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TRICARE  
MANAGEMENT ACTIVITY

MB&RB

CHANGE 98  
6010.54-M  
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PUBLICATIONS SYSTEM CHANGE TRANSMITTAL  
FOR  
TRICARE POLICY MANUAL (TPM)

The TRICARE Management Activity has authorized the following addition(s)/  
revision(s) to the 6010.54-M, issued August 2002.

CHANGE TITLE: EVOLVING PRACTICES - MARCH 2009

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.

Reta Michak  
Acting Chief, Medical Benefits and  
Reimbursement Branch

ATTACHMENT(S): 42 PAGE(S)  
DISTRIBUTION: 6010.54-M

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**INSERT PAGE(S)**

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## SUMMARY OF CHANGES

### CHAPTER 1

1. Section 2.1. Paragraph I.5. Added canaloplasty in the treatment of glaucoma as an exclusion because it is unproven. Paragraph I.20. Intracavitary administration of cisplatin for malignant disease remains unproven.
2. Section 16.1. Category III Code 0073T is proven and is a covered service, and is added as an exception. Category III Codes 0075T and 0076T are proven and are added as exceptions due to coverage for percutaneous angioplasty of the carotid artery with stenting and embolic protection for beneficiaries at high risk for Carotid Endarterectomy, while keeping all other PTA procedures of the carotid as unproven.
3. Section 17.1. Paragraph III.B.2. HCPCS Codes S2235 and S8030 are proven and are reimbursable.

### CHAPTER 2

4. Section 2.1. Paragraph IV.D. Reference added for sleep studies in the home.

### CHAPTER 4

5. Section 5.1. CPT procedure codes 15400 - 15431 for xenograft skin and acellular xenograft implants are proven technologies and are removed from the exclusion list. Removed the exclusion of endoscopic thoracic sympathectomy which is proven when performed for the treatment of hyperhidrosis.
6. Section 9.1. Paragraph III.J. Added primary percutaneous transluminal mechanical thrombectomy and secondary percutaneous transluminal mechanical thrombectomy are proven and are covered for the treatment of acute limb ischemia due to peripheral arterial occlusion, effective March 21, 2006. Paragraph III.K. Added percutaneous Transluminal Angioplasty (PTA) of the carotid artery with stenting in beneficiaries at high risk for Carotid Endarterectomy (CEA) is proven and covered when certain criteria are met. Added to EXCLUSIONS, Paragraph IV.E.: PTA of the carotid artery without stenting is unproven. PTA of the carotid artery with stenting but without embolic protection (CPT procedure code 37216) is unproven.
7. Section 13.1. Paragraph III.C. Added coverage for radiofrequency ablation which is proven for liver cancers when certain criteria are met, effective April 28, 2004.

## SUMMARY OF CHANGES (Continued)

### CHAPTER 4 (Continued)

8. Section 20.1. Paragraph IV.R. Radiofrequency ablation for the treatment of chronic spinal pain is unproven. Pulsed radiofrequency ablation for spinal pain is unproven. Paragraph IV.S. Cryoablation of Occipital Nerve (CPT procedure code 64640) for the treatment of chronic intractable headache is unproven.
9. Section 23.1. Paragraph III.Q. Added to the EXCLUSIONS, immunoablative therapy with bone marrow or peripheral stem cell transplantation is unproven and not covered for the treatment of rheumatoid arthritis and juvenile idiopathic arthritis.

### CHAPTER 5

10. Section 3.1. CPT code 0073T is proven and added.

### CHAPTER 6

11. Section 1.1. Paragraph III.F. Deletes the Nuclear Magnetic Resonance (NMR) LipoProfile-2 test from the EXCLUSIONS section and since it is proven, allows TRICARE cost-sharing for the management of lipoprotein disorders associated with cardiovascular disease, effective July 23, 2008.

### CHAPTER 7

12. Section 6.1. Paragraph IV.D. Canaloplasty in the treatment of glaucoma is unproven and is added as an exclusion.
13. Section 18.1. Paragraph III.I. Low level laser therapy in the treatment of soft tissue injuries, pain or inflammation is unproven and is added to the exclusion list.
14. Section 18.2. Paragraph IV.16. Low level laser therapy in the treatment of soft tissue injuries, pain or inflammation is unproven and is added to the exclusion list.
15. Section 19.1. Paragraph IV.F. Adds coverage for a home/portable sleep study as an alternative to in-facility polysomnography for the diagnosis of obstructive sleep apnea in adults when certain criteria are met, is proven and covered effective May 29, 2008.

## TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

### CHAPTER 1, SECTION 2.1

#### UNPROVEN DRUGS, DEVICES, MEDICAL TREATMENTS, AND PROCEDURES

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l. The following is a partial list of drugs, devices, medical treatments, or procedures considered to be unproven. Other drugs, devices, medical treatments, or procedures also considered to be unproven are listed as specific exclusions in relevant sections of the TRICARE Policy Manual. For example, Cardiomyoplasty for treatment of heart failure is considered unproven and is listed as a specific exclusion in [Chapter 4, Section 9.1](#) (Cardiovascular System). Neither the partial list below nor the exclusions cited in other sections of the TRICARE Policy Manual provide an all inclusive list of unproven drugs, devices, medical treatments, or procedures. Other unproven drugs, devices, medical treatments, or procedures are also excluded although they do not appear in the TRICARE Policy Manual.

1. Adoptive immunotherapy using either Tumor-Infiltrating Lymphocytes (TIL) or Lymphokine-Activated Killer (LAK) cells, activated in vitro by recombinant or natural IL-2 or other lymphokines, for the treatment of cancer.
2. Adrenal tissue transplant to brain.
3. Autolymphocyte Therapy (ALT).
4. Calcium EAP/calcium orotate and selenium (also known as Nieper therapy) - involves inpatient care and use of calcium compounds and other non-FDA approved drugs and special diets. Used for cancer, heart disease, diabetes, multiple sclerosis -- Not a proven treatment for any indication.
5. **Canaloplasty in the treatment of glaucoma is unproven.**
6. Services related to the candidiasis hypersensitivity syndrome, yeast syndrome, or gastrointestinal candidiasis are unproven (i.e., allergenic extracts of *Candida albicans* for immunotherapy and/or provocation/neutralization). Disseminated systemic candidiasis (ICD-9-CM 112.5) is a recognized diagnosis, and medically necessary treatment is covered.
7. Cellular therapy (HCPCS procedure code M0075).
8. Chelation therapy, except when using FDA-approved chelators for FDA-approved indications.
9. Diaphanography (Transillumination Light Scanning).
10. Dynamic Posturography (both static and computerized) (CPT<sup>1</sup> procedure code 92548).
11. Electric reflex salivary stimulation (Salitron® Electrostimulation System) in the treatment of xerostomia (dry mouth) secondary to Sjogren's syndrome (HCPCS procedure code E0755).
12. Eye Movement Desensitization and Reprocessing therapy (EMDR) for treatment of psychiatric and behavioral disorders.

