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**CHANGE 150
6010.57-M
DECEMBER 10, 2015**

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

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

CHANGE TITLE: EVOLVING PRACTICES 15-004

CONREQ: 17734

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): See page 3.

EFFECTIVE DATE: See page 3.

IMPLEMENTATION DATE: January 11, 2016.

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DN: c=US, o=U.S. Government,
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Date: 2015.12.07 13:44:18 -07'00'

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**ATTACHMENT(S): 9 PAGE(S)
DISTRIBUTION: 6010.57-M**

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REMOVE PAGE(S)

CHAPTER 4

Section 9.1, pages 5 and 6

Section 13.2, pages 1 - 5

Section 14.1, pages 1 and 2

INSERT PAGE(S)

Section 9.1, pages 5 and 6

Section 13.2, pages 1 - 5

Section 14.1, pages 1 and 2

SUMMARY OF CHANGES

CHAPTER 4

1. Section 9.1.
 - a. Paragraph 3.1.3. This change adds a benefit through the Evolving Practices Review, percutaneous transluminal mechanical thrombectomy with stent retrievers, for the treatment of adults with acute ischemic stroke. EFFECTIVE DATE: 01/07/2015.
 - b. Paragraph 3.16. This change adds a benefit through the Evolving Practices Review, continuous ambulatory electrocardiograph recording (e.g., ZIO® XT Patch) greater than 48 hours, for diagnosing cardiac arrhythmias. EFFECTIVE DATE: 11/30/2014.
2. Section 13.2. This change adds a benefit through the Evolving Practices Review, four new bariatric surgical procedures: biliopancreatic diversion, biliopancreatic diversion with duodenal switch, sleeve gastrectomy, and stand-alone laparoscopic sleeve gastrectomy. EFFECTIVE DATE: 09/01/2014.
3. Section 14.1. This change adds a benefit through the Evolving Practices Review, the posterior tibial nerve stimulation for the treatment of overactive bladder, to include urinary frequency, urgency, and incontinence (CPT code 64566). EFFECTIVE DATE: 12/09/2014.

3.11.7 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.

3.12 Transcatheter Aortic Valve Replacement (TAVR) for the treatment of severe symptomatic aortic stenosis is proven safe and effective for patients who are not candidates for Surgical Aortic Valve Replacement (SAVR).

3.13 Percutaneous transluminal mechanical thrombectomy (CPT⁴ procedure codes 37184, 37185, 37186) with stent retrievers for the treatment of adults with acute ischemic stroke is proven safe and effective.

3.14 TAVR for the treatment of severe symptomatic aortic stenosis in high-risk operative patients is considered proven safe and effective.

3.15 Intracranial angioplasty with stenting (CPT⁴ procedure code 61635) of the venous sinuses may be considered for cost-sharing for the treatment of pseudotumor cerebri (also known as idiopathic intracranial hypertension and benign intracranial hypertension).

3.16 **Cardiography: electrocardiograms, rhythm strips, stress testing; Cardiovascular Monitoring: continuous ambulatory monitors (e.g., Holter monitor, Zio Patch), mobile cardiac telemetry, and event monitors; Implantable and Wearable Cardiac Devices: pacemakers, defibrillators, and loop recorders are covered when approved by the FDA and in accordance with Chapter 8, Section 5.1.**

4.0 EXCLUSIONS

4.1 Thermogram; cephalic (CPT⁴ procedure code 93760); peripheral (CPT⁴ procedure code 93762) are unproven.

4.2 Percutaneous Myocardial Laser Revascularization (PMR) is unproven.

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

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

4.5 Percutaneous Transluminal Angioplasty (PTA) in the treatment of obstructive lesions of the 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 (CPT⁴ procedure code 37216) is unproven.

4.6 Signal-Average Electrocardiography (CPT⁴ procedure code 93278) is unproven.

4.7 Percutaneous transluminal mechanical thrombectomy vein(s) including intraprocedural pharmacological thrombolytic injections and fluroscopic guidance (CPT⁴ procedure code 37187) is unproven.

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4.8 Percutaneous transluminal mechanical thrombectomy, vein(s) including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance, repeat treatment on subsequent day during course of thrombolytic therapy (CPT⁵ procedure code 37188) is unproven.

