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MB&RS

**CHANGE 160
6010.57-M
MAY 10, 2016**

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

The Defense Health Agency has authorized the following addition(s)/revision(s).

CHANGE TITLE: EVOLVING PRACTICES 16-002

CONREQ: 17949

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): See page 3.

EFFECTIVE DATE: See page 3.

IMPLEMENTATION DATE: June 10, 2016.

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Date: 2016.05.06 07:05:09 -06'00'

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**ATTACHMENT(S): 14 PAGE(S)
DISTRIBUTION: 6010.57-M**

CHANGE 160
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MAY 10, 2016

REMOVE PAGE(S)

CHAPTER 1

Section 12.1, pages 1 and 2

Section 13.1, pages 1 and 2

CHAPTER 4

Section 6.1, pages 1 through 4

Section 21.1, pages 1 and 2

CHAPTER 7

Section 3.8, pages 1 through 3

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SUMMARY OF CHANGES

CHAPTER 1

1. Section 12.1. This change confirms the Implantable Miniature Telescope is proven for the treatment of end-stage age-related macular degeneration in individuals 65 yrs and older with severe to profound central visual impairment. EFFECTIVE DATE: 06/17/2015.
2. Section 13.1. This change adds coverage for Hip resurfacing for the treatment of Degenerative Joint Disease of the Hip. EFFECTIVE DATE: 05/21/2014.

CHAPTER 4

3. Section 6.1. This change adds coverage for Hip resurfacing for the treatment of Degenerative Joint Disease of the Hip. EFFECTIVE DATE: 05/21/2014.
4. Section 21.1. This change confirms the Implantable Miniature Telescope is proven for the treatment of end-stage age-related macular degeneration in individuals 65 years and older with severe to profound central visual impairment. EFFECTIVE DATE: 06/17/2015.

CHAPTER 7

5. Section 3.8. This change confirm Transcranial Magnetic Stimulation is used for the treatment of Adults with Major Depressive Disorder. EFFECTIVE DATE: 05/31/2014.
6. Section 15.1. This change confirms Off-Label Use of Rituximab for the Treatment of Chronic Inflammatory Demyelinating Polyneuropathy. EFFECTIVE DATE: 07/16/2010.

Category III Codes

Issue Date: March 6, 2002

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

1.0 CPT¹ PROCEDURE CODES

0073T, 0075T, 0076T, 0099T, 0184T, 0308T

2.0 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.

3.0 POLICY

3.1 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.

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

4.0 EXCEPTIONS

4.1 U.S. Food and Drug Administration (FDA) Investigational Device Exemption (IDE) (Category B) clinical trial. See [Chapter 8, Section 5.1](#).

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

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

4.4 Category III codes 0099T and 0308T are covered codes as outlined in [Chapter 4, Section 21.1](#).

4.5 Category III code 0184T is a covered service as listed in [Chapter 4, Section 13.1](#).

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5.0 EXCLUSIONS

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

5.2 Ultrasound ablation (destruction of uterine fibroids) with Magnetic Resonance Imaging (MRI) guidance (CPT² procedure code 0071T) in the treatment of uterine leiomyomata is unproven.

5.3 Computer-Aided Detection (CAD) with breast MRI (CPT² procedure code 0159T) is unproven.

5.4 XSTOP Interspinous Process Decompression System (CPT² procedure codes 0171T and 0172T, HCPCS code C1821) is unproven.

5.5 Ultrasound-guided facet joint injection (CPT² procedure codes 0216T and 0217T) is unproven.

- END -

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Healthcare Common Procedure Coding System (HCPCS) "C" And "S" Codes

Issue Date: November 6, 2007
Authority:

1.0 HCPCS "C" AND "S" CODES

C1000 - C9999; S0000 - S9999

2.0 DESCRIPTION

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

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

3.0 POLICY

3.1 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 2.2](#).

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

3.2.1 S9122, S9123, S9124, and S8940 for the Extended Care Health Option (ECHO) respite care benefit and the ECHO Home Health Care (EHHC) benefit;

3.2.2 S0812, S1030, S1031, S1040, S2083, S2202, S2235, S2325, S2360, S2361, S2401 - S2405, S2411, S3620, S8030, S8185, S8265, S8270, and S9430 for all beneficiaries; and

3.2.3 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 18, Section 8](#).)

