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TRICARE
MANAGEMENT ACTIVITY

MB&RB

CHANGE 105
6010.54-M
AUGUST 26, 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 - JULY 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.

A large, stylized handwritten signature in black ink, appearing to read "Reta Michak".

Reta Michak
Acting Chief, Medical Benefits and
Reimbursement Branch

ATTACHMENT(S): 24 PAGE(S)
DISTRIBUTION: 6010.54-M

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

CHANGE 105
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REMOVE PAGE(S)

INSERT PAGE(S)

CHAPTER 1

Section 17.1, pages 1 and 2

Section 17.1, pages 1 and 2

CHAPTER 4

Section 6.1, pages 1 and 2

Section 6.1, pages 1 and 2

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Section 9.1, pages 3 through 6

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Section 21.1, pages 1 and 2

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CHAPTER 5

Section 1.1, pages 1 through 4, and 7

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CHAPTER 7

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SUMMARY OF CHANGES

CHAPTER 1

1. Section 17.1. Cross-reference correction.

CHAPTER 4

2. Section 6.1. Total Ankle Replacement (TAR) CPT Codes 27702 and 27703, now proven, removed from the No Government Pay List (NGPL), and added coverage language to the TRICARE Policy Manual. Revised CPT codes for exclusions of total disc arthroplasty, removal and total disc arthroplasty, and artificial intervertebral disc replacement due to coding changes that were effective January 1, 2009.
3. Section 9.1. Corrected two typographical errors.
4. Section 14.1. Added an Exclusion: Cryoablation for the treatment of renal angiomyolipoma is unproven.
5. Section 21.1. Added an Exclusion: Optonol ExPRESS Miniature Tube Shunt in the treatment of glaucoma is unproven.
6. Section 22.2. Revised policy and added coverage for unilateral and bilateral cochlear implantation for children and adults.

CHAPTER 5

7. Section 1.1. Paragraph IV.B. Added clarification that this list of indications is not all inclusive. Other indications may be covered when documented by reliable evidence as safe, effective, and comparable to conventional technology (proven). Also adds an additional covered indication for breast MRI: For guidance of interventional procedures such as vacuum assisted biopsy and preoperative wire localization for lesions that are occult on mammography or sonography and are demonstrable only with MRI.

CHAPTER 7

8. Section 7.1 Adds two CPT codes for auditory rehabilitation services in conjunction with the revised policy on cochlear implantation in Chapter 4, Section 22.2.
9. Section 18.2. Revises the policy to exclude Spinalator Therapy and Spinalator Table as unproven.

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SUMMARY OF CHANGES (Continued)

CHAPTER 8

10. Section 9.1. Adds irinotecan (Camptosar™) for the treatment of metastatic esophageal cancer as an exclusion because it is unproven.

HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS) "C" AND "S" CODES

ISSUE DATE: November 6, 2007

AUTHORITY:

I. HCPCS "C" AND "S" CODES

C1000 - C9999; S0000 - S9999

II. DESCRIPTION

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

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

III. POLICY

A. 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 II.B](#).

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

1. S9122, S9123, and S9124 for the ECHO respite care benefit and the ECHO Home Health Care (EHHC) benefit; S1040 for ECHO durable equipment; and

2. S0812, S1030, S1031, S2066, S2067, S2068, S2075, S2076, S2077, S2083, S2202, S2235, S2360, S2361, S2400, S2401, S2402, S2403, S2405, S2411, S3818, S3819, S3820, S3822, S3823, S8030, S8185, S8265, S8270, and S9430 for all beneficiaries; and

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 20, Section 10](#)).

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"S" CODES

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

IV. EXCLUSIONS

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

- END -

MUSCULOSKELETAL SYSTEM

ISSUE DATE: August 26, 1985

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

I. CPT¹ PROCEDURE CODES

20000 - 22505, 22520 - 22525, 22532 - 22534, 22548 - 28825, 28899 - 29863, 29866, 29867, 29870 - 29999

II. HCPCS CODES

S2360, S2361

III. DESCRIPTION

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

IV. POLICY

A. 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.

B. 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.

C. Single or multilevel anterior cervical microdiscectomy with allogenic or autogenic iliac crest grafting and anterior plating is covered for the treatment of cervical spondylosis.

