I. POLICY

A. TRICARE/CHAMPUS regulations and program policies restrict benefits to those devices, treatments, or procedures for which the safety and efficacy have been proven to be comparable or superior to conventional therapies. Any device, medical treatment, or procedure whose safety and efficacy has not been established is unproven. Services and supplies considered to be unproven are excluded from coverage.

B. This exclusion includes all services directly related to the unproven device, medical treatment, or procedure.

C. Cost-sharing may be allowed for services or supplies when there is no logical or casual relationship between the unproven device, treatment, or procedure and the treatment at issue or where such a logical or causal relationship cannot be established with a sufficient degree of certainty. This cost-sharing is authorized in the following circumstances:

1. Treatment that is not related to the unproven device, treatment, or procedure; e.g., medically necessary treatment the beneficiary would have received in the absence of the unproven device, treatment, or procedure.

2. Treatment which is a necessary follow-up to the unproven device, treatment, or procedure, but which might have been necessary in the absence of the unproven treatment.

D. In making a determination that a device, medical treatment, or procedure has moved from the status of unproven to the position of nationally accepted medical practice, TMA uses the following hierarchy of reliable evidence:

1. Well controlled studies of clinically meaningful endpoints, published in refereed medical literature.

2. Published formal technology assessments.

3. The published reports of national professional medical associations.

4. Published national medical policy organization positions.
5. The published reports of national expert opinion organizations.

E. With respect to clinical studies, only those reports and articles containing scientifically valid data and published in the refereed medical and scientific literature shall be considered as meeting the requirements of reliable evidence. Specifically not included in the meaning of reliable evidence are reports, articles, or statements by providers or groups of providers containing only abstracts, anecdotal evidence or personal professional opinions. Also not included is the fact that a provider or a number of providers have elected to adopt a device, medical treatment or procedure as their personal treatment or procedure of choice or standard of practice.

F. TRICARE Policy and benefit structure are never based solely on coverage offered by other third party payers, including Medicare, since each operates under different rules and requirements.

G. The following is a partial list of devices, medical treatments, and procedures considered to be unproven. These are excluded from benefits. The list is not all inclusive. Other unproven devices, medical treatments, and procedures are similarly excluded, although they do not appear on this partial list. The codes listed have been associated with the respective unproven device, medical treatment, or procedure but may also be used for other applications which are not unproven. The listing of the procedure codes is for contractors to use in screening for unproven as opposed to proven application. The date listed with each device, medical treatment, or procedure indicates the date TRICARE Management Activity (TMA) reviewed the most recent literature to determine whether the device medical treatment, or procedure should remain on the unproven list. This partial list will be reviewed and updated periodically as new information becomes available. With respect to any device, medical treatment or procedure included on this partial list, if and when TMA determines that based on reliable evidence such device, medical treatment or procedure has proven medical effectiveness, TMA will initiate action to remove the device, medical treatment or procedure from this partial list of unproven devices, medical treatments or procedures. From the date established by TMA as the date the device, medical treatment or procedure has established proven medical effectiveness until the date the regulatory change is made to remove the device, medical treatment or procedure from the partial list, TMA will suspend treatment of the device, medical treatment or procedure as unproven. Following is the partial list of unproven devices, medical treatments or procedures, all of which are excluded from benefits:


3. Allogeneic bone marrow transplantation for:


4. Allogeneic donor bone marrow transplantation (infusion) performed with or after organ transplants for the purpose of increasing tolerance of the organ transplant. December 1996.

5. Ambulatory blood pressure monitoring. CPT\(^1\) procedure codes are 93784 - 93790. February 1997.


15. 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. December 1998.

16. 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. December 5, 1996.


18. Carotid Body Resection, both unilateral and bilateral, when done solely to relieve the symptoms of pulmonary dyspnea, including chronic obstructive pulmonary disease, is considered unproven. October 1996.

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21. Cervicography. While it shows promise as a screening procedure when used in conjunction with the pap smear, additional studies are needed before it’s considered beyond the unproven state.


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


26. Diaphanography (Transillumination Light Scanning).


29. Dorsal root entry zone (DREZ) thermocoagulation or microcoagulation neurosurgical procedure. August 1996.


36. Extraoperative electrocorticography for stimulation and recording in order to determine electrical thresholds of neurons as an indicator of seizure focus. December 1998.


40. Gastric wrapping/gastric banding. October 1996.


42. Growth factor, including platelet-derived growth factors, for treating non-healing wounds. This includes Procuren®, a platelet-derived wound-healing formula. January 1997.

