of the ovaries before development of cancerous cells. Carefully selected indications have been developed for prophylactic oophorectomy and are included in this policy.

C. Prophylactic hysterectomy is removal of the uterus before development of cancerous cells. Carefully selected indications have been developed for prophylactic hysterectomy and are included in this policy.

III. POLICY

A. Bilateral prophylactic mastectomies are covered for patients at increased risk of developing breast carcinoma who have one or more of the following:

1. Atypical hyperplasia of lobular or ductal origin confirmed on biopsy; or
2. A negative or positive Breast Cancer (BRCA) genetic test and family history of breast cancer in a first-degree relative (especially a mother or sister) who is premenopausal and has bilateral breast cancer (Family Cancer Syndrome); or
3. Fibronodular, dense breasts which are mammographically and/or clinically difficult to evaluate and the patient presents with either of the above (or both) clinical presentations.

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B. Unilateral prophylactic mastectomies are covered when the contralateral breast has been diagnosed with cancer for patients with:

1. Diffuse microcalcifications in the remaining breast, especially when ductal in-situ carcinoma has been diagnosed in the contralateral breast; or
2. Lobular carcinoma in-situ; or
3. Large breast and/or ptotic, dense or disproportionately-sized breast that are difficult to evaluate mammographically and clinically; or
4. In whom observational surveillance is elected for lobular carcinoma in-situ and the patient develops either invasive lobular or ductal carcinoma; or
5. A negative or positive BRCA genetic test and family history of breast cancer in a first-degree relative (especially a mother or sister) who is premenopausal and has bilateral breast cancer (Family Cancer Syndrome).

C. Prophylactic oophorectomy is covered for women who meet any of the following criteria:

1. Women who have been diagnosed with an hereditary ovarian cancer syndrome based on a family pedigree constructed by an authorized provider competent in determining the presence of an autosomal dominant inheritance pattern; or
2. Women with a personal history of steroid hormone receptor-positive breast cancer; or
3. Women with a personal history of breast cancer and at least one first degree relative (mother, sister, daughter) with a history of ovarian cancer; or
4. Women who have two or more first degree relatives with a history of breast or ovarian cancer; or
5. Women with one first degree relative and one or more second degree relative (grandmother, aunt, or niece) with ovarian cancer.
6. Some families have pedigrees that are very small, and therefore have only one first degree relative with ovarian cancer or young-onset breast, colon, or endometrial cancer that may suggest increased risk for ovarian cancer. These individuals may also be considered for prophylactic oophorectomy. Effective January 1, 2006.

D. Prophylactic hysterectomy is covered:

1. For women who are about to undergo or are undergoing tamoxifen therapy.
2. For women who have been diagnosed with Hereditary Nonpolypoid Colorectal Cancer (HNPCC) or are found to be carriers of HNPCC-associated mutations.

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CHAPTER 4, SECTION 5.3

PROPHYLACTIC MASTECTOMY, PROPHYLACTIC OOPHORECTOMY, AND PROPHYLACTIC HYSTERECTOMY

E. Benefits will only be allowed for subcutaneous mastectomies performed as an alternative treatment for benign breast diseases if the individual is not at high risk of breast cancer.

IV. EXCLUSION

Subcutaneous mastectomy, a procedure that is not extirpative, fails to remove all breast tissue. Therefore, subcutaneous mastectomy is not effective as prophylactic assurance against breast cancer in high risk indications, nor is subcutaneous mastectomy a cancer treatment. Therefore, benefits will not be allowed for subcutaneous mastectomy in the prevention of breast carcinoma. (From October 25, 1993, through the implementation date of this policy, subcutaneous mastectomy was listed as a covered benefit.) Claims processed during this time should not be recouped.

V. EFFECTIVE DATE

January 1, 2006, for prophylactic hysterectomy.

