



OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
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TRICARE
MANAGEMENT ACTIVITY

MB&RB

**CHANGE 123
6010.54-M
MAY 20, 2010**

**PUBLICATIONS SYSTEM CHANGE TRANSMITTAL
FOR
TRICARE POLICY MANUAL (TPM), AUGUST 2002**

The TRICARE Management Activity has authorized the following addition(s)/revision(s).

CHANGE TITLE: EVOLVING PRACTICES - MARCH 2010

CONREQ: 15013

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.


**John A. D'Alessandro
Chief, Medical Benefits and
Reimbursement Branch**

ATTACHMENT(S): 22 PAGE(S)
DISTRIBUTION: 6010.54-M

**CHANGE 123
6010.54-M
MAY 20, 2010**

REMOVE PAGE(S)

CHAPTER 1

Section 3.1, pages 1 and 2
Section 16.1, pages 1 and 2

CHAPTER 4

Section 6.1, page 3
Section 9.1, pages 5 and 6
Section 20.1, pages 3 and 4
Section 24.1, pages 3 and 4

CHAPTER 5

Section 1.1, pages 7 and 8

CHAPTER 7

Table of Contents, pages i through iii
Section 2.8, page 1
Section 16.3, pages 1 and 2

CHAPTER 8

Section 16.1, page 1

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Section 9.1, pages 5 and 6
Section 20.1, pages 3 and 4
Section 24.1, pages 3 and 4

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Section 2.8, pages 1 and 2
Section 16.3, pages 1 through 3

Section 16.1, page 1

SUMMARY OF CHANGES

CHAPTER 1

1. Section 3.1. Intracranial angioplasty with stenting of the venous sinuses for treatment of pseudotumor cerebri is unproven and added as an exclusion.
2. Section 16.1. Computer-Aided Detection (CAD) with breast MRI is unproven and added as an exclusion.

CHAPTER 4

3. Section 6.1. Femoroplasty for the treatment of Femoroacetabular Impingement Syndrome (FAI) is unproven and added as an exclusion. Osteochondral allograft of the humeral head with meniscal transplant and glenoid microfracture in the treatment of shoulder pain and instability is unproven and added as an exclusion.
4. Section 9.1. Intracranial angioplasty with stenting of the venous sinuses for treatment of pseudotumor cerebri is unproven and added as an exclusion. Editorial correction provided.
5. Section 20.1. Editorial corrections.
6. Section 24.1. Removed age greater than or equal to 65 years from the list of contraindications for heart-lung and lung transplantation.

CHAPTER 5

7. Section 1.1. Computer-Aided Detection with breast MRI is unproven and added as an exclusion.

CHAPTER 7

8. Table of Contents. Subject title of Section 2.8 changed.
9. Section 2.8. Removed "Excludes Chemotherapy" from title. Allows for off-label use of zoledronic acid (Zometa) for treatment of breast cancer.
10. Section 16.3. Adds covered indications for paclitaxel (Taxol) and paclitaxel protein-bound particles (Abraxane) for the treatment of breast cancer.

**CHANGE 123
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SUMMARY OF CHANGES (Continued)

CHAPTER 8

11. Section 16.1. Intrapulmonary Percussive Ventilation (IPV) for the treatment of Cystic Fibrosis (CF) is unproven and added as an exclusion.

RARE DISEASES

ISSUE DATE: May 18, 1994

AUTHORITY: 32 CFR 199.2(b) and 32 CFR 199.4(g)(15)

I. DESCRIPTION

TRICARE defines a rare disease as any disease or condition that affects less than 200,000 persons in the United States.

II. POLICY

A. Coverage for treatment of rare diseases may be considered on a case-by-case basis. Case-by-case review is not required for drugs, devices, medical treatments, and procedures that have already been established as safe and effective for treatment of rare diseases.

B. In reviewing the case, any or all of the following sources may be used to determine if the proposed benefit is considered safe and effective.

1. Trials published in refereed medical literature.
2. Formal technology assessments.
3. National medical policy organization positions.
4. National professional associations.
5. National expert opinion organizations.

C. If case review indicates that the proposed benefit for a rare disease is safe and effective for that disease, benefits may be allowed. If benefits are denied, an appropriate appealing party may request an appeal.