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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 1, SECTION 2.1

UNPROVEN DRUGS, DEVICES, MEDICAL TREATMENTS, AND PROCEDURES

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13. Growth factor, including platelet-derived growth factors, for treating non-healing wounds. This includes Procuren®, a platelet-derived wound-healing formula.
14. Hand transplant from a cadaver donor.
15. Histamine therapy.
16. Holding therapy - involves holding the patient in an attempt to achieve interpersonal contact, and to improve the patient's ability to concentrate on learning tasks.
17. Hyperosmotic blood-brain barrier disruption produced by infusion of Manitol to increase drug delivery to brain tumors.
18. Hyperventilation Provocation Test (HVPT) for diagnosing hyperventilation syndrome.
19. Immunotherapy for malignant disease except when using drugs approved by the FDA for this purpose.
20. Intracavitary administration of cisplatin for malignant disease is unproven, except for patients with optimally debulked Stage III ovarian cancer.
21. Iridology (links flaws in eye coloration with disease elsewhere in the body).
22. Light therapy for Seasonal Depression (also known as seasonal affective disorder (SAD)). This therapy uses varying degrees of light to treat depression.
23. Neurofeedback.
24. All organ transplants not listed as covered in the TRICARE Policy Manual or [32 CFR 199.4\(e\)\(5\)](#).
25. Portable nocturnal hypoglycemia monitors.
26. Pupillometry.
27. Sensory Afferent Stimulation (SAS) devices for relief of nausea (e.g., Relief Band®).
28. Spinoscopy. Use of a Spinoscope with skin markers to assess the function of the spine.
29. Synaptic 2000 for acute and chronic pain.
30. Tinnitus Masker.
31. Transdermal nicotine therapy used to treat ulcerative colitis.

TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 1, SECTION 2.1

UNPROVEN DRUGS, DEVICES, MEDICAL TREATMENTS, AND PROCEDURES

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32. Transfer factor (TF). This is a **D**ialyzable **L**eukocyte **E**xtract (DLE) used to transfer delayed hypersensitivity from an immune to a nonimmune subject and is considered unproven.

**Note:** See [Chapter 1, Section 3.1](#) for policy on Rare Diseases.

**Note:** See [Chapter 7, Section 24.1](#) for policy on cancer clinical trials.

**Note:** See [Chapter 8, Section 5.1](#) for policy on Medical Devices, including coverage of Humanitarian Use Devices and a FDA-approved Investigational Device Exemption (IDE) categorized by the FDA as non-experimental/investigational (FDA Category B).

**Note:** See [Chapter 8, Section 9.1](#) for policy on off-label use of drugs.

- END -



## CATEGORY III CODES

ISSUE DATE: March 6, 2002

AUTHORITY: [32 CFR 199.2\(b\)](#) and [32 CFR 199.4\(g\)\(15\)](#)

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### I. CPT<sup>1</sup> PROCEDURE CODES

0003T, 0008T, 0016T - 0019T, 0021T, 0024T, 0026T - 0032T, 0041T - 0161T

### II. DESCRIPTION

Category III codes are a set of temporary codes for emerging technology, services, and procedures. These codes are used to track new and emerging technology to determine applicability to clinical practice. When a Category III code receives a Category I code from the American Medical Association (AMA) it does not automatically become a benefit under TRICARE. However, the codes that may have moved from unproven to proven must be forwarded to the Office of Medical Benefits and Reimbursement Branch (MB&RB) for coverage determination/policy clarification.

### III. POLICY

A. Category III codes are to be used instead of unlisted codes to allow the collection of specific data. TRICARE has not opted to track Category III codes at this time.

B. Category III codes are excluded from coverage since clinical safety and efficacy or applicability to clinical practice has not been established.

### IV. EXCEPTIONS

A. Category III code 0024T may be covered under the Rare Disease Policy for children.

B. FDA IDE (Category B) clinical trial. See [Chapter 8, Section 5.1](#).

C. Category III codes 0145T - 0151T as outlined in [Chapter 5, Section 1.1](#).

D. Category III code 0073T is a covered service as listed in [Chapter 5, Section 3.1](#).

E. Category III codes 0075T and 0076T are covered codes as outlined in [Chapter 4, Section 9.1](#).

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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 1, SECTION 16.1

CATEGORY III CODES

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V. EXCLUSION

Unlisted codes for Category III codes. Effective January 1, 2002.

- END -

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

ISSUE DATE: November 6, 2007

AUTHORITY:

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### 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 III.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; S1040 for ECHO durable equipment; and

2. S0812, S1030, S1031, S2066, S2067, S2068, S2075, S2076, S2077, S2083, S2202, **S2235**, S2360, S2361, S2400, S2401, S2402, S2403, S2405, S2411, 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](#)).

**TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002**  
CHAPTER 1, SECTION 17.1  
HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS) "C" AND  
"S" CODES

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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 -

## HOME SERVICES

ISSUE DATE: March 3, 1992

AUTHORITY: [32 CFR 199.4\(c\)\(2\)\(iv\)](#) and [\(e\)\(12\)\(ii\)](#)

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### I. CPT<sup>1</sup> PROCEDURE CODES

Physician Code Range: 90801, 90802, 90804 - 90815, 90847, 90862, 99341 - 99350

Non-Physician Code Range: 90801, 90802, 90804 - 90815, 90847, 90862, 99341 - 99350, 99500 - 99507, 99511, 99512, 99600 - 99602

NOTE: TRICARE payment for non-physician services is limited to those authorized non-physician providers recognized in [32 CFR 199.6](#).

NOTE: Skilled nursing service (99341 - 99350) may be reported separately, using the modifier-25, if the patient's condition requires a significant separately identifiable E/M service, beyond the home health service(s)/procedure(s) (99500 - 99539).

### II. HCPCS PROCEDURES CODES

Non-Physician Code Range: G0151 - G0154, G0156

### III. DESCRIPTION

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

### IV. 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.

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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 2, SECTION 2.1

HOME SERVICES

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B. If the patient has been determined to be receiving custodial care, those home visits which are specifically related to the treatment of the custodial care conditions are covered only as follows:

1. When provided by a visiting nurse, such visits may be covered up to one hour per day for skilled nursing care.

2. When provided by a physician, may be covered up to 12 visits per calendar year (not to exceed one per month). Note that physician visits, regardless of the place of services, will be limited to this calendar year maximum when the treatment is of the custodial care condition. Physician visits for other than the custodial care condition are not limited to this calendar year maximum.