- END -

NEGATIVE PRESSURE WOUND THERAPY (NPWT)

ISSUE DATE: December 15, 2009

AUTHORITY: 32 CFR 199.4(c)(2), (c)(3), and (e)(21)(ii)

I. CPT¹ PROCEDURE CODES

11000 - 11044, 97597 - 97606

II. HCPCS CODES

A6550, A7000, E2402

III. DESCRIPTION

Negative Pressure Wound Therapy (NPWT) applies a localized vacuum to draw the edges of an open wound together while providing a moist environment conducive to rapid wound healing. NPWT is also known as Topical Negative Pressure (TNP) and Vacuum-Assisted Closure (VAC). The goal of NPWT is to create a controlled, closed wound amenable to surgical closure, grafting, or healing by secondary intention. An evacuation tube is embedded in a dressing made of foam. After thorough wound debridement, the foam dressing is placed within the wound bed and covered by a dressing to form an airtight seal, and the tube is attached to a vacuum unit. Continuous or intermittent negative pressure is applied. The amount of pressure is determined by the wound type. NPWT is designed to result in: (1) removal of excess fluid; (2) increased blood flow and decreased bacterial colonization; (3) granulation tissue formation; and (4) partial or complete wound closure with or without the need for additional procedures.

IV. POLICY

A. A NPWT pump and supplies are covered when one of the following conditions exists:

1. Complications of surgically created wound (e.g., dehiscence, poststernotomy disunion with exposed sternal bone, poststernotomy mediastinitis, or postoperative disunion of the abdominal wall).

2. Traumatic wound (e.g., preoperative flap or graft, exposed bones, tendons, or vessels) and a need for accelerated formation of granulation tissue not achievable by other

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CHAPTER 4, SECTION 5.8

NEGATIVE PRESSURE WOUND THERAPY (NPWT)

topical wound treatments (e.g., the individual has comorbidities that will not allow for healing times usually achievable with other available topical wound treatments).

3. Chronic nonhealing Stage III or IV pressure ulcer, diabetic neuropathic ulcer or chronic venous ulcer with lack of improvement for at least the previous 30 days despite standard wound therapy, including the application of moist topical dressings, debridement of necrotic tissue (if present), maintenance of an adequate nutritional status, and weekly evaluations with documentation of wound measurements (i.e., length, width, and depth).

B. NPWT is covered:

1. For a period of up to four months (including the time NPWT was applied in an inpatient setting prior to discharge to the home) in the treatment of any wound. The medical necessity of NPWT beyond four months will be given individual consideration based upon required additional documentation including but not limited to:

a. Documentation of progression of healing of the wound on two successive dressing changes, as determined by quantitative measurements of wound characteristics including wound length and width (surface area), or depth, serially observed and documented; and

b. Documentation of appropriate medical professional supervision or performance of weekly wound measurement and assessment functions as well as the negative pressure wound therapy dressing changes required; or

2. In the judgment of the treatment physician, until adequate wound healing has occurred to the degree that NPWT may be discontinued; or

3. Until equipment or supplies are no longer being used for the patient, whether or not by the physician's order.

C. A licensed health care professional, for the purposes of this policy, may be a physician, Physician's Assistant (PA), Registered Nurse (RN), Licensed Practical Nurse (LPN), or Physical Therapist (PT). The practitioner should be licensed to assess wounds and/or administer wound care within the state where the beneficiary is receiving NPWT.

D. NPWT devices must be FDA approved.

V. EXCLUSION

A. An NPWT pump and supplies are excluded under any of the following conditions:

1. For patients whose wounds respond to standard therapeutic measures.

2. The patient cannot tolerate the use of NPWT.

3. For patients with the following contraindications:

a. Active bleeding;

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CHAPTER 4, SECTION 5.8

NEGATIVE PRESSURE WOUND THERAPY (NPWT)

- b. Anticoagulant use;
 - c. Difficult wound hemostasis;
 - d. Exposed vital organs;
 - e. Inadequately debrided wounds;
 - f. Untreated osteomyelitis;
 - g. Infection in the wound;
 - h. Malignancy in the wound; and
 - i. Fistulas to organs or body cavities.
4. Uniform granulation tissue has been obtained.
5. The depth of the wound is less than one mm, as wounds of this depth cannot accommodate the sponge.

