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TRICARE
MANAGEMENT ACTIVITY

MB&RB

**CHANGE 128
6010.54-M
AUGUST 31, 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 - JUNE 2010

CONREQ: 15101

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): See page 3.

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): 23 PAGE(S)
DISTRIBUTION: 6010.54-M

CHANGE 128
6010.54-M
AUGUST 31, 2010

REMOVE PAGE(S)

CHAPTER 1

Section 16.1, pages 1 and 2

Section 17.1, pages 1 and 2

CHAPTER 4

Section 6.1, pages 1 - 3

Section 13.1, pages 1 and 2

Section 14.1, pages 1 and 2

Section 20.1, pages 3 and 4

Section 24.5, pages 3 - 5

Section 24.6, pages 3 and 4

CHAPTER 5

Section 4.1, pages 1 - 4

INSERT PAGE(S)

Section 16.1, pages 1 and 2

Section 17.1, pages 1 and 2

Section 6.1, pages 1 - 3

Section 13.1, pages 1 - 3

Section 14.1, pages 1 and 2

Section 20.1, pages 3 - 5

Section 24.5, pages 3 and 4

Section 24.6, pages 3 and 4

Section 4.1, pages 1 - 4

SUMMARY OF CHANGES

CHAPTER 1

1. Section 16.1. Added coverage for Category III code 0184T.
2. Section 17.1. Added HCPCS code S2325.

CHAPTER 4

3. Section 6.1. Added core decompression of the femoral head (hip) for early (pre-collapse state I or II) avascular necrosis may be considered for cost-sharing, effective May 1, 2008.
4. Section 13.1. Added coverage for Transanal Endoscopic Microsurgery (TEM) for treatment of benign lesions or T1 tumors when certain conditions are met. Effective date of coverage is June 2, 2009. Radiofrequency Ablation (RFA) for treatment of liver metastases from primary sites other than colorectal metastases is unproven and added as an exclusion.
5. Section 14.1. Posterior Tibial Nerve Stimulation (PTNS) for treatment of overactive bladder, to include urinary frequency, urge and incontinence (CPT procedure code 64555) is unproven and added as an exclusion.
6. Section 20.1. Allows coverage for epidural steroid injections for the treatment of pain due to symptomatic thoracic disc herniation when: 1) pain is radicular and 2) pain is unresponsive to conservative treatment.
7. Section 24.5. Liver transplantation and LDLT is excluded when active alcohol or other substance abuse interferes with compliance to strict treatment regimen.
8. Section 24.6. Combined liver-kidney transplantation is excluded when active alcohol or other substance abuse interferes with compliance to strict treatment regimen.

CHAPTER 5

9. Section 4.1. PET and PET/CT for ruling out recurrence of ovarian cancer as a covered indication. PET and PET/CT for the initial diagnosis staging, and monitoring of treatment of ovarian cancer is added to Exclusions as unproven. PET and PET/CT for staging, restaging and detection of recurrence of colorectal cancer as covered indications. PET and PET/CT for the initial diagnosis and monitoring of treatment of colorectal cancer is added to Exclusions as unproven.

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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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 1, SECTION 16.1

CATEGORY III CODES

F. Category III code 0184T is a covered service as listed in Chapter 4, Section 13.1.

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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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; and

2. S0812, S1030, S1031, S1040, S2066, S2067, S2068, S2075, S2076, S2077, S2083, S2202, S2235, **S2325**, S2360, S2361, S2401, S2402, S2403, S2405, S2411, S3620, 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](#)).

TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002
CHAPTER 1, SECTION 17.1
HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS) "C" AND
"S" CODES

4. S2400 for prenatal surgical intervention of temporary tracheal occlusion of Congenital Diaphragmatic Hernia (CDH) for fetuses with prenatal diagnosis of CDH shall be determined on a case-by-case basis, based on the Rare Disease policy, effective October 1, 2009. Procedural guidelines for review of rare disease are contained in [Chapter 1, Section 3.1](#).