D. Percutaneous vertebroplasty (CPT¹ procedure codes 22520-22522, S2360, S2361) and balloon kyphoplasty (CPT¹ procedure codes 22523-22525) are covered for the treatment of painful osteolytic lesions and osteoporotic compression fractures refractory to conservative medical treatment.

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E. Total Ankle Replacement (TAR) (CPT² 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.

V. EXCLUSIONS

A. Meniscal transplant (CPT² procedure code 29868) for meniscal injury is unproven.

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

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

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

E. IDET (Intradiscal Electrothermal Therapy) for Chronic Discogenic Pain (CPT² procedure codes 0062T and 0063T) is unproven.

F. Botox (chemodenervation) for migraine headaches is unproven.

G. Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace, cervical; single interspace (CPT² procedure code 22856) each additional interspace (CPT² procedure code 0092T) is unproven.

H. Removal of total disc arthroplasty anterior approach cervical; single interspace (CPT² procedure code 22864) each additional interspace (CPT² procedure code 0095T) is unproven. Also see Chapter 4, Section 1.1.

I. Artificial intervertebral disc revision including replacement for degenerative disc disease is unproven (CPT² procedure codes 22861 and 0098T).

J. Extracorporeal shock wave, high energy involving the plantar fascia (CPT² procedure code 28890).

K. X STOP Interspinous Process Decompression System for the treatment of neurogenic intermittent claudication secondary to lumbar spinal stenosis is unproven.

L. Hip core decompression is unproven.

VI. EFFECTIVE DATE

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

B. May 1, 2008, for Total Ankle Replacement (TAR).

- END -

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- c. Hemorrhage from a ruptured varix.
- d. Ulceration from venous stasis where incompetent varices are a contributing factor.
- e. Symptomatic incompetence of the great or small saphenous veins (symptoms as in [paragraph III.G.1.a.](#)).

2. A trial of conservative, non-operative treatment has failed. This would include mild exercise, avoidance of prolonged immobility, periodic elevation of legs, and compressive stockings.

3. The patient's anatomy is amenable to endovenous ablation.

H. Ambulatory Blood Pressure Monitoring (ABPM) is only covered for beneficiaries with suspected white coat hypertension and is NOT covered for any other uses. The information obtained by ABPM is necessary in order to determine the appropriate medical management of the beneficiary. Suspected white coat hypertension is considered to exist when the following is documented:

- 1. There is no evidence of end-organ damage;
- 2. Office blood pressure greater than 140/90 mm Hg on at least three separate clinic/office visits with two separate measurements made at each visit; and
- 3. At least two blood pressure measurements taken outside the office which are less than 140/90 mm Hg.

I. Pulmonary vein isolation/ablation (CPT³ procedure code 93651) is covered for beneficiaries who meet the guidelines published in the Heart Rhythm Society (HRS)/European Heart Rhythm Association (EHRA)/European Cardiac Arrhythmia Society (ECAS) 2007 Consensus Statement as follows:

- 1. Symptomatic Atrial Fibrillation (AF) refractory or intolerant to at least one Class 1 or 3 antiarrhythmic medication.
- 2. In rare clinical situations, as first line therapy.
- 3. Selected symptomatic patients with heart failure and/or reduced ejection fraction.
- 4. The presence of a Left Atrial (LA) thrombus is a contraindication.

J. Primary percutaneous transluminal mechanical thrombectomy (CPT³ procedure codes 37184 and 37185) and secondary percutaneous transluminal mechanical thrombectomy (CPT³ procedure code 37186) are proven and are covered for the treatment of acute limb ischemia due to peripheral arterial occlusion.