5.0 EFFECTIVE DATES

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

5.2 January 1, 2002, for TMR.

5.3 October 1, 2003, for VADs as destination therapy.

5.4 December 1, 2003, for endovenous RFA/obliteration.

5.5 January 1, 2005, for ABPM.

5.6 March 17, 2005, for PTA of the carotid artery with stenting in beneficiaries at high risk for CEA.

5.7 March 21, 2006, for percutaneous transluminal mechanical thrombectomy for acute limb ischemia.

5.8 January 1, 2007, for pulmonary vein isolation/ablation.

5.9 January 1, 2009, for endovenous laser ablation/therapy.

5.10 May 1, 2011, for endovenous RFA/obliteration for the treatment of incompetent perforator veins.

5.11 July 27, 2012, for endovenous laser ablation/therapy for the treatment of incompetent perforator veins.

5.12 February 8, 2012, for TAVR for the treatment of severe symptomatic aortic stenosis in patients who are not candidates for SAVR.

5.13 July 27, 2012, for TAVR, for the treatment of severe symptomatic aortic stenosis in high-risk operative patients.

5.14 June 25, 2014, for intracranial angioplasty with stenting of the venous sinuses for the treatment of pseudotumor cerebri.

5.15 November 30, 2014, for continuous ambulatory Electrocardiogram (ECG) recording greater than 48 hours.

5.16 January 7, 2015, for percutaneous transluminal mechanical thrombectomy with stent retrievers.

- END -

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Surgery For Morbid Obesity

Issue Date: November 9, 1982

Authority: [32 CFR 199.2\(b\)](#) and [32 CFR 199.4\(e\)\(15\)](#)

1.0 CPT¹ PROCEDURE CODES

43633, 43644, 43635, 43770 - 43775, 43842, 43845 - 43848

2.0 HCPCS PROCEDURE CODE

S2083

3.0 DESCRIPTION

3.1 Surgery for morbid obesity, termed bariatric surgery, is based on two principles:

- Divert food from the stomach to a lower part of the digestive tract where the normal mixing of digestive fluids and absorption of nutrients cannot occur (i.e., malabsorptive surgical procedures); or
- Restrict the size of the stomach and decrease intake (i.e., restrictive surgical procedures). Surgery can combine both types of procedures.

3.2 Bariatric surgery is performed for the treatment of morbid obesity. Morbid obesity is a Body Mass Index (BMI) equal to or greater than 40 kilograms per meter squared (kg/m²), or a BMI equal to or greater than 35 kg/m² in conjunction with high-risk co-morbidities, which is based on the guidelines established by the National Heart, Lung and Blood Institute on the Identification and Management of Patients with Obesity.

3.3 BMI, which describes relative weight for height, is significantly correlated with total body fat content and is a practical indicator of the severity of obesity with a direct calculation based on height and weight regardless of gender. BMI is equal to weight in kilograms divided by height in meters squared.

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4.0 POLICY

4.1 Bariatric surgery, using a covered procedure outlined in [paragraph 4.2](#) is covered for the treatment of morbid obesity when all the following conditions are met:

4.1.1 The patient has completed growth (18 years of age or documentation of completion of bone growth).

4.1.2 The patient has been previously unsuccessful with medical treatment for obesity. Failed attempts at non-surgical medical treatment for obesity must be documented in the patient's medical record.

4.1.2.1 Commercially available diet programs or plans, such as Weight Watchers®, Jenny Craig, or similar plans are acceptable methods of dietary management, if there is concurrent documentation of at least monthly clinical encounters with the physician.

Note: These programs are not covered by TRICARE.

4.1.2.2 Physician-supervised programs consisting exclusively of pharmacological management are not sufficient to meet this requirement.

4.1.3 The patient has evidence of either of the following:

- A body-mass index greater than or equal to 40 kg/m².
- A body-mass index of 35-39.9 kg/m² with one clinically significant co-morbidity, including but not limited to, cardiovascular disease, type 2 diabetes mellitus, obstructive sleep apnea, pickwickian syndrome, hypertension, coronary artery disease, obesity-related cardiomyopathy, or pulmonary hypertension.

4.2 When the specific medical necessity criteria stated in [paragraph 4.1](#) have been met for bariatric surgery, TRICARE shall cost share any of the following open or laparoscopic surgical procedure:

- Roux-en-Y gastric bypass
- Vertical banded gastroplasty
- Gastroplasty (stomach stapling)
- Adjustable gastric banding (i.e., adjustable LAP-BAND®)
- Biliopancreatic diversion with or without duodenal switch for individuals with a BMI greater than or equal to 50 kg/m²
- Sleeve Gastrectomy
- Stand-alone laparoscopic sleeve gastrectomy

4.3 Revision Bariatric Surgery

4.3.1 Medically necessary surgical reversal (i.e., takedown or revision) of the bariatric procedure is covered when the beneficiary develops a complication (e.g., stricture or obstruction) from the original covered surgery.

