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TRICARE
MANAGEMENT ACTIVITY

MB&RB

CHANGE 100
6010.54-M
JUNE 24, 2009

PUBLICATIONS SYSTEM CHANGE TRANSMITTAL
FOR
TRICARE POLICY MANUAL (TPM)

The TRICARE Management Activity has authorized the following addition(s)/
revision(s) to the 6010.54-M, issued August 2002.

CHANGE TITLE: EVOLVING PRACTICES - JUNE 2009

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): See pages 3 and 4.

EFFECTIVE AND IMPLEMENTATION DATE: As indicated, otherwise upon
direction of the Contracting Officer.

Reta Michak
Acting Chief, Medical Benefits and
Reimbursement Branch

ATTACHMENT(S): 32 PAGE(S)
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WHEN PRESCRIBED ACTION HAS BEEN TAKEN, FILE THIS TRANSMITTAL WITH BASIC DOCUMENT

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REMOVE PAGE(S)

INSERT PAGE(S)

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Section 16.1, pages 1 and 2

CHAPTER 4

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SUMMARY OF CHANGES

CHAPTER 1

1. Section 16.1. Paragraph V.B. Added ultrasound ablation as an exclusion as it is unproven.

CHAPTER 4

2. Section 17.1. CPT Code 37210 added. Ultrasound ablation with MRI guidance in treatment of uterine leiomyomata is unproven and added to the exclusion list.
3. Section 20.1. CPT codes 64554, 64556 – 64639, 64641 – 64999 are proven and were added as payable. Implantation of Occipital Nerve Stimulator is unproven and added as an exclusion.
4. Section 21.1. Transpupillary thermotherapy for treatment of coroidal melanoma is unproven and was added as an exclusion.
5. Section 23.1. Immunoablation therapy for autologous bone marrow or autologous peripheral stem cell transplant for systemic lupus erythematosus refractory to conventional treatment is proven and added as covered treatment. Immunoablation therapy with allogenic bone marrow or allogenic peripheral stem cell transplant for the treatment of systemic lupus erythematosus not refractory to conventional treatment is unproven and was added as an exclusion.
6. Section 24.1. AlloMap molecular expression testing for cardiac transplant rejection surveillance is unproven and is added as an exclusion.
7. Section 24.2. AlloMap molecular expression testing for cardiac transplant rejection surveillance is unproven and is added as an exclusion.
8. Section 24.3. AlloMap molecular expression testing for cardiac transplant rejection surveillance is unproven and is added as an exclusion.

CHAPTER 5

9. Section 4.1. Ultrasound ablation with Magnetic Resonance Imaging guidance in the treatment of leiomyomata is unproven and added as an exclusion.

CHAPTER 6

10. Section 1.1. Oncotype Dx is not covered due to US FDA status and is added as an exclusion.

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SUMMARY OF CHANGES (Continued)

CHAPTER 7

11. Section 6.1. Paragraph III.D. Heidelberg Retina Tomograph, Optical Coherence Tomograph, and Scanning laser polarimetry to diagnose progression of suspected glaucoma is proven and may be considered for cost-sharing. Effective October 28, 2008.

CHAPTER 8

12. Section 9.1. Irinotecan for treatment of metastatic esophageal cancer is unproven and is added as an exclusion.

CATEGORY III CODES

ISSUE DATE: March 6, 2002

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

I. CPT¹ PROCEDURE CODES

0003T, 0008T, 0016T - 0019T, 0021T, 0024T, 0026T - 0032T, 0041T - 0161T

II. 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.

III. POLICY

A. 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.

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

IV. EXCEPTIONS

A. Category III code 0024T may be covered under the Rare Disease Policy for children.

B. FDA IDE (Category B) clinical trial. See [Chapter 8, Section 5.1](#).

C. Category III codes 0145T - 0151T as outlined in [Chapter 5, Section 1.1](#).

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

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

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CHAPTER 1, SECTION 16.1

CATEGORY III CODES

V. EXCLUSIONS

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

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

- END -

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FEMALE GENITAL SYSTEM

ISSUE DATE: August 26, 1985

AUTHORITY: [32 CFR 199.4\(c\)\(2\)](#), [\(c\)\(3\)](#), [\(e\)\(3\)](#), and [\(g\)\(34\)](#)

I. CPT¹ PROCEDURE CODES

11975 - 11977, [37210](#), 55980, 56405 - 58301, 58340, 58345, 58346, 58350, 58353, 58356, 58400 - 58671, 58679, 58700 - 58740, 58800 - 58960, 58999, 59001

II. DESCRIPTION

The female genital system includes the female organs of reproduction.

III. POLICY

A. Services and supplies required in the diagnosis and treatment of illness or injury involving the female genital system are covered. Infertility testing and treatment, including correction of the physical cause of infertility, are covered under this provision. This does not include artificial insemination, which is excluded from coverage.

B. Uterine suspension; parametrial fixation as treatment for uterine prolapse may be cost-shared only to retain the uterus for biologic purposes.

C. Intersex surgery (CPT¹ procedure code 55980) is limited to surgery performed to correct sex gender confusion/ambiguous genitalia which is documented to have been present at birth.

NOTE: For policy on prophylactic mastectomy, prophylactic oophorectomy, and prophylactic hysterectomy, see [Chapter 4, Section 5.3](#).

IV. POLICY CONSIDERATION

Benefits are payable for Uterine Artery Embolization (UAE), as an alternative treatment (CPT¹ procedure code 37210) to hysterectomy or myomectomy, for those individuals with confirmed, symptomatic uterine fibroids who are premenopausal and who do not wish to preserve their childbearing potential.

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V. EXCLUSIONS

A. Prophylactics (condoms).

B. Over-the-counter (OTC) spermicidal products.

C. Reversal of a surgical sterilization procedure (CPT² procedure codes 58672, 58673, 58750-58770).

D. Artificial insemination, including any costs related to donors and semen banks (CPT² procedure codes 58321-58323).

E. In-Vitro Fertilization (IVF), Gamete Intrafallopian Transfer (GIFT) and all other non-coital reproductive procedures, including all services and supplies related to, or provided in conjunction with, those technologies (CPT² procedure codes 58970-58976).