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K. Percutaneous Transluminal Angioplasty (PTA) of the carotid artery with stenting (CPT⁴ procedure codes 37215, 0075T, and 0076T) in beneficiaries at high risk for Carotid Endarterectomy (CEA) is proven and covered when all of the following criteria are met:

1. Beneficiaries who have symptomatic Carotid Artery Stenosis (CAS) greater than 70%.

2. Beneficiaries are at high risk for CEA due to one or more of the following significant comorbidities and/or anatomic risk factors:

- a. Congestive heart failure (New York Heart Association Class I, II/IV).
- b. Left ventricular ejection fraction of less than 30%.
- c. Myocardial Infarction (MI) within past 30 days.
- d. Unstable Angina.
- e. Known severe Coronary Artery Disease (CAD).
- f. Severe Chronic Obstructive Pulmonary Disease (COPD).
- g. Contralateral carotid artery occlusion.
- h. Contralateral laryngeal nerve palsy.
- i. Previous radiation therapy to the neck.
- j. Previous radical neck dissection.
- k. Previous ipsilateral endarterectomy with restenosis.
- l. Surgically inaccessible lesion.
- m. Inability to move the neck to a suitable position for surgery.
- n. Tracheostomy.
- o. Coagulopathy or other coagulation issues leading to contraindication for endarterectomy.

3. Beneficiaries who have had a disabling stroke are excluded from coverage.

4. Coverage is limited to procedures performed using FDA approved carotid artery stents and embolic protection devices.

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CARDIOVASCULAR SYSTEM

5. The use of a distal embolic protection device is required. If deployment of the distal embolic protection device is not technically possible, then the procedure should be aborted due to the risks of CAS without distal embolic protection.

6. The degree of CAS shall be measured by duplex Doppler ultrasound or carotid artery angiography and recorded in the beneficiary's medical records. If the stenosis is measured by ultrasound prior to the procedure, then the degree of stenosis must be confirmed by angiography at the start of the procedure. If the stenosis is determined to be less than 70% by angiography, then CAS should not proceed.

7. All procedures are performed in a Centers for Medicare and Medicaid Services (CMS) approved facility that has been determined to be competent in performing the evaluation, procedure, and follow-up necessary to ensure optimal patient outcomes.

IV. EXCLUSIONS

A. Thermogram; cephalic (CPT⁵ procedure code 93760); peripheral (CPT⁵ procedure code 93762) are unproven.

B. Percutaneous Myocardial Laser Revascularization (PMR) is unproven.

C. Cardiomyoplasty (Cardiac Wrap) for treatment of heart failure is unproven.

D. Minimally Invasive CABG surgery to include Minimally Invasive Direct Coronary Artery Bypass (MIDCAB) and Port Access Coronary Artery Bypass (PACAB) are unproven.

E. Percutaneous Transluminal Angioplasty (PTA) in the treatment of obstructive lesions of the vertebral and cerebral arteries is unproven. PTA of the carotid artery without stenting is unproven. PTA of the carotid artery with stenting but without embolic protection (CPT⁵ procedure code 37216) is unproven.

F. Signal-Average Electrocardiography (CPT⁵ procedure code 93278) is unproven.

G. Percutaneous transluminal mechanical thrombectomy vein(s) including intraprocedural pharmacological thrombolytic injections and fluroscopic guidance (CPT⁵ procedure code 37187) is unproven.

H. Percutaneous transluminal mechanical thrombectomy, vein(s) including intraprocedural pharmacological thrombolytic injections and fluroscopic guidance, repeat treatment on subsequent day during course of thrombolytic therapy (CPT⁵ procedure code 37188) is unproven.

V. EFFECTIVE DATES

A. March 1, 2001, for gamma and beta intracoronary radiotherapy (brachytherapy).

B. January 1, 2002, for TMR.

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- C. October 1, 2003, for ventricular assist devices as destination therapy.
- D. December 1, 2003, for endovenous radiofrequency ablation/obliteration.
- E. January 1, 2005, for ABPM.
- F. *March 17, 2005, for PTA of the carotid artery with stenting in beneficiaries at high risk for CEA.*
- G. *March 21, 2006, for percutaneous transluminal mechanical thrombectomy for acute limb ischemia.*
- H. January 1, 2007, for pulmonary vein isolation/ablation.