VI. EFFECTIVE DATE

November 9, 2007.

- END -

MUSCULOSKELETAL SYSTEM

ISSUE DATE: August 26, 1985

AUTHORITY: [32 CFR 199.4\(c\)\(2\)](#) and [\(c\)\(3\)](#)

I. CPT¹ PROCEDURE CODES

20000 - 22505, 22520 - 22525, 22532 - 22534, 22548 - 28825, 28899 - 29863, 29866, 29867, 29870 - 29999

II. HCPCS CODES

S2360, S2361

III. DESCRIPTION

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

IV. POLICY

A. 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.

B. 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.

C. Single or multilevel anterior cervical microdiscectomy with allogenic or autogenic iliac crest grafting and anterior plating is covered for the treatment of cervical spondylosis.

D. Percutaneous vertebroplasty (CPT¹ procedure codes 22520-22522, S2360, S2361) and balloon kyphoplasty (CPT¹ procedure codes 22523-22525) are covered for the treatment of painful osteolytic lesions and osteoporotic compression fractures refractory to conservative medical treatment.

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CHAPTER 4, SECTION 6.1

MUSCULOSKELETAL SYSTEM

E. Total Ankle Replacement (TAR) (CPT² 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.

V. EXCLUSIONS

A. Meniscal transplant (CPT² procedure code 29868) for meniscal injury is unproven.

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

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

D. Trigger point injection (CPT² procedure codes 20552 and 20553) for migraine headaches.

E. IDET (Intradiscal Electrothermal Therapy) for Chronic Discogenic Pain (CPT² procedure codes 0062T and 0063T) is unproven.

F. Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace, cervical; single interspace (CPT² procedure code 22856) each additional interspace (CPT² procedure code 0092T) is unproven.

G. Removal of total disc arthroplasty anterior approach cervical; single interspace (CPT² procedure code 22864) each additional interspace (CPT² procedure code 0095T) is unproven. Also see [Chapter 4, Section 1.1](#).

H. Artificial intervertebral disc revision including replacement for degenerative disc disease is unproven (CPT² procedure codes 22861 and 0098T).

I. Extracorporeal shock wave, high energy involving the plantar fascia (CPT² procedure code 28890).

J. X STOP Interspinous Process Decompression System for the treatment of neurogenic intermittent claudication secondary to lumbar spinal stenosis is unproven.

K. Hip core decompression is unproven.

L. Femoroacetabular Impingement (FAI) open surgery, surgical dislocation (CPT² procedure codes 27140 and 27179), for the treatment of hip impingement syndrome or labral tear is unproven.

M. Hip arthroscopy (CPT² procedure code 29862) for the treatment of FAI and debridement of articular cartilage is unproven.

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RESPIRATORY SYSTEM

ISSUE DATE: August 26, 1985

AUTHORITY: [32 CFR 199.4\(c\)\(2\)](#)

I. CPT¹ PROCEDURE CODES

30000 - 32488, 32491, 32500 - 32999, 96570, 96571

II. DESCRIPTION

The respiratory system is comprised of the tubular and cavernous organs and structures by means of which pulmonary ventilation and gas exchange between ambient air and the blood are brought about.

III. POLICY

A. Services and supplies required in the diagnosis and treatment of illness or injury involving the respiratory system are covered.

B. Resection of pneumatoceles is a covered procedure.

C. Lung Volume Reduction Surgery (LVRS) is a covered procedure, see [Chapter 4, Section 8.2](#).

D. Endoscopic thoracic sympathectomy (CPT¹ procedure code 32664) is covered for treatment of severe primary hyperhidrosis when appropriate nonsurgical therapies have failed and the hyperhidrosis results in significant functional impairment.