4.3.2 Replacement of an adjustable band because of complications (e.g., port leakage, slippage) that cannot be corrected with band manipulation or adjustments is covered.

4.3.3 Repeat/revision of a covered bariatric surgical procedure due to technical failure of the original procedure is covered when all of the following criteria are met:

- The patient has failed to achieve adequate weight loss, which is defined as failure to lose at least 50% of excess body weight or failure to achieve body weight to within 10% of ideal body weight at least two years following the original surgery.
- The patient met all the screening criteria, including BMI requirements of the original procedure, and has been compliant with a prescribed nutrition and exercise program following the original surgery.
- The requested procedure is a covered bariatric surgery.

Note: Inadequate weight loss due to individual noncompliance with postoperative nutrition and exercise recommendations is not a medically necessary indication for revision or conversion surgery and is not payable under TRICARE.

4.4 Any device utilized for a bariatric surgical procedure must have the U.S. Food and Drug Administration (FDA) approval specific to the indication, otherwise the device is considered unproven and not payable under TRICARE.

5.0 LIMITATIONS

5.1 Coverage is limited to one bariatric surgery per lifetime, except in those conditions addressed in [paragraph 4.3.3](#).

5.2 The following are examples of conditions that are always denied a second bariatric surgical procedure because they do not qualify as a complication or technical failure:

5.2.1 Weight gain or weight plateau resulting from failure to follow the regimen of diet and exercise recommended after the initial bariatric surgery.

5.2.2 Weight gain or weight plateau resulting from the dilation and other stabilization of the gastric pouch as a natural and ordinary occurrence in the aftermath of the initial bariatric surgery.

6.0 POLICY CONSIDERATIONS

Benefits are authorized for otherwise covered medical services and supplies directly related to complications of obesity when such services and supplies are an integral and necessary part of the course of treatment that was aggravated by the obesity (e.g., excision of redundant skin folds after weight loss in areas such as, but not limited to, the abdomen, lumbar region, arms, and/or thighs). TRICARE payment shall be considered for medically necessary services when the beneficiary has met the following criteria:

6.1 The beneficiary had a covered bariatric surgical procedure with subsequent weight loss, is at least 18 months postoperative, and has maintained weight for at least six months.

6.2 The beneficiary's medical record documents a redundant skin fold or excessive skin that significantly interferes with mobility (e.g., a large hanging abdominal pannis - a Grade 2 panniculus or greater) or causes a physical functional impairment such as uncontrollable inflammation and/or infection resulting in pain, ulceration, or otherwise complicates medical conditions, persistent and refractory to medical treatment. (Examples of agents that may be used for conservative treatment are antifungal, antibacterial or moisture-absorbing agents, topically applied skin barriers, and supportive garments.)

Note: In this policy, physical functional impairment means a limitation from normal (or baseline) of physical functioning that may include, but is not limited to, problems with ambulation, mobilization, skin integrity, or distortion of nearby body parts. Physical functional impairment excludes social, emotional and psychological impairments or potential impairments.

7.0 EXCEPTIONS

7.1 Benefits for adjustments to the gastric banding device by injection or aspiration of saline, including any adjustment-related complications, shall be allowed for patients who underwent the laparoscopic adjustable gastric banding (i.e., LAP-BAND®) surgery before the effective date of coverage only if the patient criteria discussed in [paragraph 4.1](#) were met or would have been met at the time of surgery.

7.2 TRICARE will not cost-share any complication resulting from the initial surgery, including band-related complications, for those patients who surgeries were performed prior to the effective date of coverage. If, however, a complication results from a separate medical condition, benefits shall be allowed for the otherwise covered treatment. A separate medical condition exists when it causes a systemic effect, or occurs in a different body system from the noncovered treatment.

7.3 Documentation must be submitted that gives the patient's history and shows that the patient met or would have met the criteria for the morbid obesity benefit at the time of surgery. The contractor shall conduct a medical review to assure compliance with [paragraph 4.1](#). Where necessary, additional clinical documentation shall be obtained as part of this review.

8.0 EXCLUSIONS

8.1 Nonsurgical treatment related to obesity, morbid obesity, or weight reduction (e.g., weight control services, weight control/loss programs, exercise programs, food supplements, weight loss drugs, etc.).