- END -

URINARY SYSTEM

ISSUE DATE: August 26, 1985

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

I. CPT¹ PROCEDURE CODES

50010 - 53899, 64561, 64581, 64585, 64590, 64595

II. DESCRIPTION

The urinary system involves those organs concerned in the production and excretion of urine.

III. POLICY

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

B. Benefits may be considered for the implantation of similar FDA approved devices. The Sacral Nerve Root Stimulation (SNS) has received FDA approval. Services and supplies related to the implantation of the SNS may be covered for individuals with urge incontinence, nonobstructive urinary retention, or symptoms of urgency-frequency syndrome that is not due to a neurologic condition, who have failed previous conservative treatments, and who have had a successful peripheral nerve evaluation test.

C. The use of a bedwetting alarm for the treatment of primary nocturnal enuresis may be considered for cost sharing when prescribed by a physician and after physical or organic causes for nocturnal enuresis have been ruled out.

D. Collagen implantation of the urethra and/or bladder neck may be covered for patients not amenable to other forms of urinary incontinence treatment.

E. Cryoablation for renal cell carcinoma (CPT¹ procedure codes 50250 and **50593**) may be considered for coverage under the Rare Disease policy ([Chapter 1, Section 3.1](#)) on a case-by-case basis. Effective June 1, 2006.

F. Under the provisions for the treatment of rare diseases, coverage of laparoscopic radiofrequency ablation (CPT¹ procedure code 50542) and percutaneous radiofrequency

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ablation (CPT² procedure code 50592) may be considered on a case-by-case basis for the treatment of Renal Cell Carcinoma (RCC) and genetic syndromes associated with RCC including von Hippel-Lindau syndrome, hereditary papillary cell carcinoma, or hereditary clear-cell carcinoma for patients who are not appropriate candidates for surgical intervention.

IV. EXCLUSIONS

A. Peri-urethral Teflon injection is unproven.

B. Silastic gel implant.

C. Acrylic prosthesis (Berry prosthesis).

D. Bladder stimulators, direct or indirect, such as spinal cord, rectal and vaginal electrical stimulators, or bladder wall stimulators. Payment for any related service or supply, including inpatient hospitalization primarily for surgical implementation of a bladder stimulator.

E. Transurethral balloon dilation of the prostate (CPT² procedure code 52510) is unproven.

F. Cryoablation for the treatment of renal angiomyolipoma is unproven.

V. EFFECTIVE DATE

A. Transurethral Needle Ablation (TUNA) of the prostate is proven (CPT² procedure code 53852). Effective June 1, 2004.

B. March 28, 2007, for laparoscopic radiofrequency ablation or percutaneous radiofrequency ablation for the treatment of RCC and genetic syndromes associated with RCC, including von Hippel-Lindau syndrome, hereditary papillary cell carcinoma, or hereditary clear-cell carcinoma.

- END -

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EYE AND OCULAR ADNEXA

ISSUE DATE: August 26, 1985

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

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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EYE AND OCULAR ADNEXA

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.

G. Optonol ExPRESS Miniature Tube Shunt (CPT² procedure code 0192T) in the treatment of glaucoma is unproven.

- END -

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COCHLEAR IMPLANTATION

ISSUE DATE: March 2, 1988

AUTHORITY: 32 CFR 199.4(c)(2), (c)(3), (d)(3), and 32 CFR 199.5(c)(2)

I. CPT¹ PROCEDURE CODES

69930, 90669, 90732, 92601 - 92604, 92626, 92627

II. HCPCS PROCEDURE CODES

Level II Codes L8614 - L8624

III. DESCRIPTION

A cochlear implant device is an electronic instrument, part of which is implanted surgically to stimulate auditory nerve fibers, and part of which is worn or carried by the individual to capture and amplify sound. Cochlear implant devices are available in single channel and multi-channel models. The purpose of implanting the device is to provide an awareness and identification of sounds and to facilitate communication for persons who are profoundly hearing impaired.