IV. EXCLUSIONS

A. Pillar palatal implant system for the treatment of Obstructive Sleep Apnea (OSA) is unproven.

B. Uvulopalatopharyngoplasty (UPPP) (CPT¹ procedure code 42145) for the treatment of Upper Airway Resistance Syndrome (UARS) is unproven.

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V. EFFECTIVE DATE

December 1, 2006, for endoscopic thoracic sympathectomy for severe primary hyperhidrosis.

- END -

EYE AND OCULAR ADNEXA

ISSUE DATE: August 26, 1985

AUTHORITY: [32 CFR 199.4\(c\)\(2\)](#), [\(c\)\(3\)](#) and [\(g\)\(46\)](#)

I. CPT¹ PROCEDURE CODES

65091 - 65755, 65772 - 68899, 77600 - 77615

II. DESCRIPTION

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

III. POLICY

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

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

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

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

E. Transpupillary thermotherapy (laser hyperthermia, CPT¹ procedure codes 77600 - 77615), with chemotherapy, is covered for the treatment of retinoblastoma. See also [Chapter 5, Section 5.1](#).

F. 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.

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IV. EXCLUSIONS

I A. Refractive corneal surgery except as noted in [paragraph III.D](#). (CPT² procedure codes 65760, 65765, 65767, 65770, 65771).

B. Eyeglasses, and contact lenses except as noted in [Chapter 7, Section 6.2](#).

C. Orthokeratology.

D. Orthoptics, also known as visual training, vision therapy, eye exercises, eye therapy, is excluded by [32 CFR 199.4\(g\)\(46\)](#) (CPT² procedure code 92065).

E. Epikeratophakia for treatment of aphakia and myopia is unproven.

F. Transpupillary thermotherapy (CPT² procedure code 0016T) for treatment of coroidal melanoma is unproven.

G. Optonol ExPRESS Miniature Tube Shunt (CPT² procedure code 0192T) in the treatment of glaucoma is unproven.

- END -

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COCHLEAR IMPLANTATION

ISSUE DATE: March 2, 1988

AUTHORITY: 32 CFR 199.4(c)(2), (c)(3), (d)(3), and 32 CFR 199.5(c)(2)

I. CPT¹ PROCEDURE CODES

69930, 92601 - 92604, 92626, 92627

II. HCPCS PROCEDURE CODES

Level II Codes L8614 - L8624

III. DESCRIPTION

A cochlear implant device is an electronic instrument, part of which is implanted surgically to stimulate auditory nerve fibers, and part of which is worn or carried by the individual to capture and amplify sound. Cochlear implant devices are available in single channel and multi-channel models. The purpose of implanting the device is to provide an awareness and identification of sounds and to facilitate communication for persons who are profoundly hearing impaired.

IV. POLICY

A. Cochlear implantation using **U.S. Food and Drug Administration (FDA)**-approved single or multichannel cochlear implants and when used according to approved labeling is a covered benefit.

B. Simultaneous or sequential bilateral cochlear implantation is a covered benefit for:

1. Adults aged 18 years and older with bilateral, pre or post-linguistic, sensorineural, moderate to profound hearing impairment who meet both of the following criteria:

a. Individual has bilateral severe to profound sensorineural hearing loss determined by a pure tone average of 70 dB or greater at 500 Hz, and 2000 Hz; and

b. Individual has limited benefit from appropriately fitted binaural hearing aids. Limited benefit from amplification is defined by test scores of 40% correct or less in best-

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aided listening condition on open-set sentence cognition (e.g., Central Institute for the Deaf (CID) sentences, Hearing in Noise Test (HINT) sentences).