43. Hair analysis to identify mineral deficiencies from the chemical composition of hair is unproven. Hair analysis testing may be reimbursed when necessary to determine lead poisoning. January 1997.


47. High dose chemotherapy with stem cell rescue (HDC/SCR) for any of the following malignancies:
   
   
   
   


49. 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. December 1998.

50. Home uterine activity monitoring for the purpose of preventing pre-term labor and/or delivery. April 2000.

52. Hyperbaric oxygen therapy for treatment or complications of peripheral vascular disease. October 1996.


55. Immunotherapy for malignant disease except when using drugs approved by the FDA for this purpose. July 1996.

56. Implantable infusion pumps, except for treatment of spasticity, chronic intractable pain, and hepatic artery perfusion chemotherapy for the treatment of primary liver cancer or metastatic colorectal liver cancer. August 1996.


58. Intraoperative monitoring of sensory evoked potentials (SEP) to define conceptional or gestational age in pre-term infants. October 1996.


61. Ketogenic Diet. (Monitoring of the Ketogenic diet may be cost-shared when there is an otherwise covered medically necessary treatment for epilepsy).


63. Light therapy for Seasonal Depression (also known as seasonal affective disorder (SAD)). - This therapy uses varying degrees of light to treat depression. July 1996.


67. Minimally Invasive Coronary Artery Bypass Graft (CABG) Surgery to include Minimally Invasive Direct Coronary Artery Bypass (MIDCAB) and Port Access Coronary Artery Bypass (PACAB). July 1998.


69. Muscle resection for severe Parkinsonian tremor, intention tremor, or dystonia.
70. Myofunctional or tongue thrust therapy.


73. All organ transplants not listed as covered in the TRICARE Policy Manual or 32 CFR 199.4(e)(5). October 1998.

74. Orthoptics, also known as eye exercises, eye therapy, training, vision therapy, vision training. January 1996.

NOTE: Orthoptics are excluded by 32 CFR 199.4(g)(46).


78. Peri-urethral Teflon injections to manage urinary incontinence.


83. Rhizotomy for Parkinsonian tremor, intention tremor, or dystonia.


85. Selective peripheral denervation for severe Parkinsonian tremor, intention tremor, or dystonia.

86. Sensory afferent stimulation (SAS) devices for relief of nausea (e.g., Relief Band®). August 1996.

87. Sensory evoked potentials (SEP) monitoring of the sciatic nerve during total hip replacement. SEP for monitoring simple laminectomies or other spinal procedures which are not considered to be a significant risk to the spinal cord. Recording SEPs in unconscious head injured patients to assess the status of the somatosensory system. The use of SEPs to define conceptional or gestational age in pre-term infants. April 1997.

89. Small intestinal bypass (jejunoileal bypass) for treatment of morbid obesity - (CPT² procedure code 44131).


91. Sperm evaluation test (CPT² procedure code 89329).

92. Spinoscopy. Use of a Spinoscope with skin markers to assess the function of the spine. CPT² procedure codes 95999 and 97799 have been used. August 1996.

93. Stem Cell Assay, Differential Staining Cytotoxicity (Disc) Assay and Thymidine Incorporation Assay. Laboratory procedures to predict the type and dose of cancer chemotherapy drugs to be used, based on in vitro analysis of their effects on cancer cells taken from an individual. The efficacy of these tests is not established by scientific data and does not reflect standard laboratory procedures provided in the United States. July 1996.


99. Thermography.

100. Tinnitus Masker.

101. Topical Application of Oxygen. The clinical efficacy of oxygen by topical application has not been established and is considered unproven. August 1996.

102. Topographic brain mapping (TBM) procedure. “Brain mapping” performed from the surface of the scalp rather than from the surface of the brain or from deeper structures in the brain using indwelling electrodes. February 1997.

103. Transcatheter hepatic arterial embolization for the treatment of cancers that have metastasized to the liver, unresectable hepatocellular carcinoma and resectable hepatocellular carcinoma. June 1997.


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106. Transfer factor (TF). This is a dialyzable leukocyte extract (DLE) used to transfer delayed hypersensitivity from an immune to a nonimmune subject and is considered unproven. December 1989.


111. Vestibular rehabilitation therapy used to treat benign paroxysmal positional vertigo. February 1997.

112. Videofluoroscopy evaluation in speech pathology.