IV. POLICY

A. Cochlear implantation using FDA-approved **single or multichannel** cochlear implants and when used according to approved **labeling** is a covered benefit.

B. **Simultaneous or sequential bilateral** cochlear **implantation** is a covered **benefit for:**

1. **Adults aged 18 years and older with bilateral, pre or post-linguistic, sensorineural, moderate to profound hearing impairment who meet both of the following criteria:**

a. **Individual has bilateral severe to profound sensorineural hearing loss determined by a pure tone average of 70 dB or greater at 500 Hz, and 2000 Hz; and**

b. **Individual has limited benefit from appropriately fitted binaural hearing aids. Limited benefit from amplification is defined by test scores of 40% correct or less in best-**

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aided listening condition on open-set sentence cognition (e.g., Central Institute for the Deaf (CID) sentences, Hearing in Noise Test (HINT) sentences).

2. Children aged 12 months to 17 years 11 months, with bilateral sensorineural hearing impairment who meet all of the following criteria:

a. Child has profound, bilateral sensorineural hearing loss determined by a pure tone average of 90 dB or greater at 500, 1000 and 2000 Hz; and

b. Child has limited benefit from appropriately fitted binaural hearing aids. For children four years of age or younger, limited benefit is defined as failure to reach developmentally appropriate auditory milestones measured using the Infant-Toddler Meaningful Auditory Integration Scale, the Meaningful Auditory Integration Scale, or the Early Speech Perception test, or less than 20% correct on open-set word recognition test (Multisyllabic Lexical Neighborhood Test (MLNT)) in conjunction with appropriate amplification and participation in intensive aural habilitation over a three to six month period. For children older than four years of age, limited benefit is defined as less than 12% correct on the Phonetically Balanced-Kindergarten Test, or less than 30% correct on the Hearing in Noise Test for children, the open-set MLNT or Lexical Neighborhood Text (LNT), depending on the child's cognitive ability and linguistic skills; and

c. A three to six month hearing aid trial has been undertaken and failed by a child without previous experience with hearing aids.

3. The following additional criteria must also be met for unilateral (monaural) or bilateral (binaural) cochlear implantation in adults and children:

a. The individual must have had an assessment by an audiologist and from an otolaryngologist experienced in this procedure indicating the likelihood of success with this device; and

b. The individual must have the cognitive ability to use auditory clues and a willingness to undergo an extended program of rehabilitation. A post-cochlear implant rehabilitation program is necessary to achieve benefit from the cochlear implant. The rehabilitation program consists of six to ten sessions that last approximately 2.5 hours each. The rehabilitation program includes development of skills in understanding running speech, recognition of consonants and vowels, and tests of speech perception ability. See [Chapter 7, Section 7.1](#) and [18.1](#); and

c. The individual should be up-to-date on age appropriate pneumococcal vaccination at least two weeks prior to the implant, in accordance with the Centers for Disease Control and Prevention (CDC).

C. Replacement of the cochlear implant external speech processor device is covered.

V. EXCLUSIONS

A. Cochlear implantation is contraindicated when preoperative radiographic evidence indicates an underdeveloped internal auditory canal, the absence of cochlear development or

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CHAPTER 4, SECTION 22.2

COCHLEAR IMPLANTATION

a physical condition which precludes placement of the electrode array or receiver-stimulator (e.g., cochlear ossification that prevents electrode insertion).

B. Cochlear implantation is contraindicated when there is a middle ear infection, the cochlear lumen is structurally unsuited to implantation, or there is a lesion in the auditory nerve or acoustic area of the central nervous system.

C. Cochlear implantation may not be cost-shared when there is a contraindication to surgery and implantation, such as poor anesthetic risk, severe mental retardation, severe psychiatric disorders, and organic brain syndrome.

VI. EFFECTIVE DATE

April 4, 2005.