2. Children aged 12 months to 17 years 11 months, with bilateral sensorineural hearing impairment who meet all of the following criteria:

a. Child has profound, bilateral sensorineural hearing loss determined by a pure tone average of 90 dB or greater at 500, 1000 and 2000 Hz; and

b. Child has limited benefit from appropriately fitted binaural hearing aids. For children four years of age or younger, limited benefit is defined as failure to reach developmentally appropriate auditory milestones measured using the Infant-Toddler Meaningful Auditory Integration Scale, the Meaningful Auditory Integration Scale, or the Early Speech Perception test, or less than 20% correct on open-set word recognition test (Multisyllabic Lexical Neighborhood Test (MLNT)) in conjunction with appropriate amplification and participation in intensive aural habilitation over a three to six month period. For children older than four years of age, limited benefit is defined as less than 12% correct on the Phonetically Balanced-Kindergarten Test, or less than 30% correct on the Hearing in Noise Test for children, the open-set MLNT or Lexical Neighborhood Text (LNT), depending on the child's cognitive ability and linguistic skills; and

c. A three to six month hearing aid trial has been undertaken and failed by a child without previous experience with hearing aids.

3. The following additional criteria must also be met for unilateral (monaural) or bilateral (binaural) cochlear implantation in adults and children:

a. The individual must have had an assessment by an audiologist and from an otolaryngologist experienced in this procedure indicating the likelihood of success with this device; and

b. The individual must have the cognitive ability to use auditory clues and a willingness to undergo an extended program of rehabilitation. A post-cochlear implant rehabilitation program is necessary to achieve benefit from the cochlear implant. The rehabilitation program consists of six to ten sessions that last approximately 2.5 hours each. The rehabilitation program includes development of skills in understanding running speech, recognition of consonants and vowels, and tests of speech perception ability. See [Chapter 7, Section 7.1](#) and [18.1](#); and

c. The individual should be up-to-date on age appropriate pneumococcal vaccination at least two weeks prior to the implant, in accordance with the Centers for Disease Control and Prevention (CDC).

C. Replacement of the cochlear implant external speech processor device is covered.

V. EXCLUSIONS

A. Cochlear implantation is contraindicated when preoperative radiographic evidence indicates an underdeveloped internal auditory canal, the absence of cochlear development or

standard of care by the American College of Obstetricians and Gynecologists (ACOG) include:

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

b. Individuals who have vertebral abnormalities.

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

d. Individuals with primary hyperparathyroidism.

e. Individuals with positive family history of osteoporosis.

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

IV. EXCLUSIONS

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

B. PET for the diagnosis and monitoring of treatment of Alzheimer's disease, fronto-temporal dementia or other forms of dementia is unproven.

C. PET and PET/CT for the initial diagnosis of differentiated thyroid cancer and for medullary cell thyroid cancer.

D. Ultrasound ablation (destruction of uterin fibroids) with Magnetic Resonance Imaging (MRI) guidance (CPT³ procedure code 0071T) in the treatment of uterine leiomyomata is unproven.

E. PET and PET/CT for the diagnosis, staging, restaging, and monitoring of treatment of gastric cancer is unproven.

V. EFFECTIVE DATES

A. January 1, 1995, for PET for ischemic heart disease.

B. December 1, 1996, for PET for lung cancer.

C. October 14, 1990, for SPECT for myocardial perfusion imaging.

D. January 1, 1991, for SPECT for brain imaging.

E. October 28, 1996, for ¹¹¹In-Capromab Pendetide, CyT 356 (ProstaScint™).

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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 5, SECTION 4.1

NUCLEAR MEDICINE

- F. June 1, 1994, for Octreoscan Scintigraphy.
- G. May 26, 1994, for bone density studies.
- H. January 1, 2007, for PET and PET/CT for lymphoma.
- I. January 1, 2006, for PET and PET/CT for pancreatic cancer.
- J. February 16, 2006, for PET and PET/CT for thyroid cancer.