C. See the TRICARE Reimbursement Manual (TRM), Chapter 8, reimbursement of Skilled Nursing Care.

D. See Chapter 7, Section 19.1 for sleep studies in the home.

V. EXCLUSIONS

A. Home visit, Day Life Activity (CPT<sup>2</sup> procedure code 99509).

B. Home visit, sing/m/fam/couns (CPT<sup>2</sup> procedure code 99510).

C. Home infusion for tocolytic therapy.

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## INTEGUMENTARY SYSTEM

ISSUE DATE: August 26, 1985

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

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### I. CPT<sup>1</sup> 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. Topical 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.

### 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.

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**TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002**

CHAPTER 4, SECTION 5.1

INTEGUMENTARY SYSTEM

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C. Subcutaneous hormone (estradiol and/or testosterone) pellet implantation (CPT<sup>2</sup> procedure code 11980) is unproven. Estradiol pellets are not FDA approved for general use in humans.

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## CARDIOVASCULAR SYSTEM

ISSUE DATE: August 26, 1985

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

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### I. CPT<sup>1</sup> PROCEDURE CODES

33010 - 33130, 33140, 33141, 33200 - 37186, 37195 - 37215, 37250 - 37785, 92950 - 93272, 93303 - 93581, 93600 - 93745, 93770, 93797 - 93799, 0075T, 0076T

### II. DESCRIPTION

The cardiovascular system involves the heart and blood vessels, by which blood is pumped and circulated through the body.

### III. POLICY

A. Medically necessary services and supplies required in the diagnosis and treatment of illness or injury involving the cardiovascular system are covered.

#### B. Ventricular Assist Devices (VADs).

1. VADs (external and implantable) are covered if the device is Food and Drug Administration (FDA) approved and used in accordance with FDA approved indications.

2. VADs as destination therapy (CPT<sup>1</sup> 33979) are covered if they have received approval from the FDA for that purpose and are used according to the FDA-approved labeling instructions. Benefits are authorized when the procedure is performed at a TRICARE-certified heart transplantation center, a TRICARE-certified pediatric consortium heart transplantation center, or a Medicare facility which is approved for VAD implantation as destination therapy, for patients who meet all of the following conditions:

a. The patient has chronic end-stage heart failure (New York Heart Association Class IV end-stage left ventricular failure for at least 90 days with a life expectancy of less than two years).

b. The patient is not a candidate for heart transplantation.

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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 4, SECTION 9.1

CARDIOVASCULAR SYSTEM

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- c. The patient's Class IV heart failure symptoms have failed to respond to optimal medical management, including a dietary salt restriction, diuretics, digitalis, beta-blockers, and ACE inhibitors (if tolerated) for at least 60 of the last 90 days.
- d. The patient has Left Ventricular Ejection Fraction (LVEF) less than 25%.
- e. The patient has demonstrated functional limitation with a peak oxygen consumption of less than 12 ml/kg/min; or the patient has a continued need for intravenous inotropic therapy owing to symptomatic hypotension, decreasing renal function, or worsening pulmonary congestion.
- f. The patient has the appropriate body size (by device per FDA labeling) to support the VAD implantation.

C. Gamma and beta intracoronary radiotherapy (brachytherapy) is covered for the treatment of in-stent restenosis in native coronary arteries.

D. Transmyocardial Revascularization (TMR) (CPT<sup>2</sup> procedures codes 33140 and 33141).

1. Coverage is available for patients with stable class III or IV angina which has been found refractory to standard medical therapy, including drug therapy at the maximum tolerated or maximum safe dosages. In addition, the angina symptoms must be caused by areas of the heart not amenable to surgical therapies such as percutaneous transluminal coronary angioplasty, stenting, coronary atherectomy or coronary bypass.

2. Coverage is limited to those uses of the laser used in performing the procedure which have been approved by the FDA for the purpose for which they are being used.

E. TMR as an adjunct to Coronary Artery Bypass Graft (CABG) is covered for patients with documented areas of the myocardium that are not amenable to surgical revascularization due to unsuitable anatomy.

F. FDA approved IDE clinical trials. See [Chapter 8, Section 5.1, paragraph D.](#) and [F.](#) for policy.

G. Endovenous radiofrequency ablation/obliteration (CPT<sup>2</sup> procedure codes 36475 and 36476) for the treatment of saphenous venous reflux with symptomatic varicose veins is covered when:

1. One of the following indications is present:

a. Persistent symptoms interfering with activities of daily living in spite of conservative/non-surgical management. Symptoms include aching, cramping, burning, itching and/or swelling during activity or after prolonged standing.

b. Significant recurrent attacks of superficial phlebitis.

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- c. Hemorrhage from a ruptured varix.
- d. Ulceration from venous stasis where incompetent varices are a contributing factor.
- e. Symptomatic incompetence of the great or small saphenous veins (symptoms as in [paragraph III.G.1.a.](#)).

2. A trial of conservative, non-operative treatment has failed. This would include mild exercise, avoidance of prolonged immobility, periodic elevation of legs, and compressive stockings.

3. The patient's anatomy is amenable to endovenous ablation.

H. Ambulatory Blood Pressure Monitoring (ABPM) is only covered for beneficiaries with suspected white coat hypertension and is NOT covered for any other uses. The information obtained by ABPM is necessary in order to determine the appropriate medical management of the beneficiary. Suspected white coat hypertension is considered to exist when the following is documented:

- 1. There is no evidence of end-organ damage;
- 2. Office blood pressure greater than 140/90 mm Hg on at least three separate clinic/office visits with two separate measurements made at each visit; and
- 3. At least two blood pressure measurements taken outside the office which are less than 140/90 mm Hg.

I. Pulmonary vein isolation/ablation (CPT<sup>3</sup> procedure code 93651) is covered for beneficiaries who meet the guidelines published in the Heart Rhythm Society (HRS)/European Heart Rhythm Association (EHRA)/European Cardiac Arrhythmia Society (ECAS) 2007 Consensus Statement as follows:

- 1. Symptomatic Atrial Fibrillation (AF) refractory or intolerant to at least one Class 1 or 3 antiarrhythmic medication.
- 2. In rare clinical situations, as first line therapy.
- 3. Selected symptomatic patients with heart failure and/or reduced ejection fraction.
- 4. The presence of a Left Atrial (LA) thrombus is a contraindication.

J. Primary percutaneous transluminal mechanical thrombectomy (CPT<sup>3</sup> procedure codes 37184 and 37185) and secondary percutaneous transluminal mechanical thrombectomy (CPT<sup>3</sup> procedure code 37186) are proven and are covered for the treatment of acute limb ischemia due to peripheral arterial occlusion.

