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HEALTH AGENCY

HPOD

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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 20-003**

CONREQ: 21374

SUMMARY OF CHANGE(S): This manual change adds clarifying coverage of Spravato and adds coverage of Hypoglossal Nerve Stimulation for the Treatment of Moderate-to-Severe Obstructive Sleep Apnea.

EFFECTIVE DATE: As stated in the issuance.

IMPLEMENTATION DATE: December 30, 2020.

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WHEN PRESCRIBED ACTION HAS BEEN TAKEN, FILE THIS TRANSMITTAL WITH BASIC DOCUMENT.

Chapter 4 Section 8.1

Respiratory System

Issue Date: August 26, 1985
Authority: 32 CFR 199.4(c)(2)

1.0 CPT[1] PROCEDURE CODES

30000 - 32488, 32491, 32500 - 32999, 64568 - 64570, 96570, 96571, 0466T - 0468T

2.0 HCPCS CODES

C1767, C1778, C1787

3.0 DESCRIPTION

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

4.0 POLICY

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

4.2 Resection of pneumatoceles is a covered procedure.

4.3 Lung Volume Reduction Surgery (LVRS) is a covered procedure, see Section 8.2.

4.4 Endoscopic thoracic sympathectomy (CPT[1] procedure code 32664) is covered for treatment of severe primary hyperhidrosis when appropriate nonsurgical therapies have failed and the hyperhidrosis results in significant functional impairment.

4.5 Implantable Hypoglossal Nerve Stimulation (HGNS) (CPT[1] procedure codes 64568 and 0466T) for the treatment of moderate-to-severe Obstructive Sleep Apnea (OSA) is covered in accordance with the U.S. Food and Drug Administration (FDA) labeled indications.

5.0 EXCLUSIONS

5.1 Pillar palatal implant system for the treatment of OSA is unproven.

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5.2 Uvulopalatopharyngoplasty (UPPP) (CPT[2] procedure code 42145) for the treatment of Upper Airway Resistance Syndrome (UARS) is unproven).

5.3 Nitric oxide expired gas determination (CPT[2] procedure code 95012) for asthma is unproven.

5.4 Bronchial Thermoplasty (BT) (CPT[2] procedure codes 31660 and 31661) for the treatment of asthma is unproven.

5.5 Radiofrequency Ablation (RFA) of the tongue base to treat Obstructive Sleep Apnea (OSA) is unproven.

6.0 EFFECTIVE DATES

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

6.2 August 15, 2019, for HGNS for the treatment of moderate-to-severe OSA.

- END -

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5.1.3 Medically or psychologically necessary psychiatric PHP care (see Section 3.4);

5.1.4 Medically or psychologically necessary psychiatric IOP care (see Section 3.16).

Note: Institutional benefits for SUDs are covered in Section 3.5, paragraph 3.2.1.

5.2 Professional Services

5.2.1 Individual psychotherapy, adult or child (see Section 3.11);

5.2.2 Group psychotherapy (see Section 3.11);

5.2.3 Family or conjoint psychotherapy (see Section 3.12);

5.2.4 Psychoanalysis (see Section 3.11, paragraph 4.3.3);

5.2.5 Psychological testing and assessment (see Section 3.10);

5.2.6 Specific mental health coverage descriptions are outlined in eating disorder treatment (see Section 3.15), specific learning disorder (see Section 3.6), Attention Deficit Hyperactivity Disorder (see Section 3.7), and Gender Dysphoria (see Section 1.2);

5.2.7 Administration of 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 (see Section 3.13);

5.2.8 Electroconvulsive treatment (CPT[2] 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;

5.2.9 Collateral visits (see Section 3.14);

5.2.10 Medication Assisted Treatment (MAT) (see Section 3.18);

5.2.11 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;

5.2.12 All providers 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.

5.2.13 Transcranial Magnetic Stimulation (TMS) (also referred to as repetitive TMS (rTMS)) for the treatment of major depressive disorder (CPT[2] procedure codes 90867, 90868, and 90869), is proven.