F. Hysterectomy (CPT² procedure codes 58150-58285, 58550, 59525) performed solely for purposes of sterilization in the absence of pathology.

G. Subtotal hysterectomy performed exclusively to preserve sexual function and/or to prevent postoperative complications (e.g., urinary incontinence; vaginal prolapse).

H. Cervicography (CPT² category III procedure code 0003T) is unproven.

I. Uterine Artery Embolization (UAE) for individuals with specific contraindications, including such conditions as pelvic malignancy and pelvic inflammatory disease, and premenopausal patients who wish to preserve their childbearing potential.

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

- END -

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NERVOUS SYSTEM

ISSUE DATE: August 26, 1985

AUTHORITY: 32 CFR 199.4(c)(2) and (c)(3)

I. CPT¹ PROCEDURE CODES

61000 - 61626, 61680 - 61860, 61863 - 63048, 63055 - 64484, 64508 - 64554, 64556 - 64639, 64641 - 64999, 95961, 95962, 95970 - 95975, 95978, 95979

II. DESCRIPTION

A. The nervous system consists of the central and peripheral nervous systems. The central is comprised of the brain and spinal cord and the peripheral includes all the other neural elements. The nervous system is the organ system which along with the endocrine system, correlates the adjustments and reactions of an organism to internal and environmental conditions.

B. Therapeutic embolization is a type of procedure that is commonly performed by interventional radiologist to occlude blood vessels. A microcatheter or balloon is threaded into a vein, or artery for the purposes of embolization, blocking a pathologic vascular channel.

C. Stereotactic implantation of depth electrodes is an invasive procedure in which needle-like electrodes are implanted through burr holes in the skull into the depths of specific brain areas to localize a seizure focus in patients who are candidates for surgery or to implant a brain stimulator in the thalamus to control tremors.

D. Psychosurgery is brain surgery directed at destroying normal and healthy brain tissue in order to relieve mental and psychic symptoms that other treatment modalities such as drug therapy and psychotherapy have been ineffectual in treating, for the purpose of changing or controlling behavior.

E. The Guglielmi Detachable Coil (GDC) is an extremely fine wire made from platinum, one of the softest metals, at the end of a longer stainless steel wire. In a controlled manner, the surgeon uses a micro-catheter to thread each coil through blood vessels to the aneurysm site. Application of a very-low-voltage electric current detaches and releases the coil into the aneurysm. Once in place, the GDC coils fill the aneurysm, isolating it from circulation to reduce the likelihood of rupture and hemorrhagic stroke. By applying a low voltage direct

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current to a stainless steel wire at the base of the coil, the platinum coil is detached. This applied current not only detaches the coil but also promotes electrothrombosis within the aneurysm.

III. POLICY

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

B. Therapeutic embolization (CPT² procedure code 61624) may be covered for the following indications. The list of indications is not all inclusive. Other indications are covered when documented by reliable evidence as safe, effective and comparable or superior to standard care (proven).

1. Cerebral Arteriovenous Malformations.
2. Vein of Galen Aneurysm.
3. Inoperable or High-Risk Intracranial Aneurysms.
4. Dural Arteriovenous Fistulas.
5. Meningioma.

C. Implantation of depth electrodes is covered. Implantation of a FDA approved vagus nerve stimulator as adjunctive therapy in reducing the frequency of seizures in adults and adolescents over 12 years of age, which are refractory to anti-epileptic medication is covered. Battery replacement is also covered.

D. Spinal cord and deep brain stimulation are covered in the treatment of chronic intractable pain. Coverage includes:

1. The accessories necessary for the effective functioning of the covered device.
2. Repair, adjustment, replacement and removal of the covered device and associated surgical costs.

E. The GDC may be cost-shared for embolizing unruptured intracranial aneurysms that, because of their morphology, their location, or the patient's general medical condition, are considered by the treating neurosurgical team to be:

1. Very high risk for management by traditional operative techniques; or
2. Inoperable; or

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3. For embolizing other vascular malformation such as arteriovenous malformations and arteriovenous fistulae of the neurovasculature, to include arterial and venous embolizations in the peripheral vasculature.

IV. EXCLUSIONS

A. N-butyl-2-cyanoacrylate (Histacryl Bleu®), iodinated poppy seed oils (e.g., Ethiodol®), and absorbable gelatin sponges are not FDA approved.

B. Transcutaneous, percutaneous, functional dorsal column electrical stimulation in the treatment of multiple sclerosis or other motor function disorders is unproven.

C. Deep brain neurostimulation in the treatment of insomnia, depression, anxiety, and substance abuse is unproven.

D. Psychosurgery is not in accordance with accepted professional medical standards and is not covered.

E. Endovascular GDC treatment of wide-necked aneurysms and rupture is unproven.

F. Cerebellar stimulators/pacemakers for the treatment of neurological disorders are unproven.

G. Dorsal Root Entry Zone (DREZ) thermocoagulation or microcoagulation neurosurgical procedure is unproven.

H. Epidural steroid injections for thoracic pain are unproven.

I. Extraoperative electrocortigraphy for stimulation and recording in order to determine electrical thresholds of neurons as an indicator of seizure focus is unproven.

J. Neuromuscular electrical stimulation for the treatment of denervated muscles is unproven.

K. Stereotactic cingulotomy is unproven.

L. Sacral nerve neurostimulator (CPT³ procedure codes 64561, 64581, 64585, and 64590). See [Chapter 4, Section 14.1](#) for coverage policy for the urinary system and the Sacral Nerve Root Stimulation (SNS).

M. Laminoplasty, cervical with decompression of the spinal cord, two or more vertebral segments with reconstruction of the posterior bony elements (CPT³ procedure codes 63050 and 63051).

N. Balloon angioplasty, intracranial, percutaneous (CPT³ procedure code 61630) is unproven. Effective January 1, 2006.

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O. Transcatheter placement of intravascular stent(s) intracranial, (e.g., atherosclerotic stenosis) including angioplasty, if performed (CPT⁴ procedure code 61635) is unproven. Effective January 1, 2006.