8.2 Redundant skin surgery when performed solely for the purpose of improving appearance or to treat psychological symptomatology or psychosocial complaints related to one's appearance.

8.3 Gastric bubble or balloon for treatment of morbid obesity is unproven.

8.4 Gastric wrapping/open gastric banding (CPT² procedure code 43843) for treatment of morbid obesity is unproven.

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TRICARE Policy Manual 6010.57-M, February 1, 2008

Chapter 4, Section 13.2

Surgery For Morbid Obesity

8.5 Unlisted CPT³ procedure codes 43659 (laparoscopy procedure, stomach); 43999 (open procedure, stomach); and 49329 (laparoscopy procedure, abdomen, peritoneum and omentum) for gastric bypass procedures.

9.0 EFFECTIVE DATES

9.1 Laparoscopic surgical procedure for gastric bypass and gastric stapling (gastroplasty), including vertical banded gastroplasty are covered, effective December 2, 2004.

9.2 Laparoscopic adjustable gastric banding is covered, effective February 1, 2007.

9.3 Biliopancreatic diversion, biliopancreatic diversion with duodenal switch, sleeve gastrectomy, and stand-alone laparoscopic sleeve gastrectomy, effective September 1, 2014.

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Urinary System

Issue Date: August 26, 1985

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

1.0 CPT¹ PROCEDURE CODES

50010 - 53899, 64561, 64581, 64585, 64590, 64595

2.0 DESCRIPTION

The urinary system involves those organs concerned in the production and excretion of urine.

3.0 POLICY

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

3.2 Benefits may be considered for the implantation of similar U.S. Food and Drug Administration (FDA) approved devices. The Sacral Nerve Root Stimulation (SNS) has received FDA approval. Services and supplies related to the implantation of the SNS may be covered for individuals with urge incontinence, nonobstructive urinary retention, or symptoms of urgency-frequency syndrome that is not due to a neurologic condition, who have failed previous conservative treatments, and who have had a successful peripheral nerve evaluation test.

3.3 The use of a bedwetting alarm for the treatment of primary nocturnal enuresis may be considered for cost-sharing when prescribed by a physician and after physical or organic causes for nocturnal enuresis have been ruled out.

3.4 Collagen implantation of the urethra and/or bladder neck may be covered for patients not amenable to other forms of urinary incontinence treatment.

3.5 Cryoablation for renal cell carcinoma (CPT¹ procedure codes 50250 and 50593) may be considered for coverage under the Rare Disease policy ([Chapter 1, Section 3.1](#)) on a case-by-case basis. Effective June 1, 2006.

3.6 Under the provisions for the treatment of rare diseases, coverage of laparoscopic Radiofrequency Ablation (RFA) (CPT¹ procedure code 50542) and Percutaneous Radiofrequency Ablation (PRFA) (CPT¹ procedure code 50592) may be considered on a case-by-case basis for the treatment of Renal Cell Carcinoma (RCC) and genetic syndromes associated with RCC including von

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Hippel-Lindau syndrome, hereditary papillary cell carcinoma, or hereditary clear-cell carcinoma for patients who are not appropriate candidates for surgical intervention.

3.7 Posterior Tibial Nerve Stimulation (PTNS) for treatment of overactive bladder, to include urinary frequency, urge, and incontinence (CPT² procedure code 64566) is proven.

4.0 EXCLUSIONS

4.1 Peri-urethral Teflon injection is unproven.

4.2 Silastic gel implant.

4.3 Acrylic prosthesis (Berry prosthesis).

4.4 Bladder stimulators, direct or indirect, such as spinal cord, rectal and vaginal electrical stimulators, or bladder wall stimulators. Payment for any related service or supply, including inpatient hospitalization primarily for surgical implementation of a bladder stimulator.

4.5 Transurethral balloon dilation of the prostate (CPT² procedure code 52510) is unproven.

4.6 Cryoablation for the treatment of renal angiomyolipoma is unproven.

5.0 EFFECTIVE DATE

5.1 Transurethral Needle Ablation (TUNA) of the prostate is proven (CPT² procedure code 53852). Effective June 1, 2004.

5.2 March 28, 2007, for laparoscopic RFA or PRFA for the treatment of RCC and genetic syndromes associated with RCC, including von Hippel-Lindau syndrome, hereditary papillary cell carcinoma, or hereditary clear-cell carcinoma.

5.3 December 9, 2014, for PTNS for the treatment of overactive bladder.

- END -

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