3.2.4 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

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case-by-case basis, based on the Rare Disease policy, effective October 1, 2009. Procedural guidelines for review of rare disease are contained in [Section 3.1](#).

3.2.5 S0189 for testosterone pellets as provided in [Chapter 4, Section 5.1](#).

3.2.6 S8999 for resuscitation bag for use by the patient on artificial respiration during power failure or other catastrophic event. The bag must be U.S. Food and Drug Administration (FDA) approved, used in accordance with FDA indications, and must be prescribed by a physician.

3.2.7 S9900 for services rendered by an authorized Christian Science Practitioner as provided in [Chapter 11, Section 1.1](#).

3.2.8 S0190 and S0191 as provided in [Chapter 4, Section 18.3](#).

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

3.4 S2095 for the treatment of unresectable liver metastases from neuroendocrine tumors, as stated in [Chapter 1, Section 3.1](#).

3.5 S5110 and S5115 are covered as part of the Applied Behavior Analysis (ABA) benefit as outlined in [Chapter 7, Section 3.16](#). The end date is December 31, 2014.

3.6 S9480 as described in [Chapter 7, Section 3.4, paragraph 3.8](#) and [Chapter 7, Section 3.5, paragraph 3.3.1.2.3](#).

3.7 S2118 hip resurfacing with an FDA approved device is covered as a benefit as outlined in [Chapter 4, Section 6.1](#).

4.0 EXCLUSIONS

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

4.2 HCPCS S2066, S2067, and S2068 shall no longer be used. Current Procedural Terminology (CPT)¹ code 19364 is the more appropriate representation of these services.

- END -

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Musculoskeletal System

Issue Date: August 26, 1985

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

1.0 CPT¹ PROCEDURE CODES

20005 - 20551, 20555 - 22328, 22510 - 22515, 22532 - 22856, 22861, 22864 - 27138, 27146 - 27178, 27181 - 29861, 29870 - 29913, 29999

2.0 HCPCS CODES

S2118, S2325, S2360, S2361

3.0 DESCRIPTION

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

4.0 POLICY

4.1 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.

4.2 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.

4.3 Single or multilevel anterior cervical microdiscectomy with allogeneic or autogeneic iliac crest grafting and anterior plating is covered for the treatment of cervical spondylosis.

4.4 Percutaneous vertebroplasty (CPT¹ procedure codes 22510-22512, S2360, S2361) and balloon kyphoplasty (CPT¹ procedure codes 22513-22515) are covered for the treatment of painful osteolytic lesions and osteoporotic compression fractures refractory to conservative medical treatment.

4.5 Total Ankle Replacement (TAR) (CPT¹ 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.

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4.6 Core decompression of the femoral head (hip) for early (precollapse stage I or II) avascular necrosis may be considered for cost-sharing (Healthcare Common Procedure Coding System (HCPCS) code S2325).

4.7 Single-level, cervical Total Disc Replacement (TDR) (CPT² procedure code 22856) using an FDA approved cervical artificial intervertebral disc for the treatment of cervical DDD, intractable radiculopathy, and/or myelopathy is covered if the disc is used in accordance with its FDA labeled indications.

4.8 High Energy Extracorporeal Shock Wave Therapy (HE ESWT) for the treatment of plantar fasciitis is covered when all of the following conditions are met:

- Patients have chronic plantar fasciitis of at least six months duration;
- Patients have undergone and failed six months of appropriate conservative therapy; and
- HE ESWT is defined as Energy Flux Density (EFD) greater than 0.12 millijoules per square millimeter (mJ/mm²).

4.9 Meniscal allograft transplant of the knee is covered.

4.10 Hip resurfacing (CPT² procedure codes 27125 and 27130, and HCPCS S2118) with an FDA approved device is proven for the treatment of Degenerative Joint Disease (DJD) of the hip in patients who are less than 65 years old and who meet all of the following criteria:

- Have chronic, persistent pain and/or disability;
- Are otherwise healthy and active;
- Have normal proximal femoral bone geometry and bone quality; and
- Would otherwise receive a conventional Total Hip Replacement (THR), but are likely to outlive a conventional THR implant system's expected life.