P. Balloon dilation of intracranial vasospasm, initial vessel (CPT⁴ procedure code 61640) each additional vessel in same family (CPT⁴ procedure code 61641) or different vascular family (CPT⁴ procedure code 61642) is unproven. Effective January 1, 2006.

Q. Sphenopalatine ganglion block (CPT⁴ procedure code 64505) for the treatment of chronic migraine headaches and neck pain is unproven.

R. Radiofrequency ablation (percutaneous radiofrequency facet denervation, percutaneous facet coagulation, percutaneous radiofrequency neurotomy, radiofrequency facet rhizotomy, radiofrequency articular rhizolysis) (CPT⁴ procedure codes 64622, 64623, 64626, 64627) for the treatment of chronic spinal pain is unproven. Pulsed radiofrequency ablation for spinal pain is unproven.

S. **Implantation of Occipital Nerve Stimulator (CPT⁴ procedure code 64555) for the treatment of chronic intractable migraine headache is unproven.**

T. Cryoablation of Occipital Nerve (CPT⁴ procedure code 64640) for the treatment of chronic intractable headache is unproven.

V. EFFECTIVE DATES

A. January 1, 1989, for PAVM.

B. April 1, 1994, for therapeutic embolization for treatment of meningioma.

C. July 14, 1997, for GDC.

D. The date of FDA approval of the embolization device for all other embolization procedures.

E. June 1, 2004, for Magnetoencephalography.

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EYE AND OCULAR ADNEXA

ISSUE DATE: August 26, 1985

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

I. CPT¹ PROCEDURE CODES

65091 - 65755, 65772 - 68899, 77600 - 77615

II. DESCRIPTION

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

III. POLICY

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

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

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

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

E. 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](#).

IV. EXCLUSIONS

A. Refractive corneal surgery except as noted in [paragraph III.D.](#) (CPT¹ procedure codes 65760, 65765, 65767, 65770, 65771).

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

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C. Orthokeratology.

D. 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).

E. Epikeratophakia for treatment of aphakia and myopia is unproven.

F. Transpupillary thermotherapy (CPT² procedure code 0016T) for treatment of coroidal melanoma is unproven.

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HIGH DOSE CHEMOTHERAPY AND STEM CELL TRANSPLANTATION

ISSUE DATE: November 1, 1983

AUTHORITY: [32 CFR 199.4\(e\)\(5\)](#) and [\(g\)\(15\)](#)

I. CPT¹ PROCEDURE CODES

38230 - 38241, 88240, 88241

II. DESCRIPTION

A. High dose chemotherapy (HDC) is defined as the use of cytotoxic therapeutic agents (that are otherwise approved by the FDA for general use in humans) in dosages and/or frequencies of dosage that exceed the FDA labelling for the agent. HDC is generally considered when conventional regimens of chemotherapeutic agents have failed to arrest disease progression. One of the major adverse effects of HDC is that of bone marrow suppression, itself a potentially lethal process.

B. Stem cell "transplantation" or "rescue" is defined as a technique for collecting stem cells from a donor (either from the bone marrow or from the bloodstream), preparing and storing the collected stem cells, then reinfusing the prepared stem cells into the bloodstream of a patient in the treatment of oncologic, hematologic or lymphoproliferative disease with curative potential. The goal of stem cell "transplantation" or "rescue" is to reverse the bone marrow suppression caused by either HDC or by a primary bone marrow disease process (e.g., aplastic anemia).

There are five general types of stem cell "transplantation" or "rescue":

1. Autologous bone marrow transplant (ABMT), where the patient is both donor and recipient of stem cells harvested from the bone marrow.
2. Autologous peripheral stem cell transplantation (PSCT), where the patient is both donor and recipient of stem cells harvested from the bloodstream using the apheresis process.
3. Allogeneic bone marrow transplantation (BMT), where stem cells from a histocompatible donor (other than the patient) are harvested from the bone marrow, then later infused into the bloodstream of the patient. With BMT, the patient may have either a

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related or unrelated donor who has the same or closely matched human leukocyte antigen (HLA) typing necessary for successful transplantation.

4. Allogeneic **PSCT**, where stem cells are harvested from the bloodstream of a histocompatible donor (other than the patient) then later infused into the bloodstream of the patient.

5. Umbilical cord blood stem cell transplantation (UCBT), where stem cells are harvested from the umbilical cord and placenta, then later infused into the bloodstream of the patient.

III. POLICY

A. Benefits are allowed for HDC with ABMT or autologous PSCT, allogeneic **BMT** or Allogeneic **PSCT**, with or without HDC, and allogeneic **UCBT**, with or without HDC.

1. TRICARE Prime enrollee must have a referral from his/her Primary Care Manager (PCM) and an authorization from the contractor before obtaining transplant-related services. If network providers furnish transplant-related services without prior PCM referral and contractor authorization, penalties will be administered according TRICARE network provider agreements. If Prime enrollees receive transplant-related services from non-network civilian reporters without the required PCM referral and contractor authorization, Managed Care Support (MCS) contractors shall reimburse charges for the services on a Point of Services basis. Special cost-sharing requirements apply to Point of Service claims.

2. For Standard and Extra patients residing in a Managed Care Support (MCS) region, preauthorization authority is the responsibility of the MCS Medical Director or other designated utilization staff.

B. HDC with ABMT or autologous PSCT is covered in the treatment of the following malignancies. The list of indications is not all inclusive. Other indications are covered when documented by reliable evidence as safe, effective and comparable or superior to standard care (proven).

1. Non-Hodgkin's lymphoma, follicular, intermediate, or high-grade; when:

- a. Conventional dose chemotherapy has failed; or
- b. The patient has relapsed following a course of radiation therapy; or
- c. The patient is in first complete remission with risk factors for relapse.

NOTE: For purposes of coverage, mantle cell lymphomas will be considered as intermediate grade, non-Hodgkin's lymphomas.