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K. Percutaneous Transluminal Angioplasty (PTA) of the carotid artery with stenting (CPT<sup>4</sup> procedure codes 37215, 0075T, and 0076T) in beneficiaries at high risk for Carotid Endarterectomy (CEA) is proven and covered when all of the following criteria are met:

1. Beneficiaries who have symptomatic Carotid Artery Stenosis (CAS) greater than 70%.

2. Beneficiaries are at high risk for CEA due to one or more of the following significant comorbidities and/or anatomic risk factors:

- a. Congestive heart failure (New York Heart Association Class I, II/IV).
- b. Left ventricular ejection fraction of less than 90%.
- c. Myocardial Infarction (MI) within past 30 days.
- d. Unstable Angina.
- e. Known severe Coronary Artery Disease (CAD).
- f. Severe Chronic Obstructive Pulmonary Disease (COPD).
- g. Contralateral carotid artery occlusion.
- h. Contralateral laryngeal nerve palsy.
- i. Previous radiation therapy to the neck.
- j. Previous radical neck dissection.
- k. Previous ipsilateral endarterectomy with restenosis.
- l. Surgically inaccessible lesion.
- m. Inability to move the neck to a suitable position for surgery.
- n. Tracheostomy.
- o. Coagulopathy or other coagulation issues leading to contraindication for endarterectomy.

3. Beneficiaries who have had a disabling stroke are excluded from coverage.

4. Coverage is limited to procedures performed using FDA approved carotid artery stents and embolic protection devices.

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5. The use of a distal embolic protection device is required. If deployment of the distal embolic protection device is not technically possible, then the procedure should be aborted due to the risks of CAS without distal embolic protection.

6. The degree of CAS shall be measured by duplex Doppler ultrasound or carotid artery angiography and recorded in the beneficiary's medical records. If the stenosis is measured by ultrasound prior to the procedure, then the degree of stenosis must be confirmed by angiography at the start of the procedure. If the stenosis is determined to be less than 70% by angiography, then CAS should not proceed.

7. All procedures are performed in a Centers for Medicare and Medicaid Services (CMS) approved facility that has been determined to be competent in performing the evaluation, procedure, and follow-up necessary to ensure optimal patient outcomes.

#### IV. EXCLUSIONS

A. Thermogram; cephalic (CPT<sup>5</sup> procedure code 93760); peripheral (CPT<sup>5</sup> procedure code 93762) are unproven.

B. Percutaneous Myocardial Laser Revascularization (PMR) is unproven.

C. Cardiomyoplasty (Cardiac Wrap) for treatment of heart failure is unproven.

D. Minimally Invasive CABG surgery to include Minimally Invasive Direct Coronary Artery Bypass (MIDCAB) and Port Access Coronary Artery Bypass (PACAB) are unproven.

E. Percutaneous Transluminal Angioplasty (PTA) in the treatment of obstructive lesions of the carotid, vertebral and cerebral arteries is unproven. PTA of the carotid artery without stenting is unproven. PTA of the carotid artery with stenting but without embolic protection (CPT<sup>5</sup> procedure code 37216) is unproven.

F. Signal-Average Electrocardiography (CPT<sup>5</sup> procedure code 93278) is unproven.

G. Percutaneous transluminal mechanical thrombectomy vein(s) including intraprocedural pharmacological thrombolytic injections and fluroscopic guidance (CPT<sup>5</sup> procedure code 37187) is unproven.

H. Percutaneous transluminal mechanical thrombectomy, vein(s) including intraprocedural pharmacological thrombolytic injections and fluroscopic guidance, repeat treatment on subsequent day during course of thrombolytic therapy (CPT<sup>5</sup> procedure code 37188) is unproven.

#### V. EFFECTIVE DATES

A. March 1, 2001, for gamma and beta intracoronary radiotherapy (brachytherapy).

B. January 1, 2002, for TMR.

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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 4, SECTION 9.1

CARDIOVASCULAR SYSTEM

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- C. October 1, 2003, for ventricular assist devices as destination therapy.
- D. December 1, 2003, for endovenous radiofrequency ablation/obliteration.
- E. January 1, 2005, for ABPM.
- F. *March 17, 2005, for PTA of the carotid artery with stenting in beneficiaries at high risk for CEA.*
- G. *March 21, 2006, for percutaneous transluminal mechanical thrombectomy for acute limb ischemia.*
- H. January 1, 2007, for pulmonary vein isolation/ablation.

- END -

## DIGESTIVE SYSTEM

ISSUE DATE: August 26, 1985

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

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### I. CPT<sup>1</sup> PROCEDURE CODES

40490 - 40831, 40899 - 43644, 43647, 43648, 43651 - 43761, 43800, 43810, 43820, 43842, 43846, 43848, 43880 - 43882, 43999, 44005 - 47362, 47370, 47371, 47379 - 47382, 47399 - 49999, 91123, 96570, 96571

### II. DESCRIPTION

The digestive system involves the organs associated with the ingestion, digestion, and absorption of nutrients, and the elimination of solid waste.

### III. POLICY

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

B. Gastric electrical stimulation (CPT<sup>1</sup> procedure codes 43647, 43648, 43881, and 43882) for treatment of symptoms of nausea and vomiting from chronic gastroparesis that is refractory to medical management may be considered for coverage as a Humanitarian Use Device (HUD).

C. Radiofrequency Ablation (RFA) (CPT<sup>1</sup> procedure codes 47370, 47380, and 47382) for treatment of unresectable hepatocellular carcinoma or unresectable liver metastases from colorectal cancer is proven and may be covered when all of the following conditions are met:

1. Tumors are less than five centimeters in diameter;
2. There are five or fewer tumors; and
3. There is no evidence of extrahepatic metastasis.

All procedures must be performed using an Food and Drug Administration (FDA) approved electrosurgical cutting and coagulation device.

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IV. EXCLUSIONS

A. Vestibuloplasty (CPT<sup>2</sup> procedure code range 40840-40845) EXCEPT for adjunctive dental care ([Chapter 8, Section 13.1](#)).

B. The Stretta System (Curon Medical, Sunnyvale, CA) and Bard Endoscopic Suturing System for the treatment of refractory gastroesophageal reflux disease (GERD) is unproven (CPT<sup>2</sup> procedure codes 43201 and 43257).

C. For bariatric procedures, see [Section 13.2](#).

V. EFFECTIVE DATE

RFA (CPT<sup>2</sup> procedure codes 47370, 47380, and 47382) for treatment of unresectable hepatocellular carcinoma or unresectable liver metastases from colorectal cancer is proven and covered, effective April 28, 2004.

- END -

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3. For embolizing other vascular malformation such as arteriovenous malformations and arteriovenous fistulae of the neurovasculature, to include arterial and venous embolizations in the peripheral vasculature.

#### IV. EXCLUSIONS

A. N-butyl-2-cyanoacrylate (Histacryl Bleu®), iodinated poppy seed oils (e.g., Ethiodol®), and absorbable gelatin sponges are not FDA approved.

B. Transcutaneous, percutaneous, functional dorsal column electrical stimulation in the treatment of multiple sclerosis or other motor function disorders is unproven.