D. Off-label use of rituximab may be considered for cost-sharing for the treatment of recurrent nodular CD20 positive lymphocyte predominant Hodgkin's disease. The effective date is January 1, 2003.

E. Off-label use of rituximab may be considered for cost-sharing in reducing proteinuria for the treatment of Immunoglobulin A (IgA) nephropathy (proliferative glomerulonephritis). The effective date is May 1, 2007.

F. Effective May 13, 2009, Intraperitoneal Hyperthermic Chemotherapy (IPHC) (CPT¹ procedure codes 77600, 77605, and 96445) in conjunction with cytoreductive surgery or peritonectomy for treatment of pseudomyxoma peritonei resulting from appendiceal carcinoma may be covered on a case-by-case basis for adult patients when all of the following criteria are met:

1. There is no evidence of distant metastasis.
2. There is evidence of low histological aggressiveness of the disease.
3. The patient has not undergone preoperative systemic chemotherapy.
4. The patient's condition does not preclude major surgery.
5. The chemotherapeutic agents used are Mitomycin C, Cisplatin (also known as Cisplatinum), or Fluorouracil.

III. EXCLUSION

Intracranial angioplasty with stenting (CPT¹ procedure code 61635) of the venous sinuses for treatment of pseudotumor cerebri (also known as idiopathic intracranial hypertension and benign intracranial hypertension) is unproven.

- END -

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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.

C. Computer-Aided Detection (CAD) with breast MRI (CPT² procedure code 0159T) is unproven.

- END -

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CHAPTER 4, SECTION 6.1

MUSCULOSKELETAL SYSTEM

N. Femoroplasty (CPT³ procedure code 29999) for the treatment of FAI syndrome is unproven.

O. Osteochondral allograft of the humeral head with meniscal transplant and glenoid microfracture in the treatment of shoulder pain and instability 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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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.

I. Intracranial angioplasty with stenting (CPT⁵ procedure code 61635) of the venous sinuses for treatment of pseudotumor cerebri (also known as idiopathic intracranial hypertension and benign intracranial hypertension) is unproven.

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CHAPTER 4, SECTION 9.1

CARDIOVASCULAR SYSTEM

V. EFFECTIVE DATES

- A. March 1, 2001, for gamma and beta intracoronary radiotherapy (brachytherapy).
- B. January 1, 2002, for TMR.
- C. October 1, 2003, for VADs 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 -

3. For embolizing other vascular malformation such as AVMs 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 (NMES) 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.

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O. Transcatheter placement of intravascular stent(s) intracranial (e.g., atherosclerotic or venous sinus stenosis) including angioplasty, if performed (CPT⁴ procedure code 61635) is unproven.

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.

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 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.

U. Spinal cord and deep brain neurostimulation in the treatment of chronic intractable headache or migraine pain 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.

- END -

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transplantation or at the development of end-stage heart-lung disease (because of substantial exacerbation of hypertension with post-transplantation drug regimen).

7. Cachexia, even in the absence of major end organ failure (because of the significantly less favorable survival of these patients).

8. Obesity, with weight being an increasingly severe adverse factor as the patient exceeds by 20 percent of ideal weight for height and sex (because of more difficult post-operative mobilization and impaired diaphragmatic function, as well as the difficulty of weight control once corticosteroid immunosuppressant is instituted).

9. A history of a behavior pattern or psychiatric illness considered likely to interfere significantly with compliance with a disciplined medical regimen (because a lifelong medical regimen is necessary requiring multiple drugs several times a day, with serious consequences in the event of their interruption of excessible consumption).

10. Active cigarette smoking (abstinence of a minimum of four months prior to transplantation is recommended).

11. Previous thoracic or cardiac surgery or other bases for pleural adhesions may be a serious adverse factor depending upon site of thoracotomy/sternotomy, the degree of adhesions and the type of transplant anticipated (because of scar tissue and the propensity for inadequately controlled bleeding).

12. Recent or current history of gastrointestinal problems (because of common post-operative gastrointestinal problems and hemorrhage).

13. Chronic corticosteroid therapy that cannot be tapered and discontinued prior to transplantation has been considered a serious adverse factor by many (because of the increased risk of tracheal or bronchial dehiscence in the early post-operative period).