2. Hodgkin's disease when:

- a. Conventional dose chemotherapy has failed; or

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b. The patient has relapsed following a course of radiation therapy, and has also failed at least one course of conventional dose chemotherapy subsequent to the failed radiation therapy; and

c. The patient is in second or third complete remission.

3. Neuroblastoma.

a. Stage III or IV, when the patient is one for whom further treatment with a conventional dose therapy is not likely to achieve a durable remission.

b. Tandem autologous **PSCT** for high-risk neuroblastoma (INSS Stage III with either N-MYC gene amplification or unfavorable Shimada histology or INSS Stage IV).

4. Acute lymphocytic or nonlymphocytic leukemias (e.g., myelocytic, myelogenous, myeloblastic, or myelomonoblastic);

5. Primitive Neuroectodermal Tumors (PNET)/Ewing's Sarcoma.

6. Gliofibromas (also known as desmoplastic astrocytoma; desmoplastic glioblastoma).

7. Glioblastoma multiforme.

8. Posterior fossa teratoid brain tumors.

9. Rhabdomyosarcoma and undifferentiated sarcomas.

10. Multiple myeloma. Tandem autologous stem cell transplantation is covered for the treatment of multiple myeloma.

11. Chronic myelogenous leukemia.

12. Waldenstrom's macroglobulinemia.

13. AL (Amyloid Light-Chain) Amyloidosis.

14. Wilms'tumor.

15. Trilateral retinoblastoma/pineoblastoma.

16. Osteosarcoma (osteogenic sarcoma).

17. Germ cell tumors in a second or subsequent relapse.

18. HDC with ABMT or PSCT for the treatment of desmoplastic small round cell tumor may be considered on a case-by-case basis under the TRICARE provisions for treatment of rare diseases.

19. Immunoablative therapy with ABMT or autologous PSCT for the treatment of severe systemic lupus erythematosus refractory to conventional treatment.

C. Allogeneic **BMT** or allogeneic **PSCT**, with or without HDC, is covered in the treatment of the following disease processes when either a related or unrelated donor is used. The list of indications is not all inclusive. Other indications are covered when documented by reliable evidence as safe, effective and comparable or superior to standard care (proven).

1. Aplastic anemia.
2. Acute lymphocytic or nonlymphocytic leukemias (e.g., myelocytic, myelogenous, myeloblastic, myelomonoblastic); Chronic Myelogenous Leukemia (CML); or preleukemic syndromes.
3. Severe combined immunodeficiency; e.g., adenosine deaminase deficiency and idiopathic deficiencies.
 - a. Partially matched-related donor stem cell transportation (without regard for the number of mismatched antigens in determining histocompatibility) in the treatment of Bare Lymphocyte Syndrome.
 - b. Unrelated donor and/or related donor (without regard for mismatched antigens) with or without T cell lymphocyte depletion in the treatment of familial erythrophagocytic lymphohistiocytosis, (FEL; generalized lymphohistiocytic infiltration; familial lymphohistiocytosis; familial reticuloendotheliosis; Familial Hemophagocytic Lymphohistiocytosis; FHL) for patients whose medical records document failure of conventional therapy (etoposide; corticosteroids; intrathecal methotrexate; and cranial irradiation).
 - c. Partially matched-related donor stem cell transplantation (without regard for the number of mismatched antigens) in the treatment of X-linked severe combined immunodeficiency syndrome (X-Linked SCID).
4. Wiskott-Aldrich Syndrome.
5. Infantile malignant osteopetrosis (Albers-Schonberg syndrome or marble bone disease).
6. Thalassemia major.
7. Intermediate and high grade lymphoma.
8. Myeloproliferative/dysplastic syndromes.
9. Congenital mucopolysaccharidoses.
10. Congenital amegakaryocytic thrombocytopenia.
11. Metachromatic leukodystrophy.

12. Sickle cell disease.

13. Chronic Lymphocytic Leukemia (CLL) when previous therapy has failed or when the CLL is refractory to conventional therapy.

14. Hyperesinophilic Syndrome.

15. Multiple myeloma when HDC with ABMT or PSCT has failed.

16. X-linked hyper-IgM Syndrome.

17. Chediak-Higashi Syndrome.

18. Langerhans Cell Histiocytosis, refractory to conventional treatment.

19. Hodgkin's disease.

D. Unirradiated donor lymphocyte infusion (donor buffy coat infusion, donor leukocyte infusion or donor mononuclear cell infusion) is covered for patients with CML, who relapse following their first or subsequent course of HDC with allogeneic BMT. The medical record must document that the patient:

1. Is in relapse following an adequate trial of HDC with allogeneic BMT of CML;
and

2. Qualified (or would have qualified) for authorization for HDC with allogeneic BMT according to the provisions set forth in this policy.

E. Allogeneic **UCBT**, with or without HDC, is covered in the treatment of the following disease processes when either a related or unrelated donor is used. The list of indications is not all inclusive. Other indications are covered when documented by reliable evidence as safe, effective and comparable or superior to standard care (proven).

1. Aplastic anemia.

2. Acute lymphocytic or non-lymphocytic leukemias.

3. Chronic myelogenous leukemia.

4. Severe combined immunodeficiency.

5. Wiskott-Aldrich syndrome.

6. Infantile malignant osteopetrosis.

7. Blackfan-Diamond anemia.

8. Fanconi anemia.

9. Neuroblastoma.
10. X-linked lymphoproliferative syndrome.
11. Hunter syndrome.
12. Hurler syndrome.
13. Congenital amegakaryocytic thrombocytopenia.
14. Sickle cell anemia.
15. Globoid cell leukodystrophy.
16. Adrenoleukodystrophy.
17. Kostmann's Syndrome.
18. Lesch-Nyhan disease.
19. Intermediate and high grade non-Hodgkin's lymphoma.
20. Thalassemia major.
21. Myelodysplastic Syndrome.
22. X-linked hyper-IgM Syndrome.
23. Langerhans Cell Histiocytosis, refractory to conventional treatment.