C. Deep brain neurostimulation in the treatment of insomnia, depression, anxiety, and substance abuse is unproven.

D. Psychosurgery is not in accordance with accepted professional medical standards and is not covered.

E. Endovascular GDC treatment of wide-necked aneurysms and rupture is unproven.

F. Cerebellar stimulators/pacemakers for the treatment of neurological disorders are unproven.

G. Dorsal Root Entry Zone (DREZ) thermocoagulation or microcoagulation neurosurgical procedure is unproven.

H. Epidural steroid injections for thoracic pain are unproven.

I. Extraoperative electrocortigraphy for stimulation and recording in order to determine electrical thresholds of neurons as an indicator of seizure focus is unproven.

J. Neuromuscular electrical stimulation for the treatment of denervated muscles is unproven.

K. Stereotactic cingulotomy is unproven.

L. Sacral nerve neurostimulator (CPT<sup>3</sup> procedure codes 64561, 64581, 64585, and 64590). See [Chapter 4, Section 14.1](#) for coverage policy for the urinary system and the Sacral Nerve Root Stimulation (SNS).

M. Laminoplasty, cervical with decompression of the spinal cord, two or more vertebral segments with reconstruction of the posterior bony elements (CPT<sup>3</sup> procedure codes 63050 and 63051).

N. Balloon angioplasty, intracranial, percutaneous (CPT<sup>3</sup> procedure code 61630) is unproven. Effective January 1, 2006.

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CHAPTER 4, SECTION 20.1

NERVOUS SYSTEM

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O. Transcatheter placement of intravascular stent(s) intracranial, (e.g., atherosclerotic stenosis) including angioplasty, if performed (CPT<sup>4</sup> procedure code 61635) is unproven. Effective January 1, 2006.

P. Balloon dilation of intracranial vasospasm, initial vessel (CPT<sup>4</sup> procedure code 61640) each additional vessel in same family (CPT<sup>4</sup> procedure code 61641) or different vascular family (CPT<sup>4</sup> procedure code 61642) is unproven. Effective January 1, 2006.

Q. Sphenopalatine ganglion block (CPT<sup>4</sup> procedure code 64505) for the treatment of chronic migraine headaches and neck pain is unproven.

R. Radiofrequency ablation (percutaneous radiofrequency facet denervation, percutaneous facet coagulation, percutaneous radiofrequency neurotomy, radiofrequency facet rhizotomy, radiofrequency articular rhizolysis) (CPT<sup>4</sup> procedure codes 64622, 64623, 64626, 64627) for the treatment of chronic spinal pain is unproven. Pulsed radiofrequency ablation for spinal pain is unproven.

S. Cryoablation of Occipital Nerve (CPT<sup>4</sup> procedure code 64640) for the treatment of chronic intractable headache is unproven.

V. EFFECTIVE DATES

A. January 1, 1989, for PAVM.

B. April 1, 1994, for therapeutic embolization for treatment of meningioma.

C. July 14, 1997, for GDC.

D. The date of FDA approval of the embolization device for all other embolization procedures.

E. June 1, 2004, for Magnetoencephalography.

- END -

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**TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002**  
CHAPTER 4, SECTION 23.1  
HIGH DOSE CHEMOTHERAPY AND STEM CELL TRANSPLANTATION

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O. Donor lymphocyte infusion if not specifically listed as covered in [paragraph III.D.](#) under POLICY above.

P. Immunoablative therapy with bone marrow or peripheral stem cell transplantation is not covered for the treatment of multiple sclerosis.

Q. Immunoablative therapy with bone marrow or peripheral stem cell transplantation is unproven and not covered for the treatment of rheumatoid arthritis and juvenile idiopathic arthritis.

V. EFFECTIVE DATES

A. May 1, 1987, for HDC with ABMT or PSCT for Hodgkin's disease, non-Hodgkin's lymphoma and neuroblastoma.

B. November 1, 1987, for HDC with ABMT or PSCT for acute lymphocytic and nonlymphocytic leukemias.

C. November 1, 1983, for HDC with allogeneic bone marrow transplants using related donors.

D. July 1, 1989, for HDC with allogeneic bone marrow transplants using unrelated donors.

E. July 11, 1996, for HDC with ABMT or PSCT for multiple myeloma.

F. January 1, 1994, for HDC with ABMT and PSCT for Wilms' tumor.

G. January 1, 1995, for allogeneic umbilical cord blood transplants.

H. January 1, 1994, for HDC with ABMT or PSCT for chronic myelogenous leukemia.

I. January 1, 1996, for HDC with ABMT or PSCT for Waldenstrom's macroglobulinemia.

J. January 1, 1996, for allogeneic bone marrow transplants using related 3 antigen mismatch donors for patients with undifferentiated leukemia, Chronic Myelogenous Leukemia (CML), aplastic anemia, Acute Lymphocytic Leukemia (ALL) or Acute Myelogenous Leukemia (AML).

K. October 1, 1996, for HDC with ABMT or PSCT for AL Amyloidosis.

L. January 1, 1995, for allogeneic bone marrow transplant for hypereosinophilic syndrome.

M. May 1, 1997, for HDC with ABMT or PSCT for trilateral retinoblastoma/pineoblastoma.

N. January 1, 1997, for HDC with ABMT or PSCT for follicular lymphoma.

**TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002**  
CHAPTER 4, SECTION 23.1  
HIGH DOSE CHEMOTHERAPY AND STEM CELL TRANSPLANTATION

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- O. January 1, 1997, for HDC with ABMT or PSCT for non-Hodgkin's lymphoma in first complete remission.
  
- P. November 28, 1997, for HDC with ABMT or PSCT for Hodgkin's disease in second or third remission.
  
- Q. January 1, 1996, for HDC with allogeneic BMT for multiple myeloma.
  
- R. July 1, 1999, for HDC with ABMT or PSCT for germ cell tumors in a second or subsequent relapse.
  
- S. January 1, 1998, for HDC with ABMT or PSCT for osteosarcoma (osteogenic sarcoma).
  
- T. June 1, 1995, for allogeneic BMT for Chediak-Higashi syndrome.
  
- U. January 1, 1998, for allogeneic peripheral stem cell transplantation.
  
- V. June 1, 2003, for Langerhans Cell Histiocytosis, refractory to conventional treatment.
  
- W. January 24, 2002, for allogeneic stem cell transplant for Hodgkin's disease.
  
- X. May 19, 2005, for tandem autologous peripheral stem cell transplant for high-risk neuroblastoma.
  
- Y. January 1, 2006, for HDC with ABMT or PSCT for desmoplastic small round cell tumor.