14. With chronic pulmonary infection (as with bronchiectasis, chronic or cystic fibrosis), single lung transplantation is contraindicated (because of the great likelihood of the infection extending from the contaminated native lung into the transplanted lung) and the patient must meet the criteria and benefit/risk considerations of double lung or heart-lung transplantation.

15. With significant heart disease (for example, substantial irreversible right ventricular disease or significant coronary artery disease) the patient must meet the criteria and benefit/risk considerations for heart-lung transplantation; lung transplantation and concurrent repair of the cardiac abnormality may be appropriate in unusual circumstances, as in some situations with Eisenmenger's syndrome.

16. Primary or metastatic malignancies of the lung.

G. Services and supplies related to heart-lung or lung transplantation are covered for:

1. Evaluation of potential candidate's suitability for heart-lung or lung transplantation, whether or not the patient is ultimately accepted as a candidate for transplantation.
2. Pre- and post-transplant inpatient hospital and outpatient services.
3. Pre- and post-operative services of the transplant team.
4. The donor acquisition team, including the costs of transportation to the location of the donor organ and transportation of the team and the donated organ to the location of the transplantation center.
5. The maintenance of the viability of the donor organ after all existing legal requirements for excision of the donor organ have been met.
6. Donor costs.
7. Blood and blood products.
8. FDA approved immunosuppression drugs to include off-label uses when reliable evidence documents that the off-label use is safe, effective and in accordance with nationally accepted standards of practice in the medical community (proven).
9. Complications of the transplant procedure, including inpatient care, management of infection and rejection episodes.
10. Periodic evaluation and assessment of the successfully transplanted patient.
11. Cardiac rehabilitation.
12. Pulmonary rehabilitation for pre- and post-lung and heart-lung transplants
13. Transportation of the patient by air ambulance and the services of a certified life support attendant.
14. DNA-HLA tissue typing in determining histocompatibility.

H. TRICARE may cost-share for epoprostenol (FLOLAN®) for the management of severe secondary pulmonary hypertension, including those for patients with pulmonary hypertension secondary to the scleroderma spectrum of diseases, whether or not they have been authorized for and are awaiting lung transplantation.

IV. POLICY CONSIDERATION

A. In those cases where the beneficiary fails to obtain preauthorization, benefits may be extended if the services of supplies otherwise would qualify for benefits but for the failure to obtain preauthorization. If preauthorization is not received, the appropriate preauthorizing

B. Ultrafast CT (electron beam CT (HCPCS code S8092)) to predict asymptomatic heart disease is preventive. **Ultrafast CT (electron beam CT) is excluded for symptomatic patients and for screening asymptomatic patients for CAD.**

C. MRIs (CPT⁶ procedure codes 77058 and 77059) to screen for breast cancer in asymptomatic women considered to be at low or average risk of developing breast cancer; for diagnosis of suspicious lesions to avoid biopsy, to evaluate response to neoadjuvant chemotherapy, to differentiate cysts from solid lesions.

D. MRIs (CPT⁶ procedure codes 77058 and 77059) to assess implant integrity or confirm implant rupture, if implants were not originally covered or coverable.

E. 3D rendering (CPT⁶ procedure codes 76376 and 76377) for monitoring coronary artery stenosis activity in patients with angiographically confirmed CAD is unproven.

F. 3D rendering (CPT⁶ procedure codes 76376 and 76377) for evaluating graft patency in individuals who have undergone revascularization procedures is unproven.

G. 3D rendering (CPT⁶ procedure codes 76376 and 76377) for use as a screening test for CAD in healthy individuals or in asymptomatic patients who have one or more traditional risk factors for CAD is unproven.

H. CT angiography (CPT⁶ procedure codes 76376 and 76377) for acute ischemic stroke is unproven.

I. CT angiography (CPT⁶ procedure codes 76376 and 76377) for intracerebral aneurysm and subarachnoid hemorrhage is unproven.

J. CT, heart, without contrast **material, with** quantitative evaluation of coronary calcium (CPT⁶ procedure code 75571) is excluded for patients **with typical anginal chest pain with high suspicion of CAD; patients with acute MI;** and for screening asymptomatic patients for CAD.