F. Syngeneic (identical twin donor) stem cell transplantation is covered for the treatment of Hodgkin's disease.

G. TRICARE will reimburse costs for donor searches.

1. Charges for donor searches must be fully itemized and billed by the transplant center.

2. Costs for donor searches will be cost-shared in accordance with established reimbursement guidelines for outpatient diagnostic testing.

3. Donor search costs may be billed at any time. There is no limit on how many searches a transplant center may request from the search printout.

H. For the purposes of TRICARE coverage, the greatest degree of incompatibility allowed between donor or recipient (for either related or unrelated donors) is a single antigen mismatch at the A, B, or Dr. locus except for:

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1. Patients with undifferentiated leukemia, Chronic Myelogenous Leukemia (CML), aplastic anemia, Acute Lymphocytic Leukemia (ALL) or Acute Myelogenous Leukemia (AML), when histocompatible related or unrelated donors are not available, a 3 antigen mismatch is allowed for related donors.

2. For patients under 18 years of age with a relapsed leukemia, when histocompatible related or unrelated donors are not available, parental CD34++ stem cell transplantation with 2-3 antigen mismatch is allowed.

I. **BMT, PSCT, and UCBT** is a process which includes mobilization, harvesting, and transplant of bone marrow, peripheral blood stem cell, or umbilical cord blood stem cells and the administration of **HDC** or radiotherapy prior to the actual transplant. When **BMT, PSCT, or UCBT** is covered, all necessary steps are included in coverage. When **BMT, PSCT, or UCBT** is noncovered, none of the steps are covered. The prophylactic harvesting, cryopreservation and storage of bone marrow, peripheral blood stem cells, or umbilical cord blood stem cells when proposed for possible future use is not covered. In the event that the patient expires prior to the stem cell reinfusion being completed, benefits for the harvesting may be allowed.

J. Benefits are allowed for Hepatitis B and pneumococcal vaccines for patients undergoing transplantation.

K. Benefits may be allowed for Deoxyribonucleic Acid-Human leucocyte Antigen (DNA-HLA) tissue typing in determining histocompatibility.

L. Charges for stem cell and umbilical cord blood preparation and storage shall be billed through the transplantation facility in the name of the TRICARE patient.

M. Charges for the umbilical cord blood bank may be allowed only for patients who have undergone a covered transplant.

N. Claims for services and supplies related to the HDC and transplant for beneficiaries under the age of 18 will be reimbursed based on billed charges. Claims for HDC and transplant for adult patients, 18 years and older, will be reimbursed under the Diagnostic Related Group (DRG) payment system. Outpatient institutional facility charges will be paid as billed. Professional services are reimbursed under the CHAMPUS Maximum Allowable Charge (CMAC) Methodology.

O. Transportation of the patient by air ambulance may be cost-shared when determined to be medically necessary. Benefits for advanced life support air ambulance (to include attendant) may be preauthorized by the appropriate preauthorizing authority on an individual case basis in conjunction with the preauthorization for the services themselves.

P. In those cases where the beneficiary fails to obtain preauthorization, benefits may be extended if the services or supplies otherwise would qualify for benefits but for the failure to obtain preauthorization. If preauthorization is not received, the appropriate preauthorizing authority is responsible for determining if the patient meets the coverage criteria. Charges for transplant and transplant-related services provided to TRICARE Prime enrollees who failed to obtain PCM referral and contractor authorization for HDC with ABMT or PSCT will be reimbursed only under Point of Service rules.

IV. EXCLUSIONS

Benefits will not be paid for:

- A. HDC with ABMT or autologous PSCT, allogeneic BMT or allogeneic PSCT, with or without HDC, or allogeneic UCBT, with or without HDC, if the patient has a concurrent condition (other existing illness) that would jeopardize the achievement of successful transplantation.
- B. Expenses waived by the transplant center (i.e., beneficiary/sponsor not financially liable).
- C. Services and supplies not provided in accordance with applicable program criteria (i.e., part of a grant, or research program; unproven procedure).
- D. Administration of an unproven immunosuppressant drug that is not FDA approved.
- E. Pre- or post-transplant nonmedical expenses (i.e., out-of-hospital living expenses, to include, hotel, meals, privately owned vehicle for the beneficiary or family members).
- F. Transportation of a donor.
- G. Allogeneic BMT for treatment of low grade non-Hodgkin's lymphoma is not a benefit.
- H. Autologous UCBT therapy as this procedure is considered unproven.
- I. Allogeneic BMT for neuroblastoma as this procedure is considered unproven.
- J. Allogeneic donor BMT (infusion) performed with or after organ transplants for the purpose of increasing tolerance of the organ transplant is considered unproven.
- K. HDC with ABMT or PSCT is not covered for treatment of breast cancer.
- L. HDC with allogeneic BMT is not a benefit for treatment of Waldenstrom's macroglobulinemia.
- M. HDC with stem cell rescue is not a benefit for the treatment of epithelial ovarian cancer.
- N. HDC with allogeneic stem cell transplantation is not covered for the treatment of cold agglutinin disease.
- O. Donor lymphocyte infusion if not specifically listed as covered in [paragraph III.D.](#) under POLICY above.
- P. Immunoablative therapy with bone marrow or peripheral stem cell transplantation is not covered for the treatment of multiple sclerosis.

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HIGH DOSE CHEMOTHERAPY AND STEM CELL TRANSPLANTATION

Q. Immunoablative therapy with **BMT** or **PSCT** is unproven and not covered for the treatment of rheumatoid arthritis and juvenile idiopathic arthritis.

R. Immunoablative therapy with allogeneic BMT or allogeneic PSCT is not covered for the treatment of systemic lupus erythematosus not refractory to conventional treatment.