- END -

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CHAPTER 7 - MEDICINE

SECTION	SUBJECT
22.1	Telemental Health (TMH)/Telemedicine
23.1	Augmentative Communication Devices (ACD)
24.1	Phase II And Phase III Cancer Clinical Trials
25.1	Dermoscopy
26.1	Forensic Examinations Following Sexual Assault or Domestic Violence
27.1	Botulinum Toxin A Injections

SPECIAL OTORHINOLARYNGOLOGIC SERVICES

ISSUE DATE: April 19, 1983

AUTHORITY: [32 CFR 199.4\(c\)\(3\)\(iv\)](#), [\(g\)\(45\)](#), [\(g\)\(47\)](#), and [32 CFR 199.5\(c\)](#)

I. CPT¹ PROCEDURE CODES

92502 - 92512, 92516, 92520, 92526, 92551 - 92597, 92601 - 92617, 92626, 92627, 92630, 92633, 92640, 92700

II. DESCRIPTION

Otolaryngology is that branch of medicine concerned with the screening, diagnosis and management of medical and surgical disorders of the ear, the upper respiratory and upper alimentary systems and related structures and the head and neck.

Audiology is the discipline involved in the prevention, identification and the evaluation of hearing disorders, the selection and evaluation of hearing aids, and the re-habilitation of individuals with hearing impairment. Audiological services, including function tests, performed to provide medical diagnosis and treatment of the auditory system.

III. POLICY

A. Otorhinolaryngology services, including audiological services are covered for the diagnosis and treatment of a covered medical condition.

B. Prior to September 1, 2005, hearing aid services and supplies may be cost-shared only for **eligible** beneficiaries through the **Program for Persons with Disabilities (PPPWD) on the basis of a hearing disability or of multiple disabilities, one of which involves a hearing disability.**

C. On or after September 1, 2005, hearing aid services and supplies may be cost-shared only for Active Duty Family Members (ADFMs) with a profound hearing loss through the TRICARE Basic Program. See [Chapter 7, Section 8.2](#).

D. Diagnostic analysis of cochlear implant with programming is covered for patients under seven years of age (CPT¹ procedure codes 92601, 92602), and age seven years or older with programming (CPT¹ procedure codes 92603, 92604). See [Chapter 4, Section 22.2](#).

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CHAPTER 7, SECTION 8.1

SPECIAL OTORHINOLARYNGOLOGIC SERVICES

E. Evaluation for prescription of non-speech-generating augmentative and alternative communication device, including programming and modification, may be cost-shared only for eligible beneficiaries through the Extended Care Health Option (ECHO) on the basis of a speech disability or of multiple disabilities, one of which involves a speech disability (CPT² procedure codes 92605 - 92609).

IV. EXCLUSIONS

Uvulopalatopharyngoplasty (UPPP) (CPT² procedure code 42145) for the treatment of Upper Airway Resistance Syndrome (UARS) is unproven.

- END -

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NEUROLOGY AND NEUROMUSCULAR SERVICES

ISSUE DATE: April 19, 1983

AUTHORITY: [32 CFR 199.4\(b\)\(2\)\(vii\)](#) and [\(b\)\(3\)\(v\)](#)

I. CPT¹ PROCEDURE CODE RANGE

95812 - 95999

II. DESCRIPTION

The diagnosis and treatment of muscle and nerve disorders.

III. POLICY

Neurology and neuromuscular services are covered.

IV. **EXCLUSION**

Topographic brain mapping (brain electrical activity mapping, quantitative EEG, digital EEG, topographic EEG, brain mapping EEG) is unproven.

- END -

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BOTULINUM TOXIN A INJECTIONS

ISSUE DATE: October 12, 1998

AUTHORITY: 32 CFR 199.4(c)(2)(iii) and (c)(2)(iv)

I. CPT¹ PROCEDURE CODES

46505, 64612, 64613, 64640, 67345

II. DESCRIPTION

These procedures involve the injection of small amounts of botulinum toxin type A into selected muscles for the nonsurgical treatment of the conditions relating to spasticity, various dystonias, nerve disorders, and muscular tonicity deviations.