5.0 EXCLUSIONS

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

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

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

5.4 Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection), cervical, second level (CPT² procedure code 22858) and three or more levels (CPT² procedure code 0375T) is unproven.

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5.5 Removal of total disc arthroplasty (artificial disc), anterior approach, cervical, each additional interspace (CPT³ procedure code 0095T) is unproven. Also, see [Section 1.1](#).

5.6 Lumbar total disc arthroplasty (lumbar artificial intervertebral disc revision including replacement, lumbar total disc replacement) for degenerative disc disease is unproven (CPT³ procedure codes 22857, 22862, 0163T, 0164T, and 0165T).

5.7 Low Energy (LE) or radial ESWT for the treatment of plantar fasciitis is unproven. Any form of ESWT for the treatment of lateral epicondylitis is unproven.

5.8 XSTOP Interspinous Process Decompression System (CPT³ procedure codes 0171T and 0172T, HCPCS code C1821) for the treatment of neurogenic intermittent claudication secondary to lumbar spinal stenosis is unproven.

5.9 Femoroacetabular Impingement (FAI) open surgery, surgical dislocation (CPT³ procedure codes 27140 and 27179), for the treatment of hip impingement syndrome or labral tear is unproven.

5.10 Hip arthroscopy with debridement of articular cartilage (CPT³ procedure code 29862) for the treatment of FAI is unproven.

5.11 Hip arthroscopy with femoroplasty (CPT³ procedure code 29914) treatment of FAI; cam lesion is unproven.

5.12 Hip arthroscopy with acetabuloplasty (CPT³ procedure code 29915) treatment of FAI; pincer lesion is unproven.

5.13 Hip arthroscopy with labral repair (CPT³ procedure code 29916) for treatment of FAI syndrome is unproven.

5.14 Osteochondral allograft of the humeral head with meniscal transplant and glenoid microfracture in the treatment of shoulder pain and instability is unproven.

5.15 Thermal Intradiscal Procedures (TIPs) (CPT³ procedure codes 22526, 22527, 62287, and Healthcare Common Procedure Coding System (HCPCS) code S2348) are unproven. TIPs are also known as: Intradiscal Electrothermal Annuloplasty (IEA), Intradiscal Electrothermal Therapy (IDET), Intradiscal Thermal Annuloplasty (IDTA), Percutaneous Intradiscal Radiofrequency Thermocoagulation (PIRFT), Coblation Percutaneous Disc Decompression, Nucleoplasty (also known as Percutaneous Radiofrequency (RF) Thermomodulation or Percutaneous Plasma Discectomy), Radiofrequency Annuloplasty (RA), Intradiscal Biacuplasty (IDB), Percutaneous (or Plasma) Disc Decompression (PDD), Targeted Disc Decompression (TDD), Cervical Intradiscal RF Lesioning.

5.16 Spinal manipulation under anesthesia (CPT³ procedure codes 00640 and 22505) for the treatment of back pain is unproven.

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5.17 Minimally Invasive Lumbar Decompression (mild®) for the treatment of Degenerative Disc Disease (DDD) and/or spinal stenosis is unproven.

5.18 ACI surgery for the repair of patellar cartilage lesions is unproven.

5.19 iFuse Implant System (CPT⁴ procedure code 27279) for treatment of sacroiliac joint pain is unproven.

5.20 Athletic pubalgia surgery is unproven.

6.0 EFFECTIVE DATES

6.1 February 6, 2006, for percutaneous vertebroplasty and balloon kyphoplasty.

6.2 May 1, 2008, for TAR.

6.3 May 1, 2008, for core decompression of the femoral head.

6.4 December 24, 2012, for single-level, cervical TDR using an FDA approved cervical artificial intervertebral disc.

6.5 December 2, 2013, for HE ESWT for plantar fasciitis.

6.6 May 1, 2015, for meniscal allograft transplant of the knee.

6.7 May 21, 2014, for hip resurfacing for treatment of DJD of the hip.

- END -

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Eye And Ocular Adnexa

Issue Date: August 26, 1985

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

1.0 CPT¹ PROCEDURE CODES

0192T, **0308T**, 65091 - 65755, 65772 - 66172, 66180 - 68899, 77600 - 77615

2.0 DESCRIPTION

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

3.0 POLICY

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

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

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

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

3.5 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](#).