V. EFFECTIVE DATES

A. May 1, 1987, for HDC with ABMT or PSCT for Hodgkin's disease, non-Hodgkin's lymphoma and neuroblastoma.

B. November 1, 1987, for HDC with ABMT or PSCT for acute lymphocytic and nonlymphocytic leukemias.

C. November 1, 1983, for HDC with allogeneic **BMTs** using related donors.

D. July 1, 1989, for HDC with allogeneic **BMTs** using unrelated donors.

E. July 11, 1996, for HDC with ABMT or PSCT for multiple myeloma.

F. January 1, 1994, for HDC with ABMT and PSCT for Wilms' tumor.

G. January 1, 1995, for allogeneic **UCBTs**.

H. January 1, 1994, for HDC with ABMT or PSCT for chronic myelogenous leukemia.

I. January 1, 1996, for HDC with ABMT or PSCT for Waldenstrom's macroglobulinemia.

J. January 1, 1996, for allogeneic **BMTs** using related **three** antigen mismatch donors for patients with undifferentiated leukemia, Chronic Myelogenous Leukemia (CML), aplastic anemia, Acute Lymphocytic Leukemia (ALL) or Acute Myelogenous Leukemia (AML).

K. October 1, 1996, for HDC with ABMT or PSCT for AL Amyloidosis.

L. January 1, 1995, for allogeneic **BMT** for hypereosinophilic syndrome.

M. May 1, 1997, for HDC with ABMT or PSCT for trilateral retinoblastoma/pineoblastoma.

N. January 1, 1997, for HDC with ABMT or PSCT for follicular lymphoma.

O. January 1, 1997, for HDC with ABMT or PSCT for non-Hodgkin's lymphoma in first complete remission.

P. November 28, 1997, for HDC with ABMT or PSCT for Hodgkin's disease in second or third remission.

Q. January 1, 1996, for HDC with allogeneic BMT for multiple myeloma.

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- R. July 1, 1999, for HDC with ABMT or PSCT for germ cell tumors in a second or subsequent relapse.
- S. January 1, 1998, for HDC with ABMT or PSCT for osteosarcoma (osteogenic sarcoma).
- T. June 1, 1995, for allogeneic BMT for Chediak-Higashi syndrome.
- U. January 1, 1998, for allogeneic **PSCT**.
- V. June 1, 2003, for Langerhans Cell Histiocytosis, refractory to conventional treatment.
- W. January 24, 2002, for allogeneic stem cell transplant for Hodgkin's disease.
- X. May 19, 2005, for tandem autologous **PSCT** for high-risk neuroblastoma.
- Y. January 1, 2006, for HDC with ABMT or PSCT for desmoplastic small round cell tumor.
- Z. **April 2, 2009, for immunoablative therapy with ABMT or autologous PSCT for severe systemic lupus erythematosus, refractory to conventional treatment.**

- END -

authority is responsible for reviewing the claims to determine whether the beneficiary's condition meets the clinical criteria for the heart-lung or lung transplantation benefit. Charges for transplant and transplant-related services provided to TRICARE Prime enrollees who failed to obtain PCM referral and contractor authorization will be reimbursed only under Point of Service rules.

B. Benefits will only be allowed for transplants performed at a TRICARE or Medicare-certified heart, heart-lung or lung transplantation center. Benefits are also allowed for transplants performed at a pediatric facility that is TRICARE-certified as a heart, heart-lung, or lung transplantation center on the basis that the center belongs to a pediatric consortium program whose combined experience and survival data meet the TRICARE criteria for certification. The contractor is the certifying authority for transplant centers within its region. Refer to [Chapter 11, Section 7.1](#) for organ transplant center certification requirements.

C. Heart-lung, and lung transplantation will be paid under the DRG.

D. Claims for transportation of the donor organ and transplant team shall be adjudicated on the basis of billed charges, but not to exceed the transport service's published schedule of charges, and cost-shared on an inpatient basis. Scheduled or chartered transportation may be cost-shared.

E. Charges made by the donor hospital will be cost-shared on an inpatient basis and must be fully itemized and billed by the transplant center in the name of the TRICARE patient.

F. Acquisition and donor costs are not considered to be components of the services covered under the DRG. These costs must be billed separately on a standard CMS 1450 UB-04 claim form in the name of the TRICARE patient.

G. When a properly preauthorized transplant candidate is discharged less than 24-hours after admission because of extenuating circumstances, such as the available organ is found not suitable or other circumstances which prohibit the transplant from being timely performed, all otherwise authorized services associated with the admission shall be cost-shared on an inpatient basis, since the expectation at admission was that the patient would remain more than 24 hours.

H. Heart-lung and lung transplants performed on an emergency basis in an unauthorized heart-lung or lung transplant facility may be cost shared only when the following conditions have been met:

1. The unauthorized center must consult with the nearest TRICARE or Medicare-certified heart-lung or lung transplantation center regarding the transplantation case; and

2. It must be determined and documented by the transplant team physician(s) at the certified heart-lung or lung transplantation center that transfer of the patient (to the certified heart-lung or lung transplantation center) is not medically reasonable, even though transplantation is feasible and appropriate.

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CHAPTER 4, SECTION 24.1

HEART-LUNG AND LUNG TRANSPLANTATION

V. EXCLUSIONS

A. Expenses waived by the transplant center, (e.g., beneficiary/sponsor not financially liable).

B. Services and supplies not provided in accordance with applicable program criteria (i.e., part of a grant or research program; unproven procedure).

C. Administration of an unproven immunosuppressant drug that is not FDA approved or has not received approval as an appropriate "off label" drug indication.

D. Pre- or post-transplant nonmedical expenses, (e.g., out-of-hospital living expenses, to include hotel, meal, privately owned vehicle for the beneficiary or family members).

E. Transportation of an organ donor.

F. AlloMap® molecular expression testing for cardiac transplant rejection surveillance.

VI. EFFECTIVE DATES

A. February 28, 1991, for heart-lung and lung transplantation.

B. May 1, 1996, for epoprostenol.

C. June 1, 1997, for living donor lobar lung transplantation.

- END -

TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 4, SECTION 24.2

HEART TRANSPLANTATION

H. Heart transplantations performed on an emergency basis in an unauthorized heart transplant facility may be cost shared only when the following conditions have been met:

1. The unauthorized center must consult with the nearest TRICARE or Medicare-approved center regarding the transplantation case; and

2. It must be determined and documented by the transplant team physician(s) at the approved center that transfer of the patient (to the approved center) is not medically reasonable, even though transplantation is feasible and appropriate.