- END -

## RADIATION ONCOLOGY

ISSUE DATE: March 27, 1991

AUTHORITY: 32 CFR 199.4(b)(2), (c)(2), (c)(3), and (g)(15)

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### I. CPT<sup>1</sup> PROCEDURE CODES

61793, 61795, 77261 - 77421, 77427 - 77799, 0073T

### II. DESCRIPTION

A. Radiation therapy is also known as radiotherapy, radiation treatment, x-ray therapy, cobalt therapy, and proton beam therapy. The primary purpose of radiation therapy is to eliminate or shrink localized cancers (as opposed to cancers that have spread to distant parts of the body).

B. Stereotactic radiosurgery/radiotherapy is a method of delivering ionizing radiation to small intracranial targets. Stereotactic radiosurgery entails delivering a high dose in a single session. Stereotactic radiotherapy entails fractionating the dose over a number of treatments.

1. There are three main variations of stereotactic radiosurgery/radiotherapy: gamma beam or gamma knife, linear accelerator (linac), and charged particle beam (proton or helium ion). The three radiation delivery devices differ technically in several ways: source of radiation, size and shape of the radiation field, and range of radiation dosages.

2. The radiosurgical/radiotherapy procedure is preceded by a process of localizing the target, which can be performed with one or more of the following techniques: skull x-ray, cerebral angiography, computerized tomography, or magnetic resonance imaging.

### III. POLICY

A. Radiation therapy (brachytherapy, fast neutron, hyperfractionated, and radioactive chromic phosphate synoviorthesis) is covered for those indications documented by reliable evidence as safe, effective and comparable or superior to standard care (proven).

B. Hyperthermia is covered for those indications documented by reliable evidence as safe, effective and comparable or superior to standard care (proven).

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C. Gamma knife radiosurgery/radiotherapy is covered for the following indications. This list of indications is not all inclusive. Other indications are covered when documented by reliable evidence as safe, effective, and comparable or superior to standard care (proven).

1. Arteriovenous malformations.
2. Benign brain tumors.
3. Acoustic neuromas (vestibular Schwannomas).
4. Pituitary adenomas.
5. Craniopharyngiomas.
6. Other tumors of the skull base.
7. Pineal region tumors.
8. Metastatic brain tumors.
9. High grade gliomas (glioblastoma multiforme, anaplastic astrocytomas).

D. Linear accelerator radiosurgery/radiotherapy is covered for the following indications. This list of indications is not all inclusive. Other indications are covered when documented by reliable evidence as safe, effective, and comparable or superior to standard care (proven).

1. Arteriovenous malformations.
2. Acoustic neuromas (vestibular Schwannomas).
3. Metastatic brain tumors.

E. Proton beam radiosurgery/radiotherapy is covered for the following indications. This list of indications is not all inclusive. Other indications are covered when documented by reliable evidence as safe, effective, and comparable or superior to standard care (proven).

1. Arteriovenous malformations.
2. Cushing's disease or acromegaly caused by pituitary microadenomas.
3. As postoperative therapy in patients who have undergone biopsy or partial resection of the chordoma or low grade (I or II) chondrosarcoma of the basisphenoid region (skull-base chordoma or chondrosarcoma) or cervical spine.
4. As primary therapy for patients with uveal melanoma, with no evidence of metastasis or extrascleral extension, and with tumors up to 22 mm in largest diameter and 14 mm in height.

## GENERAL

ISSUE DATE:

AUTHORITY: 32 CFR 199.4(a)(1)(i), (b)(2)(ix), (b)(3)(vi), (c)(2)(x) and (g)(60)

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### I. CPT<sup>1</sup> PROCEDURE CODES

80048 - 87622, 87640, 87641, 87650 - 87999, 88104 - 89264, 89330 - 89399

### II. DESCRIPTION

A. Pathology is the medical science and specialty practice that deals with all aspects of disease, but with special reference to the essential nature, the causes, and development of abnormal conditions, as well as the structural and functional changes that result from disease processes.

B. The surgical pathology services include accession, examination, and reporting for a specimen which is defined as tissue that is submitted for individual and separate attention, requiring individual examination and pathologic diagnosis. These codes require gross and microscopic examination.

### III. POLICY

A. Pathology and laboratory services are covered except as indicated.

B. Surgical pathology procedures, billed by a pathologist, are covered services.

C. If the operating surgeon bills for surgical pathology procedures, they will be denied as incidental, since the definitive (microscopic) examination will be performed later, after fixation of the specimen, by the pathologist who will bill separately.

D. Dermatologists are qualified to perform surgical pathology services. Therefore, if a dermatologist bills for both the surgical procedure (e.g. CPT<sup>1</sup> procedure code 11100, skin biopsy) as well as the surgical pathology, both procedures are covered in full.

E. Human papillomavirus testing (CPT<sup>1</sup> procedure codes 87620 - 87622) is covered for the assessment of women with Atypical Squamous Cells of Undetermined Significance (ASCUS) cells detected upon initial pap smear.

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F. The Nuclear Magnetic Resonance (NMR) LipoProfile-2 test, used with the NMR Profiler (CPT<sup>2</sup> procedure codes 83701 and 83704) is proven and covered for the management of lipoprotein disorders associated with cardiovascular disease.

G. For Transfusion Services, refer to Chapter 6, Section 2.1.

#### IV. EXCLUSIONS

A. Autopsy and postmortem (CPT<sup>2</sup> procedure codes 88000-88099).

B. Sperm penetration assay (hamster oocyte penetration test or the zona-free hamster egg test) is excluded for IVF (CPT<sup>2</sup> procedure code 89329).

C. In-vitro chemoresistance and chemosensitivity assays (stem cell assay, differential staining cytotoxicity assay and thymidine incorporation assay) are unproven.

D. Hair analysis to identify mineral deficiencies from the chemical composition of hair is unproven. Hair analysis testing (CPT<sup>2</sup> procedure code 96902) may be reimbursed when necessary to determine lead poisoning.

E. Insemination of oocytes (CPT<sup>2</sup> procedure code 89268).

F. Extended culture of oocyte(s) embryo(s) 4-7 days (CPT<sup>2</sup> procedure code 89272).

G. Assisted oocyte fertilization, microtechnique; less than or equal to 10 oocytes (CPT<sup>2</sup> procedure code 89280).

H. Assisted oocyte fertilization, microtechnique; greater than 10 oocytes (CPT<sup>2</sup> procedure code 89281).

I. Biopsy oocyte polar body or embryo blastomere (CPT<sup>2</sup> procedure code 89290).

J. Biopsy oocyte polar body or embryo blastomere; greater than 4 embryos (CPT<sup>2</sup> procedure code 89291).

K. Cryopreservation reproductive tissue, testicular (CPT<sup>2</sup> procedure code 89335).

L. Storage (per year) embryo(s) (CPT<sup>2</sup> procedure code 89342).

M. Storage (per year) sperm/semens (CPT<sup>2</sup> procedure code 89343).

N. Storage (per year) reproductive tissue, testicular/ovarian (CPT<sup>2</sup> procedure code 89344).

O. Storage (per year) oocyte (CPT<sup>2</sup> procedure code 89346).

P. Thawing of cryopreserved, embryo(s) (CPT<sup>2</sup> procedure code 89352).

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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 6, SECTION 1.1

GENERAL

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- Q. Thawing of cryopreserved, sperm/semen, each aliquot (CPT<sup>3</sup> procedure code 89353).
- R. Thawing of cryopreserved, reproductive tissue, testicular/ovarian (CPT<sup>3</sup> procedure code 89354).
- S. Thawing of cryopreserved, oocytes, each aliquot (CPT<sup>3</sup> procedure code 89356).
- T. Allo Map<sup>™</sup> for molecular testing is unproven for use in cardiac transplant rejection surveillance.