III. POLICY

A. Botulinum toxin A injections may be considered for cost-sharing for treating conditions such as cervical dystonia (repetitive contraction of the neck muscles) in decreasing the severity of abnormal head position and neck pain for patients 16 years and older.

B. Botulinum toxin A injections may be considered for cost-sharing for treating conditions such as blepharospasm (spasm of the eyelids/uncontrolled blinking) and strabismus (squinting/eyes do not point in the same direction) associated with dystonia, including benign essential blepharospasm or VII nerve disorders for patients 12 years of age and older.

C. Botulinum toxin A injections may be considered for cost-sharing for treating conditions such as severe primary axillary hyperhidrosis (severe underarm sweating) that is inadequately managed by topical agents for patients 18 years of age and older.

D. Botox® (chemodenervation-CPT¹ procedure code 46505) may be considered for off-label cost-sharing for the treatment of chronic anal fissure unresponsive to conservative therapeutic measures, effective May 1, 2007.

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IV. EXCLUSIONS

A. Botulinum toxin A injections are unproven for the following indications:

1. Palmar hyperhidrosis.
2. Urinary urge incontinence.
3. Lower back pain/lumbago.
4. Migraine headaches and other primary headache disorders.

B. Botox® (chemodenervation-CPT² procedure code 64612) for the treatment of muscle spasms secondary to cervical degenerative disc disease and spinal column stenosis is unproven.

V. EFFECTIVE DATE

May 1, 2007, for coverage of chronic anal fissure unresponsive to conservative therapeutic measures (CPT² procedure code 46505).

- END -

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OTHER SERVICES

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1.1	Ambulance Service
2.1	Durable Medical Equipment: Basic Program
2.2	Infantile Apnea Cardiorespiratory Monitor
2.3	External And Implantable Infusion Pump
2.4	Cold Therapy Devices For Home Use
2.5	Home Prothrombin Time (PT) International Normalized Ratio (INR) Monitor
2.6	Breast Pumps
2.7	Pulsed Irrigation Evacuation (PIE)
3.1	Orthotics
4.1	Prosthetic Devices And Supplies
5.1	Medical Devices
5.2	Neuromuscular Electrical Stimulation (NMES) Devices
5.3	Continuous Glucose Monitoring System (CGMS) Devices
6.1	Medical Supplies And Dressings (Consumables)
7.1	Nutritional Therapy
7.2	Liquid Protein Diets
8.1	Diabetes Outpatient Self-Management Training Services
8.2	Therapeutic Shoes For Diabetics
9.1	Pharmacy Benefits Program
10.1	Oxygen And Oxygen Supplies
11.1	Podiatry
12.1	Wigs Or Hairpiece
13.1	Adjunctive Dental Care
13.2	Dental Anesthesia And Institutional Benefit
14.1	Physician-Assisted Suicide
15.1	Custodial Care Transitional Policy (CCTP)
16.1	Mucus Clearance Devices

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CHAPTER 8 - OTHER SERVICES

SECTION	SUBJECT
17.1	Lymphedema
18.1	Continuous Passive Motion (CPM) Devices
19.1	Smoking Cessation Counseling

ORTHOTICS

ISSUE DATE: September 20, 1990

AUTHORITY: [32 CFR 199.4\(d\)\(3\)\(viii\)](#)

I. DESCRIPTION

Orthotics is the field of knowledge relating to the making of an appliance or apparatus used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body.

II. POLICY

A. Orthotic devices are covered.

B. For individuals with diabetes, extra-depth shoes with inserts or custom molded shoes with inserts are covered.

C. Orthopedic braces including shoes which are an integral part of the brace--neither the shoe nor the brace is usable separately--are covered.