- END -

DIAGNOSTIC RADIOLOGY (DIAGNOSTIC IMAGING)

ISSUE DATE: March 7, 1986

AUTHORITY: 32 CFR 199.4(a), (b), (c), and (e)(14) and 32 CFR 199.6(d)(2)

I. CPT¹ PROCEDURE CODES

70010 - 72292, 73000 - 76083, 76086 - 76394, 76400, 76496 - 76499, 95965 - 95967, 0145T - 0151T

II. HCPCS PROCEDURE CODES

G0204 - G0207

III. DESCRIPTION

Radiology is the science that deals with the use of radiant energy, such as X-rays, radium, and radioactive isotopes, in the diagnosis and treatment of disease. Radiology is an important diagnostic tool useful for the evaluation. The techniques used for diagnostic radiology are as follows:

A. Magnetic Resonance Imaging (MRI), formerly also referred to as Nuclear Magnetic Resonance (NMR), is a non-invasive method of graphically representing the distribution of water and other hydrogen-rich molecules in the human body. MRI uses radio frequency radiation in the presence of a carefully controlled magnetic field to produce high quality cross-sectional images of the head and body in any plane. These tomographic images represent the tissue being analyzed and the environment surrounding it. MRI has become a useful diagnostic imaging modality that is capable of demonstrating a wide variety of soft-tissue lesions with contrast resolution equal or superior to Computerized Tomography (CT) scanning in various parts of the body. Among the advantages of MRI are the absence of ionizing radiation and the ability to achieve high levels of tissue contrast resolution without injected iodinated contrast agents.

B. Magnetic Resonance Angiography (MRA) techniques generate contrast between flowing blood and surrounding tissue, and provide anatomic images that can be provided in a format similar to that of conventional x-ray angiography, and can also provide physiologic information.

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C. A Computerized Tomography (CT)/Computerized Axial Tomography (CAT) scan is interchangeably referred to as either a CT or CAT scan. This diagnostic test uses x-ray technology to create three-dimensional, computerized images of internal organs. However, unlike a traditional x-ray, CT/CAT scans are able to distinguish between obscured and overlapping parts of the body. CAT scans are also capable of producing images of several different internal components, including soft tissue, blood vessels and bones.

IV. POLICY

A. MRI and MRI with contrast media are covered when medically necessary, appropriate, and the standard of care. (CPT² procedure codes 70336, 70540-70543, 70551-70553, 71550-71552, 72141-72158, 72195-72197, 73218-73223, 73718-73723, 74181-74183, 75552-75556, and 76400.)

B. Breast MRI (CPT² procedure codes 77058 and 77059) is covered for the following indications. **This list of indications is not all inclusive. Other indications may be covered when documented by reliable evidence as safe, effective, and comparable to conventional technology (proven):**

1. To detect breast implant rupture (the implantation of the breast implants must have been covered by TRICARE).
2. For detection of occult breast cancer in the setting of axillary nodal adenocarcinoma with negative physical exam and negative mammography.
3. For presurgical planning for locally advanced breast cancer before and after completion of neoadjuvant chemotherapy, to permit tumor localization and characterization.
4. For presurgical planning to evaluate the presence of multicentric disease in patients with localized or advanced breast cancer who are candidates for breast conservation treatment.
5. Evaluation of suspected cancer recurrence.
6. To determine the presence of pectoralis major muscle/chest wall invasion in patients with posteriorly located tumor.
7. **For guidance of interventional procedures such a vacuum assisted biopsy and preoperative wire localization for lesions that are occult on mammography or sonography and are demonstrable only with MRI.**

NOTE: For policy on breast MRI to screen for breast cancer in high risk women, see [Chapter 7, Sections 2.1 and 2.2](#).

C. Open MRI and Open MRI with contrast media are covered when medically necessary, appropriate, and the standard of care.

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D. MRA is covered when medically necessary, appropriate and the standard of care. (CPT² procedure codes 70544-70549, 71555, 72159, 72198, 73225, 73725, and 74185.)