K. CT, heart, with contrast material, **for evaluation of cardiac structure and morphology (including 3D image postprocessing, assessment of cardiac function, and evaluation of venous structures, if performed)** (CPT⁶ procedure code 75572) is excluded for patients with typical anginal chest pain with high suspicion for CAD; patients with acute MI; and for screening asymptomatic patients for CAD.

L. **CT, heart, with contrast material, for evaluation of cardiac structure and morphology in the setting of congenital heart disease (including 3D image postprocessing, assessment of LV cardiac function, RV structure and function and evaluation of venous structures, if performed)** (CPT⁶ procedure code 75573) is excluded for patients with typical anginal chest pain with high suspicion for CAD; patients with acute MI; and for screening asymptomatic patients for CAD.

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CHAPTER 5, SECTION 1.1

DIAGNOSTIC RADIOLOGY (DIAGNOSTIC IMAGING)

M. Computed tomographic angiography heart, coronary arteries and bypass (when present), with contrast material, including 3D image postprocessing (including evaluation of cardiac structure and morphology, assessment of cardiac function, and evaluation of venous structures, if performed) (CPT⁷ procedure code 75574) is excluded for patients with typical anginal chest pain with high suspicion for CAD; patients with acute MI; and for screening asymptomatic patients for CAD.

N. Multislice or multidetector row CT angiography of less than 16 slices per sec and 1mm or less resolution is excluded.

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

P. CAD with breast MRI (CPT⁷ procedure code 0159T) 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.

G. October 3, 2006, for CMR.

- END -

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MEDICINE

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2.2	Clinical Preventive Services - TRICARE Prime
2.3	Family Planning
2.4	Papanicolaou (PAP) Tests
2.5	Well-Child Care
2.6	Routine Physical Examinations
2.7	Chelation Therapy
2.8	Hydration, Therapeutic, Prophylactic, And Diagnostic Injections And Infusions
3.1	Limit On Acute Inpatient Mental Health Care
3.2	Limit On Residential Treatment Center (RTC) Care
3.3	Preauthorization Requirements For Acute Hospital Psychiatric Care
3.4	Preauthorization Requirements For Residential Treatment Center Care
3.5	Preauthorization Requirements For Substance Use Disorder Detoxification And Rehabilitation
3.6	Psychiatric Partial Hospitalization Programs - Preauthorization And Day Limits
3.7	Substance Use Disorders
3.8	Learning Disorders
3.9	Attention-Deficit/Hyperactivity Disorder
3.10	Treatment Of Mental Disorders
3.11	Ancillary Inpatient Mental Health Services
3.12	Psychological Testing
3.13	Psychotherapy
3.14	Family Therapy
3.15	Psychotropic Pharmacologic Management
3.16	Collateral Visits
3.17	Eating Disorders

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CHAPTER 7 - MEDICINE

SECTION	SUBJECT
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4.2	Dialysis
5.1	Gastroenterology
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6.3	Cardiovascular Therapeutic Services
7.1	Speech Services
8.1	Special Otorhinolaryngologic Services
8.2	Hearing Aids And Hearing Aid Services
9.1	Electronystagmography
10.1	Echocardiogram For Dental And Invasive Procedures
11.1	Cardiac Rehabilitation
12.1	Non-Invasive Vascular Diagnostic Studies
13.1	Pulmonary Services
14.1	Allergy Testing And Treatment
15.1	Neurology And Neuromuscular Services
15.2	Sensory Evoked Potentials (SEP)
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16.2	Health And Behavior Assessment/Intervention
16.3	Chemotherapy Administration
16.4	Education And Training For Patient Self Management
17.1	Dermatological Procedures - General
18.1	Rehabilitation - General
18.2	Physical Medicine/Therapy
18.3	Occupational Therapy
18.4	Osteopathic Manipulative Therapy
18.5	Chiropractic Manipulative Treatment
19.1	Diagnostic Sleep Studies
20.1	Hyperbaric Oxygen Therapy
21.1	Chronic Fatigue Syndrome
22.1	Telemental Health (TMH)/Telemedicine