D. The Dynamic Orthotic Cranioplasty (DOC) Band Post-Op device is covered for adjunctive use for infants from three to eighteen months of age whose synostosis has been surgically corrected, but who still have moderate to severe cranial deformities including plagiocephalic-, brachycephalic-, and scaphocephalic-shaped heads (Healthcare Common Procedure Coding System (HCPCS) code S1040).

III. EXCLUSIONS

The following types of orthoses are excluded from TRICARE coverage:

A. Orthopedic shoes (except for orthopedic shoes which are an integral part of a brace).

B. Arch supports.

C. Shoe inserts.

D. Other supportive devices of the feet, such as, wedges, specialized fillers, heels straps, pads, shanks, etc.

TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 8, SECTION 3.1

ORTHOTICS

E. Cranial orthosis (DOC Band) and cranial molding helmets are not covered for the treatment of nonsynostotic positional plagiocephaly (deformational plagiocephaly, plagiocephaly without synostosis) or for the treatment of craniosynostosis before surgery.

IV. EFFECTIVE DATE

December 17, 2004, for the DOC Band Post-Op device.

- END -

CONTINUOUS GLUCOSE MONITORING SYSTEM (CGMS) DEVICES

ISSUE DATE: December 15, 2009

AUTHORITY: 32 CFR 199

I. CPT¹ PROCEDURE CODES

95250, 95251

II. HCPCS CODES

A9276 - A9278, S1030, S1031

III. DESCRIPTION

A Continuous Glucose Monitoring System (CGMS) is a medical device used to monitor patients with diabetes mellitus. These devices, which consist of an external receiver, external transmitter, and a subcutaneously placed sensor, monitor diabetic patients by providing the physician and/or patient with periodic measurements of glucose levels in interstitial fluid. CGMS devices are usually prescribed to diabetic patients whose diabetes is not sufficiently controlled with standard diabetic medical regimens. These devices are intended only to supplement, not replace, blood glucose readings obtained from standard fingerstick glucose meters and test strips.

IV. POLICY

U.S. Food and Drug Administration (FDA) approved CGMS devices (i.e., MiniMed CGMS® System Gold™, MiniMed Guardian® Real Time System) may be cost-shared ONLY when it is documented that the recipient of the device is required to perform at least four self-monitoring blood glucose checks daily and is compliant with recommended medical regimens.

A. Short-term (up to 72-hour), intermittent (up to six times per year) use of a CGMS device may be covered for type I diabetic beneficiaries age seven years and over (or consistent with device labeling) when the beneficiary has completed a comprehensive diabetic education program, there is documentation of appropriate modification in insulin regimen, and the physician documents any one of the following:

1. Glycosylated hemoglobin level (HBA1c) is greater than 9.0% or less than 4.0%;

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CHAPTER 8, SECTION 5.3
CONTINUOUS GLUCOSE MONITORING SYSTEM (CGMS) DEVICES

2. History of unexplained large fluctuations in daily glucose values before meals (greater than 150 mg/dl);
3. History of early morning fasting hyperglycemia (“dawn phenomenon”);
4. History of severe glycemc excursions; or
5. Hypoglycemic unawareness.

B. Long-term (greater than 72-hour, continuous or periodic) use of a CGMS device (includes transmitter, receiver, and sensors), may be covered for beneficiaries who meet the criteria for short-term use and the ordering physician documents any one or more of the following:

1. History of recurrent, unexplained, severe hypoglycemic events or hypoglycemic unawareness (i.e., blood glucose less than 5 mg/dl);
2. History of recurrent episodes of ketoacidosis;
3. Hospitalizations for uncontrolled glucose levels;
4. Frequent nocturnal hypoglycemia; or
5. The beneficiary is pregnant and has poorly controlled type I diabetes or gestational diabetes.

V. EXCLUSIONS

- A. Use of a CGMS device for any condition or indication NOT included above.
- B. Use of a CGMS device that is NOT FDA approved.

VI. EFFECTIVE DATE

December 1, 2008.

- END -

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