V. EFFECTIVE DATE

July 23, 2008, for NMR LipoProfile-2 test, used with the NMR Profiler.

- END -

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## OPHTHALMOLOGICAL SERVICES

ISSUE DATE: November 3, 1992

AUTHORITY: 32 CFR 199.4(c)(2)(xvi), (e)(6), (g)(46) and (g)(50)

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### I. CPT<sup>1</sup> PROCEDURE CODE RANGES

92002 - 92060, 92070 - 92335, 92390 - 92499

### II. DESCRIPTION

Ophthalmological services may include an examination and other specialized services. The purpose of an examination is to diagnose or treat a medical condition of the eye, eyelid, lacrimal system, or orbit. A "routine eye examination" is an evaluation of the eyes, including but not limited to refractive services, that is not related to a medical or surgical condition or to the medical or surgical treatment of a covered illness or injury.

### III. POLICY

A. For all beneficiaries, ophthalmological services (including refractive services) provided in connection with the medical or surgical treatment of a covered illness or injury are covered.

B. Section 632 of P.L. 98-525 signed into effect on October 19, 1994, authorizes payment under TRICARE for one routine eye examination per year for dependents of active duty members.

1. Routine eye examinations as defined in 32 CFR 199.2 includes coverage of those services rendered in order to determine the refractive state of the eyes. The CPT<sup>2</sup> procedure codes for payment of routine eye examinations are as follows:

92002 - EYE EXAM, NEW PATIENT  
92004 - EYE EXAM, NEW PATIENT  
92012 - EYE EXAM, ESTABLISHED PATIENT  
92014 - EYE EXAM & TREATMENT  
92015 - REFRACTION  
99172 - OCULAR FUNCTION SCREEN  
99173 - VISUAL ACUITY SCREEN

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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 7, SECTION 6.1

OPHTHALMOLOGICAL SERVICES

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2. TRICARE Prime and Standard Active Duty Family Members (ADFM) are entitled to one annual routine eye examination. Prime ADFMs may receive their annual routine eye exam from any network provider without referral, authorization, or preauthorization from the Primary Care Manager (PCM), or any other authority; i.e., a Prime ADFM will be allowed to set up his or her own appointment for a routine eye examination with any network optometrist or ophthalmologist. Standard ADFMs may self-refer to any TRICARE authorized provider regardless of whether or not they are a network provider; i.e., a Standard ADFM may set up his or her own appointment with either a network or non-network TRICARE authorized optometrist or ophthalmologist.

C. For Prime enrollees, see [Chapter 7, Section 2.2](#) for additional information on routine eye examinations.

IV. EXCLUSIONS

A. Routine eye examinations are NOT covered for Standard retirees or their dependents that are not enrolled in Prime except for eye exams allowed under the well-child benefit in [Chapter 7, Section 2.5](#).

B. Orthoptics, also known as vision training, vision therapy, eye exercises, eye therapy, is excluded by [32 CFR 199.4\(g\)\(46\)](#) (CPT<sup>2</sup> procedure code 92065).

C. Heidelberg Retina Tomograph (HRT) is unproven.

**D. Canaloplasty in the treatment of glaucoma is unproven.**

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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 7, SECTION 18.1

REHABILITATION - GENERAL

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B. Vocational rehabilitation. Educational services intended to provide a beneficiary with the knowledge and skills required for the performance of a specific occupation, vocation, or job.

C. Coma stimulation. Activities of external stimulation intended to arouse a beneficiary from a coma.

D. Programs. Standard bundles of services (programs) as an all-inclusive priced unit or services.

NOTE: Services rendered during such a program encounter must be itemized and each reviewed to determine if rendered by an authorized individual professional provider, if it is a covered benefit, and whether it is medically necessary and appropriate.

E. A systematic, goal-oriented rehabilitation treatment program originally designed to improve cognitive functions and functional abilities to increase levels of self-management and independence following neurological damage to the central nervous system.

F. Cognitive rehabilitation services that are prescribed specifically and uniquely to teach compensatory methods to accomplish tasks which rely upon cognitive processes are unproven.

G. The use of a MIRE device for treatment of diabetic peripheral neuropathy is unproven.

H. Services provided to address disorders or conditions (e.g., speech, language, or communication) resulting from occupational or educational deficits.

I. Low Level Laser Therapy (LLLT) (also known as low level light therapy or cold laser therapy) for treatment of soft tissue injuries, pain, or inflammation is unproven.

- END -



**TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002**

CHAPTER 7, SECTION 18.2

PHYSICAL MEDICINE/THERAPY

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13. Vertebral Axial Decompression (VAX-D) for relieving low back pain associated with herniated disc or degenerative disc disease of the lumbar vertebrae is unproven.

14. For beneficiaries under the age of three, services and items provided in accordance with the beneficiary's Individualized Family Service Plan (IFSP) as required by Part C of the Individuals with Disabilities Education Act (IDEA), and which are otherwise allowable under the TRICARE Basic Program or the Extended Care Health Option (ECHO) but determined not to be medically or psychologically necessary, are excluded.

15. For beneficiaries aged three to 21, who are receiving special education services from a public education agency, cost-sharing of outpatient physical therapy services that are required by the IDEA and which are indicated in the beneficiary's Individualized Education Program (IEP), may not be cost-shared except when the intensity or timeliness of physical therapy services as proposed by the educational agency are not sufficient to meet the medical needs of the beneficiary.

16. Low Level Laser Therapy (LLLT) (also known as low level light therapy or cold laser therapy) for treatment of soft tissue injuries, pain, or inflammation is unproven.

