DEPARTMENT OF DEFENSE
TRICARE SUPPORT OFFICE
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PDD

CHANGE No: 24
OCHAMPUS 6010.47-M
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PUBLICATIONS SYSTEM CHANGE TRANSMITTAL
FOR
TRICARE/CHAMPUS POLICY MANUAL

THE DIRECTOR, OCHAMPUS, HAS AUTHORIZED THE FOLLOWING ADDITION(S)/REVISION(S) TO THE TRICARE/CHAMPUS POLICY MANUAL

REVISION(S)
CHAPTER(S): 1 SECTION(S): 26.5

CHAPTER(S): 3 SECTION(S): 2.7

ADDITION(S)

CHAPTER(S): SECTION(S):

REMOVE PAGE(S): Chapter 1, Section 26.5, pages 1 and 2; Chapter 3, Section 2.7, pages 1 and 2.

INSERT: ATTACHED ADDITIONAL/REPLACEMENT PAGE(S): Chapter 1, Section 26.5, pages 1 and 2; Chapter 3, Section 2.7, pages 1 and 2.

SUMMARY OF ADDITIONS/REVISIONS: This change is a correction to Change 23. In Change 23, Chapter 1, Section 26.5 and Chapter 3, Section 2.7 revisions were inadvertently excluded. These pages are being republished to include those revisions.

EFFECTIVE DATE AND IMPLEMENTATION: The Effective Date is as indicated on the attached pages. Implementation is upon direction of the Contracting Officer.

THIS CHANGE IS MADE IN CONJUNCTION WITH OPERATIONS MANUAL CHANGE NO. N/A, COM-FI NO. N/A, AND ADP MANUAL CHANGE NO. N/A.

for **Sheila H. Sparkman**
Director, Program Development and Evaluation

ATTACHMENT(S): 4 PAGE(S)
DISTRIBUTION: 6010.47-M

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

Subject: OBSTRUCTIVE SLEEP APNEA SYNDROME (OSAS)	Chapter: 1
	Section: 26.5
Authority: DoD 6010.8-R, Chapter 4, A.1.	Issue Date: October 26, 1994

PROCEDURE CODES

21141-21193, 21198, 21499, 42145, 70350, 92511, 94660, 95808-95810

DESCRIPTION

Sleep Apnea Syndromes. This is a collective term used to describe a variety of syndromes wherein the patient stops breathing for multiple periods during sleep. It is classified as resulting from obstructive disturbances of the upper airway (OSAS), from central lesions (CSAS), or from mixed causes (MSAS). In sleep apnea, the arterial oxygen saturation decreases as a consequence of the apneic periods. Cardiac arrhythmic may develop and acute elevations of systemic arterial pressure can occur. Depending on the loss of sleep and rest, the patient exhibits varying degrees of fatigue and daytime somnolence, loss of efficiency, and poor performance. Snoring is common and may be the chief complaint. In more marked situations, pulmonary hypertension may lead to right heart failure, fibrillation, and other symptoms of pulmonary insufficiency. OSAS significantly increases mortality rate.

POLICY

A. The following diagnostic procedures for OSAS are covered under TRICARE.

1. Cephalometric analysis (CPT code 70350).

NOTE: *The CPT nomenclature for this code reads "Cephalogram, orthodontic". Although there are restrictions for orthodontic services under TRICARE, benefits shall be allowed for the cephalogram under the diagnosis of OSAS.*

2. Nasopharyngoscopy with endoscope (CPT code 92511).

3. Polysomnography (CPT code 95808-95810). Polysomnography includes recording, analysis, and interpretation of multiple simultaneous physiologic measurements during sleep. The code is all inclusive for the several physiologic measurements recorded, analyzed, and interpreted during the study, therefore, no separate allowance for any component study billed along with polysomnography shall be allowed. Physiologic variables commonly monitored during polysomnography include:

a. Electroencephalography (EEG);

b. Electro-oculogram (EOG);

c. Chin and leg electromyography (EMG);

d. Electrocardiography (ECG or EKG);

e. Airflow;

f. Thoracic and abdominal effort assessments; and

g. Pulse oximetry.