3.6 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. Coverage allowed effective July 17, 2005.

3.7 Optonal ExPRESS Mini glaucoma Shunt (CPT¹ procedure code 0192T) to reduce Intraocular Pressure (IOP) in the treatment of glaucoma, that cannot be controlled effectively with medications.

3.8 Off-label use of Photodynamic Therapy (CPT¹ procedure code 67221) with Visudyne (HCPCS J3396) may be considered for cost-sharing for the treatment of retinal astrocytic hamartoma in Tuberous Sclerosis. The effective date is February 1, 2008.

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3.9 Transpupillary thermotherapy (CPT² procedure code 67299) with Plaque Radiotherapy (Brachytherapy) is covered for the treatment of choroidal melanoma. See also [Chapter 5, Section 3.2](#).

3.10 Photodynamic Therapy for the treatment of Central Serous Chorioretinopathy in accordance with the TRICARE provisions for the treatment of rare diseases.

3.11 Implantable Miniature Telescope (IMT) is covered for FDA approved indications for beneficiaries with end-stage age-related macular degeneration.

4.0 EXCLUSIONS

4.1 Refractive corneal surgery except as noted in [paragraph 3.4](#) (CPT² procedure codes 65760, 65765, 65767, 65770, 65771).

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

4.3 Orthokeratology.

4.4 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).

4.5 Epikeratophakia for treatment of aphakia and myopia is unproven.

4.6 Transpupillary thermotherapy (CPT² procedure code 67299) as primary treatment of choroidal melanoma is unproven.

4.7 Canaloplasty for the treatment of glaucoma (CPT² procedure codes 66174 and 66175).

4.8 Autologous serum eye drops for the treatment of dry eye syndrome, keratitis, or ocular hypertension is unproven.

5.0 EFFECTIVE DATES

5.1 April 1, 2011, coverage for Optonal ExPRESS Mini Glaucoma Shunt.

5.2 December 1, 2014, coverage for Photodynamic Therapy for Central Serous Chorioretinopathy.

5.3 June 17, 2015, coverage date for IMT.

- END -

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Treatment Of Mental Disorders

Issue Date: December 5, 1984

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

1.0 CPT¹ PROCEDURE CODE RANGES

90801 - 90899 for care provided through December 31, 2012.

90785 - 90899 for care provided on or after January 1, 2013.

2.0 POLICY

Benefits are payable for services and supplies that are medically or psychologically necessary for the treatment of mental disorders when:

2.1 The services are rendered by persons who meet the criteria of [32 CFR 199.6](#) for their respective disciplines (whether the person is an individual professional provider or is employed by another authorized provider), and

2.2 The mental disorder is one of those listed in the current edition of the **Diagnostic and Statistical Manual of Mental Disorders** (DSM) and is of a severity not only to cause the patient distress but also to interfere with the patient's ability to carry out his or her usual activities.

3.0 POLICY CONSIDERATIONS

3.1 Professional and Institutional Providers of Mental Health Services

3.1.1 List of authorized providers. Only the types of providers listed below are considered qualified providers of mental health services. The person providing the care must meet the criteria of [32 CFR 199.6](#), whether that person is an individual, professional provider or is employed by another authorized provider.

- Psychiatrists and other physicians;
- Clinical psychologists;
- Certified Psychiatric Nurse Specialists (CPNSs);
- Certified Clinical Social Workers (CCSWs);
- TRICARE Certified Mental Health Counselors (TCMHCs);
- Certified marriage and family therapists;
- Pastoral counselors; and
- Supervised Mental Health Counselors (SMHCs).

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3.1.2 Professional staff of institutions providing mental health services. For those types of institutional providers that are certified by Defense Health Agency (DHA), reviewers may assume that all professional staff meet regulatory criteria. Any evidence to the contrary is to be brought to the attention of DHA Special Contracts and Operations Office (SCOO), immediately. Contractors shall notify institutional providers within their jurisdictions that payment is authorized only for professional services provided by employees meeting the program requirements. In any situation where the contractor obtains evidence that an institution is billing for professional services of unqualified staff, the case is to be submitted to the DHA Office of Program Integrity (PI).