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5.2.14 Spravato™ (esketamine) nasal spray (HCPCS J3490) (CPT[3] codes G2082 and G2083) for the treatment of treatment-resistant depression and other U.S. Food and Drug Administration (FDA) approved indications, which is available to providers from the FDA's Spravato™ Risk Evaluation and Mitigation Strategy (REMS) Program, may be cost-shared. Preauthorization under the medical benefit is required. See Chapter 1, Section 7.1 and TOM, Chapter 7, Section 2.

6.0 REFERRAL AND PREAUTHORIZATION REQUIREMENT

6.1 Referral

Normal TRICARE Prime referral requirements shall apply under the following conditions:

6.1.1 A Primary Care Manager (PCM) referral is required for inpatient (non-emergency psychiatric hospitalization or RTC) services.

6.1.2 A PCM referral is required for non-office based, outpatient (e.g., PHP or IOP) mental health services. However, if the non-office based, outpatient mental health provider is a network provider, a request for preauthorization from the network provider to the contractor may be accepted in lieu of the PCM referral.

6.1.3 Office-based, outpatient mental health services by an authorized TRICARE network provider do not require a referral.

6.1.4 Point Of Service (POS) charges shall apply when services are rendered by a non-network office-based, outpatient mental health individual provider without a PCM referral when network providers are available in the TRICARE Prime Service Area (PSA).

6.2 Preauthorization

6.2.1 Medically or psychologically necessary outpatient mental health (PHP, IOP, or office) visits do not require preauthorization. However, the contractor may utilize preauthorization as a means of ensuring medical or psychological necessity absent a PCM referral (see paragraph 6.1.2). Exceptions include:

- Psychoanalysis requires preauthorization (see Chapter 1, Section 7.1, paragraph 1.5).
- Electroconvulsive treatment requires preauthorization to ensure the beneficiary has failed to respond to a less intensive form of treatment or that less intensive intervention is not more appropriate.
- TMS requires preauthorization to ensure the beneficiary has failed to respond to a less intensive form of treatment or that a less intensive intervention is not more appropriate.

6.2.2 Preauthorization is required for all non-emergency inpatient and residential levels of care. Contractors may establish additional preauthorization requirements in accordance with the TOM, Chapter 8, Section 5, paragraph 4.0.

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6.2.3 Inpatient hospital services are considered medically necessary only when the patient's condition is such that the personnel and facilities of a hospital are required. Preauthorization is not required for emergency admissions, but authorization for a continuation of services must be obtained promptly (see Section 3.1, paragraph 3.4.2).

7.0 EXCLUSIONS

7.1 Sexual dysfunctions and paraphilic disorders (see Section 1.1).

7.2 Drug maintenance programs when one addictive drug is substituted for another on a maintenance basis, except as otherwise authorized in Sections 3.5 and 3.18.

7.3 Specific developmental disorders.

7.4 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, insomnia, or Post-Traumatic Stress Disorder (PTSD) and electrical stimulation devices used to apply this therapy (see Section 15.1).

7.5 Off-label use of Ketamine (subcutaneous, sublingual, IV, injectable, nasal spray, or orally) is excluded.

7.6 Off-label use of Spravato™ (esketamine) is excluded.

8.0 EFFECTIVE DATES

8.1 November 13, 1984.

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

8.3 Removal of day limits in any fiscal year for TRICARE beneficiaries of all ages for the provision of inpatient (including residential) mental health services on or after December 19, 2014.

8.4 Removal of all remaining quantitative treatment limitations on mental health care, and inclusion of IOPs, October 3, 2016.

8.5 Spravato™ (esketamine) nasal spray for treatment of: treatment resistant depression, effective March 5, 2019; coverage for other FDA approved indications may be allowed on or after the date the indication was added to the label (e.g., August 3, 2020 for adults with major depressive disorder with acute suicidal ideation or behavior).

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