IV. EXCLUSIONS

A. Expenses waived by the transplant center (e.g., beneficiary/sponsor not financially liable).

B. Services and supplies not provided in accordance with applicable program criteria (i.e., part of a grant or research program; unproven procedure).

C. Administration of an unproven immunosuppressant drug that is not FDA approved or has not received approval as an appropriate "off-label" drug indication.

D. Pre- or post-transplant nonmedical expenses (e.g., out-of-hospital living expenses, to include hotel, meals, privately owned vehicle for the beneficiary or family members).

E. Transportation of an organ donor.

F. Prolonged extracorporeal circulation for cardiopulmonary insufficiency (CPT² procedure codes 33960 and 33961).

G. Artificial hearts.

H. AlloMap® molecular expression testing for cardiac transplant rejection surveillance. |

V. EFFECTIVE DATES

A. November 7, 1986, for heart transplants.

B. The date of FDA approval for ventricular assist devices.

- END -

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to obtain PCM referral and contractor authorization will be reimbursed only under Point of Service rules.

B. Benefits will only be allowed for transplants performed at a center that is TRICARE or Medicare-certified for heart transplantation and Medicare-approved for renal transplantation. Benefits are also allowed for transplants performed at a pediatric facility that is TRICARE-certified as a heart transplantation center on the basis that the center belongs to a pediatric consortium program whose combined experience and survival data meet the TRICARE criteria for certification. The contractor is the certifying authority for transplant centers within its region. Refer to [Chapter 11, Section 7.1](#) for organ transplant center certification requirements.

C. Claims for institutional services and supplies related to the transplantation will be reimbursed based on billed charges until such time as a DRG is established. Effective August 1, 2003, CHKTs shall be paid under the assigned DRG based on the patient's diagnosis.

D. Claims for transportation of the donor organ and transplantation team shall be adjudicated on the basis of billed charges, but not to exceed the transport service's published schedule of charges, and cost-shared on an inpatient basis. Scheduled or chartered transportation may be cost-shared.

E. Charges made by the donor hospital will be cost-shared on an inpatient basis and must be fully itemized and billed by the transplantation center in the name of the TRICARE patient.

F. Acquisition and donor costs are not considered to be components of the services covered under the DRG and will be reimbursed based on billed charges. These costs must be billed separately on a standard [CMS 1450 UB-04](#) claim form in the name of the TRICARE patient.

G. When a properly preauthorized candidate is discharged less than 24 hours after admission because of extenuating circumstances, such as the available organ is found not suitable or other circumstances which prohibit the transplant from being timely performed, all otherwise authorized services associated with the admission shall be cost-shared on an inpatient basis, since the expectation at admission was that the patient would remain more than 24 hours.

H. Combined heart-kidney transplants performed on an emergency basis in an unauthorized renal and heart transplant facility may be cost-shared by TRICARE only when the following conditions have been met:

1. The unauthorized center must consult with the nearest center that is TRICARE or Medicare-certified for heart transplantation and Medicare-approved for renal transplantation regarding the transplantation case; and

2. It must be determined and documented by the transplant team physician(s) at the center that is TRICARE or Medicare certified for heart transplantation and Medicare-approved for renal transplantation that transfer of the patient (to a center that is TRICARE or Medicare-certified for heart transplantation and Medicare-approved for renal

transplantation) is not medically reasonable, even though transplantation is feasible and appropriate.

III. EXCLUSIONS

A. Combined heart-kidney transplantation is excluded:

1. When any of the following contraindications exist:

- a. Severe pulmonary hypertension (pulmonary vascular resistance above 5 Wood units or pulmonary artery systolic pressure over 65 mm Hg) not reversible with intravenous agents.
- b. Active infection.
- c. HIV positivity.
- d. Active alcohol or other substance abuse including current use of tobacco (verified abstinence for six months is mandatory).
- e. Active malignant disease.
- f. Hepatic dysfunction not explained by the underlying heart failure and not deemed reversible.
- g. Symptomatic or asymptomatic cerebrovascular disease.
- h. Systemic hypertension, either at transplantation or prior to development of end stage cardiac disease, that is not controlled, even with multi-drug therapy.
- i. History of noncompliance or psychiatric illness of such magnitude as to jeopardize postoperative compliance.
- j. Recent and unresolved pulmonary infarction or undiagnosed pulmonary nodules.
- k. Any chronic systemic illness that will limit or preclude survival and rehabilitation after transplantation.
- l. Current or recent history of diverticulitis or current peptic ulcer disease require evaluation by a gastroenterology specialist prior to determining candidacy.

2. For:

- a. Expenses waived by the transplantation center (e.g., beneficiary/sponsor not financially liable).
- b. Services and supplies not provided in accordance with applicable program criteria (i.e., part of a grant or research program; unproven procedure).

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CHAPTER 4, SECTION 24.3

COMBINED HEART-KIDNEY TRANSPLANTATION (CHKT)

c. Administration of an unproven immunosuppressant drug that is not FDA approved or has not received TRICARE approval as an appropriate "off-label" drug indication.

d. Pre- or post-transplantation nonmedical expenses (e.g., out-of-hospital living expenses, to include hotel, meals, privately owned vehicle for the beneficiary or family members).

e. Transportation of an organ donor.

B. AlloMap® molecular expression testing for cardiac transplant rejection surveillance. |

IV. EFFECTIVE DATE March 27, 1997.

- END -

standard of care by the American College of Obstetricians and Gynecologists (ACOG) include:

a. Women who are estrogen-deficient and at a clinical risk of or osteoporosis. Naturally or surgically post-menopausal women who have not been on **long-term** Hormone Replacement Therapy (HRT). However, **current** use of HRT does not preclude estrogen deficiency.

b. Individuals who have vertebral abnormalities.

c. Individuals receiving long-term glucocorticoid (steroid) therapy.

d. Individuals with primary hyperparathyroidism.

e. Individuals with positive family history of osteoporosis.

f. Any other high-risk factor identified by ACOG as the standard of care.