3.2 Review of Claims for Treatment of Mental Disorders

All claims for treatment of mental disorders are subject to review in accordance with claims processing procedures contained in the TRICARE Operations Manual (TOM).

3.2.1 Psychotropic drugs. All patients receiving psychotropic drugs must be under the care of a qualified mental health provider authorized by state licensure to prescribe drugs. That provider need not be the attending provider, but there must be evidence in the treatment plan of coordination between the various providers.

3.2.2 Electroconvulsive treatment (CPT² procedure codes 90870 and 90871). Electroconvulsive treatment is covered when medically or psychologically appropriate and when rendered by qualified providers. However, the use of electric shock as negative reinforcement (aversion therapy) is excluded.

3.2.3 Ancillary therapies (no code, as separate reimbursement is not permitted). Includes art, music, dance, occupational, and other ancillary therapies, when included by the attending provider in an approved inpatient treatment plan and under the clinical supervision of a licensed doctoral level mental health professional. These ancillary therapies are not separately reimbursed professional services but are included within the institutional reimbursement.

3.2.4 Services by non-medical providers. With the exception of pastoral counselors and supervised mental health counselors, approved categories of non-medical providers may render covered services independent of physician referral and supervision. All providers, however, are expected to consult with, or refer patients to, a physician for evaluation and treatment of physical conditions that may co-exist with or contribute to a mental disorder. Failure to do so will result in denial of the non-physician provider's services on quality-of-care grounds. Questionable cases will be referred to peer review.

3.2.5 Transcranial Magnetic Stimulation (TMS) (also referred to as repetitive TMS (rTMS)) for the treatment of major depressive disorder (CPT² procedure codes 90867, 90868 and 90869), is proven.

3.3 The first eight outpatient mental health visits per beneficiary in a fiscal year require no Primary Care Manager (PCM) or Health Care Finder (HCF) referral, nor is a preauthorization required (see [Chapter 1, Section 8.1](#) and the TOM, [Chapter 7, Section 2](#)). This applies to outpatient mental health visits identified by CPT² codes 90801-90857 for services provided through December 31, 2012; and, CPT² codes 90791-90853 for services provided on or after January 1, 2013.

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4.0 EXCLUSIONS

4.1 Sexual dysfunctions, paraphilias, and gender identity disorders.

4.2 Drug maintenance programs when one addictive drug is substituted for another on a maintenance basis, except as otherwise authorized in [Section 3.5](#).

4.3 Specific developmental disorders.

4.4 Microcurrent Electrical Therapy (MET), Cranial Electrotherapy Stimulation (CES), or any therapy that uses the non-invasive application of low levels of microcurrent stimulation to the head by means of external electrodes for the treatment of anxiety, depression or insomnia, and electrical stimulation devices used to apply this therapy.

5.0 EFFECTIVE DATES

5.1 November 13, 1984.

5.2 May 31, 2014, TMS (also referred to as rTMS) for the treatment of major depressive disorder, is proven.

- END -

Neurology And Neuromuscular Services

Issue Date: April 19, 1983

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

1.0 CPT¹ PROCEDURE CODES

20552, 20553, 95812 - 95999

2.0 DESCRIPTION

The diagnosis and treatment of muscle and nerve disorders.

3.0 POLICY

3.1 Neurology and neuromuscular services are covered.

3.2 The Epley Canalith Repositioning Procedure (CRP) is covered for the treatment of Benign Paroxysmal Positional Vertigo (BPPV) with an effective date of June 13, 2012.

3.3 Off-label use of rituximab may be considered for cost-sharing for the treatment of Chronic Inflammatory Demyelinating Polyneuropathy (CIDP). The effective date is July 16, 2010.

4.0 EXCLUSIONS

4.1 Topographic brain mapping (HCPCS S8040) is unproven.

4.2 Microcurrent Electrical Therapy (MET), Cranial Electrotherapy Stimulation (CES), or any therapy that uses the non-invasive application of low levels of microcurrent stimulation to the head by means of external electrodes for the treatment of anxiety, depression or insomnia, and electrical stimulation devices used to apply this therapy, are unproven.

- END -

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