E. CT scans are covered when medically necessary, appropriate and the standard of care and all criteria stipulated in 32 CFR 199.4(e) are met. (CPT³ procedure codes 70450-70498, 71250-71275, 72125-72133, 72191-72194, 73200-73206, 73700-73706, 74150-74175, 75635, and 76355-76380.)

F. TRICARE considers three-dimensional (3D) rendering (CPT³ procedure codes 76376 and 76377) medically necessary under certain circumstances (see Chapter 5, Section 2.1).

G. Helical (spiral) CT scans, with or without contrast enhancement, are covered when medically necessary, appropriate and the standard of care.

H. Chest x-rays (CPT³ procedure codes 71010-71035) are covered.

I. Diagnostic mammography (CPT³ procedure codes 76090-76092/HCPCS codes G0204-G0207) to further define breast abnormalities or other problems is covered.

J. Portable X-ray services are covered. The suppliers must meet the conditions of coverage of the Medicare program, set forth in the Medicare regulations, or the Medicaid program in that state in which the covered service is provided. In addition to the specific radiology services, reasonable transportation and set-up charges are covered and separately reimbursable.

K. Bone density studies (CPT³ procedure codes 76070-76078) are covered for the following:

1. The diagnosis and monitoring of osteoporosis.
2. The diagnosis and monitoring of osteopenia.

3. Patients must present with signs and symptoms of bone disease or be considered at high-risk for developing osteoporosis. High-risk factors which have been identified as the standard of care by the American College of Obstetricians and Gynecologists (ACOG) include:

a. Women who are estrogen-deficient and at clinical risk for 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.

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- e. Individuals with positive family history of osteoporosis.
- f. Any other high-risk factor identified by ACOG as the standard of care.

L. Radiological supervision and interpretation, percutaneous vertebroplasty or vertebral augmentation including cavity creation, per vertebral body; under fluoroscopic guidance (CPT⁴ procedure code 72291) or under CT guidance (CPT⁴ procedure code 72292) is covered.

M. Multislice or multidetector row CT angiography (CPT⁴ codes 0145T - 0151T) is covered for the following indications:

1. Evaluation of heart failure of unknown origin when invasive coronary angiography +/- Percutaneous Coronary Intervention (PCI) is not planned, unable to be performed or is equivocal.

2. In an Emergency Department (ED) for patients with acute chest pain, but no other evidence of cardiac disease (low-pretest probability), when results would be used to determine the need for further testing or observation.

3. Acute chest pain or unstable angina when invasive coronary angiography or a PCI cannot be performed or is equivocal.

4. Chronic stable angina and chest pain of uncertain etiology or other cardiac findings prompting evaluation for Coronary Artery Disease (CAD) (for example: new or unexplained heart failure or new bundle branch block).

a. When invasive coronary angiography or PCI is not planned, unable to be performed, or is equivocal; AND

b. Exercise stress test is unable to be performed or is equivocal; AND

c. At least one of the following non-invasive tests were attempted and results could not be interpreted or where equivocal or none of the following tests could be performed:

(1) Exercise stress echocardiography

(2) Exercise stress echo with dobutamine

(3) Exercise myocardial perfusion (Single Photon Emission Computed Tomography (SPECT))

(4) Pharmacologic myocardial perfusion (SPECT)

5. Evaluation of anomalous native coronary arteries in symptomatic patients when conventional angiography is unsuccessful or equivocal and when results would impact treatment.

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S. Dual Energy X-Ray Absorptiometry (DXA) composition study (CPT⁷ procedure code 0028T) is unproven.

VI. EFFECTIVE DATES

A. The effective date for MRIs with contrast media is dependent on the U.S. Food and Drug Administration (FDA) approval of the contrast media and a determination by the contractor of whether the labeled or unlabeled use of the contrast media is medically necessary and a proven indication.

B. March 31, 2006, for breast MRI.

C. March 31, 2006, for coverage of multislice or multidetector row CT angiography.

D. January 1, 2007, for CPT⁷ procedure codes 72291 and 72292.

E. January 1, 2007, for coverage of multislice or multidetector row CT angiography performed for presurgical evaluation prior to electrophysiological procedure to isolate pulmonary veins for radiofrequency ablation of arrhythmia focus.