4. Nasal continuous positive airway pressure study for two consecutive nights (CPT code 94660).

B. Following presurgical evaluation, each patient is classified according to the site of obstruction revealed during the diagnostic workup described above. These classifications include:

1. Type I patients have obstructions limited to the oropharynx.

2. Type II patients have obstructions in both the oropharynx and hypopharynx.

3. Type III patients have obstructions confined solely to the hypopharynx.

C. The surgical procedures listed below for OSAS are undertaken based upon the type of obstruction disclosed during the diagnostic workup and may be considered for cost-sharing:

1. Type I patients undergo uvulopalatopharyngoplasty (UPPP) (CPT code 42145);

2. Type II patients undergo UPPP plus mandibular osteotomy (CPT code 21198) and genioglossus advancement with hyoid myotomy/suspension (GAHM) (CPT code 21499);

3. Type III patients undergo genioglossus advancement with hyoid myotomy/ suspension (GAHM) (CPT code 21499).

D. Polysomnography for OSAS is repeated six months post-operatively. If the initial surgical intervention fails to correct the obstructive problem as evidenced by polysomnography, the patient then undergoes maxillary-mandibular advancement osteotomies (MMO) (CPT codes 21141-21193 and 21198). Cost-sharing is allowed for this procedure.

E. An FDA approved dental orthosis may be cost-shared under TRICARE for the treatment of OSAS. The device must be used for the treatment of OSAS and not for adjunctive dental.

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 orders.

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

C. Claims for diagnostic sleep studies for OSAS 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 leave after the tests are completed.

D. Institutional and professional charges related to sleep diagnostic testing performed in a TRICARE-approved hospital are covered only for narcolepsy, sleep apnea, impotency,

Subject: PROPHYLACTIC MASTECTOMY	Chapter: 3
Authority: DoD 6010.8-R, Chapter 4, C.2.	Section: 2.7
	Issue Date: October 25, 1993

DESCRIPTION

Prophylactic mastectomy is an extirpative procedure (usually simple or total mastectomy) which removes all breast tissue which would be otherwise subject to breast carcinoma. Carefully selected indications have been developed for prophylactic mastectomy and are the subject of this policy.

POLICY

A. Bilateral prophylactic mastectomies are covered for patients at increased risk of developing breast carcinoma who have one or more of the following:

1. Atypical hyperplasia of lobular or ductal origin confirmed on biopsy; or

2. Family history of breast cancer in a first-degree relative (especially a mother or sister) who is premenopausal and has bilateral breast cancer (Family Cancer Syndrome); or

3. Fibronodular, dense breasts which are mammographically and/or clinically difficult to evaluate and the patient presents with either of the above (or both) clinical presentations.

B. Unilateral prophylactic mastectomies are covered when the contralateral breast has been diagnosed with cancer for patients with:

1. Diffuse microcalcifications in the remaining breast, especially when ductal in-situ carcinoma has been diagnosed in the contralateral breast; or

2. Lobular carcinoma in-situ; or

3. Large breast and/or ptotic, dense or disproportionately-sized breast that are difficult to evaluate mammographically and clinically; or

4. In whom observational surveillance is elected for lobular carcinoma in-situ and the patient develops either invasive lobular or ductal carcinoma; or

5. Family history of breast cancer in a first-degree relative (especially a mother or sister) who is premenopausal and has bilateral breast cancer (Family Cancer Syndrome).

EXCLUSION

Subcutaneous mastectomy, a procedure that is not extirpative, fails to remove all breast tissue. Therefore, subcutaneous mastectomy is not effective as prophylactic assurance against breast cancer in high risk indications, nor is subcutaneous mastectomy a cancer treatment. Therefore, TRICARE benefits will not be allowed for subcutaneous mastectomy in the prevention of breast carcinoma. (From October 25, 1993, through the implementation date of this policy, subcutaneous mastectomy was listed as a covered

benefit.) Claims processed during this time should not be recouped.

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