- END -



## DIAGNOSTIC SLEEP STUDIES

ISSUE DATE: October 12, 1984

AUTHORITY: [32 CFR 199.4\(a\)\(1\)](#)

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### I. CPT<sup>1</sup> PROCEDURE CODES

95805-95811, 95822, 95827

### II. HCPCS PROCEDURE CODE

G0398

### III. DESCRIPTION

Sleep studies and polysomnography refer to the continuous simultaneous monitoring and recording of various physiological and pathophysiological parameters of sleep for six or more hours with physician review, interpretation, and report. The studies are performed to diagnose a variety of sleep disorders and to evaluate a patient's response to therapies such as Nasal Continuous Positive Airway Pressure (NCPAP). Polysomnography is distinguished from sleep studies by the inclusion of sleep staging which is defined to include a 1-4 lead electroencephalogram (EEG), electro-oculogram (EOG), and a submental electromyogram (EMG). Additional parameters of sleep include: ECG; airflow; ventilation and respiratory effort; gas exchange by oximetry, transcutaneous monitoring, or end tidal gas analysis; extremity muscle activity, motor activity-movement; extended EEG monitoring; penile tumescence; gastroesophageal reflux; continuous blood pressure monitoring; snoring; body positions; etc.

### IV. POLICY

Diagnostic testing can be covered only if the patient has the symptoms or complaints of one of the conditions listed below:

A. Narcolepsy. This term refers to a syndrome characterized by abnormal sleep tendencies, including excessive daytime sleepiness, disturbed nocturnal sleep and pathological manifestation of Rapid Eye Movement (REM) sleep. The most typical REM sleep manifestations are cataplexy and sleep-onset REM periods, but sleep paralysis and hypnagogic hallucinations may also be present. Related diagnostic testing (e.g., Multiple Sleep Latency Test - CPT<sup>1</sup> procedure code 95805) is covered if the patient has inappropriate

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sleep episodes (e.g., while driving, in the middle of a meal, in the midst of conversation), amnesiac episodes, or continuous agonizing drowsiness.

B. Obstructive Sleep Apnea Syndrome (OSAS).

C. Impotence effective February 1, 1988.

D. Diagnostic testing for OSAS is a covered benefit. An Food and Drug Administration (FDA) approved dental orthosis may be covered for the treatment of OSAS. The device must be used for the treatment of OSAS and not for adjunctive dental.

E. Effective February 3, 1991, for parasomnias, that is abnormal sleep behavior, such as bruxism, sleepwalking, enuresis, and seizure disorder evaluations when the distinction between seizure activity and other forms of sleep disturbances is uncertain.

F. An unattended home/portable sleep study is proven and covered as an alternative to in-facility Polysomnography (PSG) for the diagnosis of Obstructive Sleep Apnea (OSA) in an adult when ALL of the following criteria are met:

1. When ordered by a physician board eligible/board certified in sleep medicine.

2. When the patient meets all of the following criteria:

a. High pretest probability of OSA as evidenced by clinical features, signs and symptoms (e.g., age, sex, Body Mass Index (BMI), loud snoring, awakening with gasping or choking, excessive daytime sleepiness, observed cessation of breathing during sleep);

b. The ordering physician determines a home portable sleep study is an appropriate alternative to in-laboratory PSG;

c. No significant co-morbid conditions exist that could impact the accuracy of the study (e.g., moderate to severe pulmonary disease, neuromuscular disease, congestive heart failure);

d. No sleep disorders other than OSA are suspected (e.g., central sleep apnea, periodic limb movement disorder, insomnia, parasomnias, circadian rhythm disorders, narcolepsy); or

e. Diagnosis of OSA has been established, therapy has been initiated, and response to treatment is to be evaluated.

3. When the following type of portable monitor is used:

a. Type II monitor with a minimum of seven channels (e.g., electroencephalogram (EEG) and electro-oculogram (EOG) for sleep staging, electrocardiogram (ECG), chin electromyogram (EMG), airflow, breathing/respiratory effort, and oxygen saturation.

b. Type III or Type IV monitors will not be covered.

4. When the portable monitor has been validated in a typical home environment.
5. When test results are reviewed and interpreted by a physician board eligible/board certified in sleep medicine.
6. All testing must be performed using an FDA approved portable monitoring device.

#### V. POLICY CONSIDERATIONS

A. Referral by Attending Physician. The patient must be referred to the sleep disorder center by the attending physician, and the center must maintain a record of the attending physician's referral. If a copy of the referral is not submitted with the claim, the contractor must develop for a referral.

B. Diagnostic Testing. The need for diagnostic testing is confirmed by medical evidence, e.g., physical examinations and laboratory tests.

C. For narcolepsy there must be documentation that the condition is severe enough to interfere with the patient's health and well-being. Ordinarily, a maximum of two clinic sleep sessions is sufficient for diagnosis. Claims in excess of two clinic sleep sessions must be referred to the contractor's medical review.

D. Claims for diagnostic sleep studies shall be processed and paid as outpatient services. Patients who undergo the testing are not considered inpatients, although they may come to the facility in the evening for testing and then leave after their tests are over.

E. Institutional and professional charges related to sleep diagnostic testing performed in a TRICARE-approved hospital are covered only for narcolepsy, sleep apnea, impotency, parasomnia, and suspected epilepsy when the distinction between seizure activity and other forms of sleep disturbances is uncertain on an outpatient cost-sharing basis.

F. Authorized-Freestanding Clinics. Payment may be made for sleep diagnostic testing performed by a freestanding clinic under the "physician-directed clinic" category.

NOTE: A "physician-directed clinic" is one where (a) a physician (or a number of physicians) is present to perform medical (rather than administrative) services at all times the clinic is open; (b) each patient is under the care of a clinic physician; and (c) the non-physician services are under medical supervision.

#### VI. EXCLUSIONS

A. Electrosleep Therapy. Electrosleep therapy is the application of short duration, low-amplitude pulses of direct current to the patient's brain by externally placed occipital electrodes. Passage of the weak electric current through the tissues of the head induces sleep. This modality is considered unproven, as its efficacy has not been established in the United States. Claims for electrosleep therapy must, therefore, be denied.

TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 7, SECTION 19.1

DIAGNOSTIC SLEEP STUDIES

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B. Study, Grant, or Research Programs. Payment may not be made for any services or supplies provided as a part of or under a grant or research program.

C. Sleep testing is not indicated for patients whose complaint is of short duration or for patients who do not experience functional disability during the day.

D. Diagnostic testing that is duplicative of previous testing done by the attending physician, to the extent the results are still pertinent, is not covered.

E. Payment may not be made for diagnostic sleep testing of the conditions listed below. These conditions can be diagnosed through other, more appropriate means:

1. Drug dependency
2. Hypersomnia (pathologically excessive sleep)
3. Insomnia
4. Night terrors or dream anxiety attacks
5. Nocturnal myoclonus (muscle jerks)
6. Restless leg syndrome
7. Shift work and schedule disturbances
8. Migraine headaches

F. If the patient has had documented episodes of cataplexy, diagnostic testing for narcolepsy would not be necessary and is, therefore, not covered.

G. Somnoplasty system for obstructive sleep apnea is unproven.

## VII. EFFECTIVE DATE

Home/portable sleep studies for the diagnosis of OSA in adults who meet certain criteria are covered, effective May 29, 2008.

- END -

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