F. October 1, 2008, for breast MRI for guidance of interventional procedures such as vacuum assisted biopsy and preoperative wire localization for lesions that are occult on mammography or sonography and are demonstrable only with MRI.

- END -

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SPEECH SERVICES

ISSUE DATE: April 19, 1983

AUTHORITY: [32 CFR 199.5\(c\)](#), [32 CFR 199.6\(c\)](#), and Public Law 107-107

I. CPT¹ PROCEDURE CODES

92506 - 92508, [92630 - 92633](#)

II. DESCRIPTION

Medical services that provide evaluation, treatment, habilitation, and rehabilitation of speech, language, and voice dysfunctions resulting from congenital anomalies, disease, injury, hearing loss, communication or pervasive developmental disorders or a therapeutic process.

III. POLICY

A. Speech services provided or prescribed and supervised by a physician may be cost-shared.

B. Speech therapy to improve, restore, or maintain function, or to minimize or prevent deterioration of function of a patient when prescribed by a physician is covered in accordance with the rehabilitative therapy provisions found in [Chapter 7, Section 18.1](#).

IV. EXCLUSIONS

A. Services provided to address speech, language, or communication disorders resulting from occupational or educational deficits.

B. For beneficiaries under the age of 3, services and items provided in accordance with the beneficiary's Individualized Family Service Plan as required by Part C of the Individuals with Disabilities Education Act, and which are otherwise allowable under the TRICARE Basic Program or the Extended Care Health Option (ECHO) but determined not to be medically or psychologically necessary, are excluded.

C. For beneficiaries ages 3 to 21 who are receiving special education services from a public educational agency, cost-sharing of outpatient speech services that are required by the Individuals with Disabilities Education Act and which are indicated in the beneficiary's

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CHAPTER 7, SECTION 7.1

SPEECH SERVICES

Individualized Education Program (IEP), may not be cost-shared except when the intensity or timeliness of speech services as proposed by the educational agency are not appropriate medical care.

D. Myofunctional or tongue thrust therapy.

E. Maintenance therapy that does not require a skilled level after a therapy program has been designed (see [Chapter 7, Section 18.1](#)).

F. Videofluoroscopy evaluation in speech pathology.

G. Speech therapists (speech pathologists) are not authorized to bill using Evaluation and Management (E&M) codes listed in the Physicians' Current Procedural Terminology (CPT).

- END -

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CHAPTER 7, SECTION 18.2

PHYSICAL MEDICINE/THERAPY

13. Vertebral Axial Decompression (VAX-D) for relieving low back pain associated with herniated disc or degenerative disc disease of the lumbar vertebrae is unproven.

14. For beneficiaries under the age of three, services and items provided in accordance with the beneficiary's Individualized Family Service Plan (IFSP) as required by Part C of the Individuals with Disabilities Education Act (IDEA), and which are otherwise allowable under the TRICARE Basic Program or the Extended Care Health Option (ECHO) but determined not to be medically or psychologically necessary, are excluded.

15. For beneficiaries aged three to 21, who are receiving special education services from a public education agency, cost-sharing of outpatient physical therapy services that are required by the IDEA and which are indicated in the beneficiary's Individualized Education Program (IEP), may not be cost-shared except when the intensity or timeliness of physical therapy services as proposed by the educational agency are not sufficient to meet the medical needs of the beneficiary.

16. Low Level Laser Therapy (LLLT) (also known as low level light therapy or cold laser therapy) for treatment of soft tissue injuries, pain, or inflammation is unproven.

17. Spinalator therapy and use of a Spinalator Table for the treatment of neck and low back pain. Spinalator therapy is defined as a type of traction that uses the patient's weight to create the traction force in the absence of any external pulling force. The Spinalator Table is defined as a table with rollers that applies consistent pressure and movement under the patient in the absence of any external pulling devices.

- 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.

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

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.

- END -