IV. EXCLUSIONS

A. Bone density studies for the routine screening of osteoporosis.

B. PET for the diagnosis and monitoring of treatment of Alzheimer's disease, fronto-temporal dementia or other forms of dementia is unproven.

C. PET and PET/CT for the initial diagnosis of differentiated thyroid cancer and for medullary cell thyroid cancer.

D. Ultrasound ablation (destruction of uterin fibroids) with Magnetic Resonance Imaging (MRI) guidance (CPT³ procedure code 0071T) in the treatment of uterine leiomyomata is unproven.

V. EFFECTIVE DATES

A. January 1, 1995, for PET for ischemic heart disease.

B. December 1, 1996, for PET for lung cancer.

C. October 14, 1990, for SPECT for myocardial perfusion imaging.

D. January 1, 1991, for SPECT for brain imaging.

E. October 28, 1996, for ¹¹¹In-Capromab Pendetide, CyT 356 (ProstaScint™).

F. June 1, 1994, for Octreoscan Scintigraphy.

G. May 26, 1994, for bone density studies.

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CHAPTER 5, SECTION 4.1

NUCLEAR MEDICINE

- H. January 1, 2007, for PET and PET/CT for lymphoma.
- I. January 1, 2006, for PET and PET/CT for pancreatic cancer.
- J. February 16, 2006, for PET and PET/CT for thyroid cancer.

- END -

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CHAPTER 6, SECTION 1.1

GENERAL

- Q. Thawing of cryopreserved, sperm/semen, each aliquot (CPT³ procedure code 89353).
- R. Thawing of cryopreserved, reproductive tissue, testicular/ovarian (CPT³ procedure code 89354).
- S. Thawing of cryopreserved, oocytes, each aliquot (CPT³ procedure code 89356).
- T. Allo Map[®] for molecular testing is unproven for use in cardiac transplant rejection surveillance.
- U. **Oncotype Dx (S3854) is not covered due to the lack of U.S. Food and Drug Administration (FDA) status.**

V. EFFECTIVE DATE

July 23, 2008, for NMR LipoProfile-2 test, used with the NMR Profiler.

- END -

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OPHTHALMOLOGICAL SERVICES

ISSUE DATE: November 3, 1992

AUTHORITY: 32 CFR 199.4(c)(2)(xvi), (e)(6), (g)(46) and (g)(50)

I. CPT¹ PROCEDURE CODE RANGES

92002 - 92060, 92070 - 92335, 92390 - 92499

II. DESCRIPTION

Ophthalmological services may include an examination and other specialized services. The purpose of an examination is to diagnose or treat a medical condition of the eye, eyelid, lacrimal system, or orbit. A "routine eye examination" is an evaluation of the eyes, including but not limited to refractive services, that is not related to a medical or surgical condition or to the medical or surgical treatment of a covered illness or injury.

III. POLICY

A. For all beneficiaries, ophthalmological services (including refractive services) provided in connection with the medical or surgical treatment of a covered illness or injury are covered.

B. Section 632 of P.L. 98-525 signed into effect on October 19, 1994, authorizes payment under TRICARE for one routine eye examination per year for dependents of active duty members.

1. Routine eye examinations as defined in 32 CFR 199.2 includes coverage of those services rendered in order to determine the refractive state of the eyes. The CPT² procedure codes for payment of routine eye examinations are as follows:

92002 - EYE EXAM, NEW PATIENT
92004 - EYE EXAM, NEW PATIENT
92012 - EYE EXAM, ESTABLISHED PATIENT
92014 - EYE EXAM & TREATMENT
92015 - REFRACTION
99172 - OCULAR FUNCTION SCREEN
99173 - VISUAL ACUITY SCREEN

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CHAPTER 7, SECTION 6.1

OPHTHALMOLOGICAL SERVICES

2. TRICARE Prime and Standard Active Duty Family Members (ADFM) are entitled to one annual routine eye examination. Prime ADFMs may receive their annual routine eye exam from any network provider without referral, authorization, or preauthorization from the Primary Care Manager (PCM), or any other authority; i.e., a Prime ADFM will be allowed to set up his or her own appointment for a routine eye examination with any network optometrist or ophthalmologist. Standard ADFMs may self-refer to any TRICARE authorized provider regardless of whether or not they are a network provider; i.e., a Standard ADFM may set up his or her own appointment with either a network or non-network TRICARE authorized optometrist or ophthalmologist.

C. For Prime enrollees, see [Chapter 7, Section 2.2](#) for additional information on routine eye examinations.

D. Heidelberg Retina Tomograph (HRT), Optical Coherence Tomograph (OCT), and Scanning laser polarimetry (GDx) (CPT² procedure code 92135) to diagnose and monitor progression of suspected glaucoma may be considered for cost-sharing. Effective October 28, 2008.

IV. EXCLUSIONS

A. Routine eye examinations are NOT covered for Standard retirees or their dependents that are not enrolled in Prime except for eye exams allowed under the well-child benefit in [Chapter 7, Section 2.5](#).

B. Orthoptics, also known as vision training, vision therapy, eye exercises, eye therapy, is excluded by [32 CFR 199.4\(g\)\(46\)](#) (CPT² procedure code 92065).

C. Canaloplasty in the treatment of glaucoma is unproven.

- END -

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CHAPTER 8, SECTION 9.1

PHARMACY BENEFITS PROGRAM

marketing approval. However, medical care related to the use of treatment INDs may be cost-shared when the patient's medical condition warrants their administration and the care is provided in accordance with generally accepted standards of medical practice.

IV. EFFECTIVE DATES

A. Labeled uses: the date of FDA approval for the specific indication.

B. Off-labeled uses: the date that reliable evidence establishes the safety and efficacy of the drug for that specific use.

C. Orphan drugs: the date of FDA marketing approval.

V. EXCLUSION

Irinotecan (Camptosar®) for treatment of metastatic esophageal cancer is unproven.

- END -