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CHAPTER 7 - MEDICINE

SECTION	SUBJECT
23.1	Augmentative Communication Devices (ACD)
24.1	Phase II And Phase III Cancer Clinical Trials
25.1	Dermoscopy
26.1	Forensic Examinations Following Sexual Assault or Domestic Violence
27.1	Botulinum Toxin A Injections

HYDRATION, THERAPEUTIC, PROPHYLACTIC, AND DIAGNOSTIC INJECTIONS AND INFUSIONS

ISSUE DATE:

AUTHORITY: 32 CFR 199.4(b)(2)(v), (b)(3)(iii), (b)(5)(v), (d)(3)(vi), (e)(11)(ii), (e)(11)(iii), (g)(15)

I. CPT¹ PROCEDURE CODES

96360 - 96379

II. HCPCS PROCEDURE CODES

J3487, J3488

III. DESCRIPTION

Intravenous (IV) hydration infusion consists of pre-packaged fluid and electrolytes, but not infusion of drugs or other substances. A therapeutic, prophylactic, or diagnostic IV infusion or injection (other than hydration) is for the administration of substances or drugs.

Policy regarding chemotherapy administration is found in [Section 16.3](#).

IV. POLICY

A. Hydration IV infusion consistent of a pre-packaged fluid and electrolytes (e.g., normal saline, D5-1/2 normal saline +30mEq KCl/liter), but are not used to report infusion of drugs or other substances are covered.

B. Intravenous or intra-arterial push (an injection in which the health care professional who administers the substance/drug is continuously present to administer the injection and observe the patient or an infusion of 15 minutes or less) for therapy, prophylactic, or diagnosis is covered.

C. Off-label use of zoledronic acid (Zometa®) for treatment of breast cancer may be cost-shared when:

1. Patient was premenopausal at the time of diagnosis, and has stage I or II breast cancer;

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CHAPTER 7, SECTION 2.8

HYDRATION, THERAPEUTIC, PROPHYLACTIC, AND DIAGNOSTIC INJECTIONS AND INFUSIONS

2. Patient has had surgically induced menopause (e.g., oophorectomy) or has been put temporarily into menopause (chemically induced menopause with Goserelin or similar product) prior to administration of zoledronic acid;

3. Patient has hormone receptor (Estrogen Receptor (ER) and/or Progesterone Receptor (PR)) positive disease and zoledronic acid is being used in combination with hormonal therapy (e.g., Tamoxifen, Arimedex®, Aromasin®, Femara®);

4. No concurrent adjuvant chemotherapy has been given or planned;

5. Prescriber is an oncologist or an individual highly familiar with prescribing and monitoring of oncology-related medications.

V. EFFECTIVE DATE

February 12, 2009 for off-label use of zoledronic acid (Zometa®) for treatment of breast cancer.

- END -

CHEMOTHERAPY ADMINISTRATION

ISSUE DATE:

AUTHORITY: 32 CFR 199.4(b)(2)(v), (b)(3)(iii), (b)(5)(v), (d)(3)(vi), (e)(11)(i), (e)(11)(ii), (e)(11)(iii), (g)(15)

I. CPT¹ PROCEDURE CODES

96401, 96402, 96405, 96406, 96409, 96411, 96413, 96415 - 96417, 96420, 96422, 96423, 96425, 96440, 96445, 96450, 96521 - 96523, 96542, 96549

II. DESCRIPTION

Chemotherapy administration applies to parenteral administration of non-radionuclide anti-neoplastic drugs; and also to anti-neoplastic agents provided in treatment of noncancerous diagnoses (e.g., cycphosphamide for auto-immune conditions) or to substances such as monoclonal antibody agents, and other biologic response modifiers.

III. POLICY

A. Chemotherapy administration, subcutaneous or intramuscular; non-hormonal and anti-neoplastic is covered.

B. Chemotherapy administration, intralesional, up to and including **seven** lesions, more than **seven** lesions, intravenous push technique, single, initial substance/drug, each additional substance/drug is covered.

C. Chemotherapy administration, intravenous infusion technique; up to one hour, single or initial substance/drug; each additional hour, initiation of prolonged chemotherapy infusion (more than **eight** hours requiring use of a portable or implantable pump and each additional sequential infusion (different substance/drug) up to **one** hour) is covered.

D. Chemotherapy administration, intra-arterial; push technique/infusion technique, up to **one** hour; infusion technique, each additional hour up to **eight** hours infusion technique (more than **eight** hours) requiring the use of a portable or implantable pump is covered.

E. Chemotherapy administration into pleural cavity, requiring and including thoracentesis; into the peritoneal cavity requiring and including peritoneocentesis is covered.

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F. Chemotherapy administration into CNS (e.g., intrathecal requiring and including spinal puncture) is covered.

G. Refilling and maintenance of portable pump is covered. Refilling and maintenance of implantable pump or reservoir for drug delivery, systemic (e.g., intravenous-intera arterial) is covered.

H. Irrigation of implanted venous access device for drug delivery systems is covered.

I. Chemotherapy injection, subarachnid or intraventricular via subcutaneous reservoir, single or multiple agents is covered.

J. Paclitaxel (Taxol) is covered for the treatment of breast cancer for the following indications (Healthcare Common Procedure Coding System (HCPCS) code J9265). This is not all inclusive. Other U.S. Food and Drug Administration (FDA)-approved labeled indications of Taxol are also covered):

1. Adjuvant therapy for node-positive breast cancer when administered sequentially following standard Doxorubicin-containing combination chemotherapy.

2. Adjuvant therapy for early-stage breast cancer.

3. First-line therapy for metastatic breast cancer.

a. Paclitaxel alone or in combination with Anthracycline (Doxorubicin, Epirubicin) for Anthracycline-naive patients.

b. Paclitaxel for Anthracycline-resistant patients.

c. Paclitaxel and Gemcitabine following failure of adjuvant chemotherapy.

d. Paclitaxel and Trastuzumab (Herceptin®) for HER-2-positive breast cancer.

e. Paclitaxel and Bevacizumab (Avastin™) for HER-2-negative breast cancer.

f. Paclitaxel and Carboplatin for HER-2-positive breast cancer.

4. Second-line therapy for advanced breast cancer for the treatment of breast cancer in patients who have metastatic disease refractory to conventional combination chemotherapy or who have experienced relapse within six months of adjuvant chemotherapy; prior therapy should have included an Anthracycline agent unless clinically contraindicated.

K. Paclitaxel protein-bound particles (Abraxane) (HCPCS code J9264) is covered for the treatment of breast cancer after failure of combination chemotherapy for metastatic breast cancer or relapse within six months of adjuvant chemotherapy. (This is not all inclusive. Other FDA-approved labeled indications are also covered.)

IV. EFFECTIVE DATES

- A. October 25, 1999 for Paclitaxel (Taxol).
- B. January 7, 2005, for Paclitaxel protein-bound particles (Abraxane).

- END -

MUCUS CLEARANCE DEVICES

ISSUE DATE: June 5, 1995

AUTHORITY: [32 CFR 199.4](#)

I. HCPCS PROCEDURE CODES

A7025, A7026, E0480, E0482 - E0484, S8185

II. DESCRIPTION

A. Mucus clearance devices are designed to clear mucus secretions from the lungs of patients with mucociliary clearance impairment.

B. Some mucus clearance devices resemble a combination of a smoker's pipe and a referee's whistle. It consists of a hardened plastic mouthpiece at one end, a plastic perforated cover at the opposite end, and a valve on the inside created by a high-density stainless steel ball resting in a plastic circular cone.

C. Other bronchial drainage systems include an air oscillator and an inflatable vest and uses high-frequency chest wall oscillations, which also clear mucus from the airway wall. This type of system is a mechanical form of **Chest Physical Therapy (CPT)** used as an alternative to conventional CPT in patients with **Cystic Fibrosis (CF)**.

III. POLICY

A. Reimbursement of the mucus clearance device includes Cystic Fibrosis (CF), Chronic Obstructive Pulmonary Disease (COPD) (which encompasses both chronic bronchitis and emphysema), and other mucus producing lung diseases.

B. The mucus clearance device used must be **U.S. Food and Drug Administration (FDA)** approved. Coverage can only begin effective the date of FDA approval.

IV. EXCLUSION

Intrapulmonary Percussive Ventilation (IPV) (Healthcare Common Procedure Coding System (HCPCS) code E0481) for the treatment of CF is unproven.

- END -