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

[S2325](#), 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.

F. Core decompression of the femoral head (hip) for early (precollapse stage I or II) avascular necrosis may be considered for cost-sharing.

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. 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.

G. 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](#).

H. Lumbar total disc arthroplasty (lumbar artificial intervertebral disc replacement, lumbar total disc replacement) for degenerative disc disease is unproven (CPT² procedure codes 22857, 22862, 0163T, 0164T, and 0165T).

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

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

K. Femoroacetabular Impingement (FAI) open surgery, surgical dislocation (CPT² procedure codes 27140 and 27179), for the treatment of hip impingement syndrome or labral tear is unproven.

L. Hip arthroscopy (CPT² procedure code 29862) for the treatment of FAI and debridement of articular cartilage is unproven.

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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 4, SECTION 6.1

MUSCULOSKELETAL SYSTEM

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

N. 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).

C. May 1, 2008, for core decompression of the femoral head.

- END -

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DIGESTIVE SYSTEM

ISSUE DATE: August 26, 1985

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

I. CPT¹ PROCEDURE CODES

40490 - 40831, 40899 - 43644, 43647, 43648, 43651 - 43761, 43800, 43810, 43820, 43842, 43846, 43848, 43880 - 43882, 43999, 44005 - 47362, 47370, 47371, 47379 - 47382, 47399 - 49999, 91123, 96570, 96571

II. DESCRIPTION

The digestive system involves the organs associated with the ingestion, digestion, and absorption of nutrients, and the elimination of solid waste.

III. POLICY

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

B. Gastric electrical stimulation (CPT¹ procedure codes 43647, 43648, 43881, and 43882) for treatment of symptoms of nausea and vomiting from chronic gastroparesis that is refractory to medical management may be considered for coverage as a Humanitarian Use Device (HUD).

C. Radiofrequency Ablation (RFA) (CPT¹ procedure codes 47370, 47380, and 47382) for treatment of unresectable hepatocellular carcinoma or unresectable liver metastases from colorectal cancer is proven and may be covered when all of the following conditions are met:

1. Tumors are less than five centimeters in diameter;
2. There are five or fewer tumors; and
3. There is no evidence of extrahepatic metastasis.

All procedures must be performed using an Food and Drug Administration (FDA) approved electrosurgical cutting and coagulation device.

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D. Intraperitoneal Hyperthermic Chemotherapy (IPHC) (CPT² 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 under the Rare Diseases policy 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.

E. Transanal Endoscopic Microsurgery (TEM) (CPT² procedure code 0184T) for treatment of benign lesions or malignant T1 tumors is proven and may be covered when all of the following criteria are met:

1. The lesion can be adequately identified in the rectum and is a mobile, non-fixed benign lesion or T1 tumor with a diameter less than three centimeters that covers less than 30% of the circumference of the bowel, located within eight centimeters of the anal verge.
2. Pretreatment endorectal ultrasonography indicates an absence of lymphadenopathy and microscopic angiolymphatic invasion.
3. The tumor is a moderately or well differentiated grade I, with no lymphatic, vascular, or perineural invasion.
4. Resection margins are negative for greater than three millimeters.
5. There is no evidence of distant metastasis.

IV. EXCLUSIONS

A. Vestibuloplasty (CPT² procedure code range 40840-40845) EXCEPT for adjunctive dental care ([Chapter 8, Section 13.1](#)).

B. The Stretta System (Curon Medical, Sunnyvale, CA), and Bard Endoscopic Suturing System, and Transoral Incisionless Fundoplication using EsophyX (EndoGastric Solutions, Redmond, WA) for the treatment of refractory Gastro-Esophageal Reflux Disease (GERD) are unproven (CPT² procedure codes 43201 and 43257).

C. For bariatric procedures, see [Section 13.2](#).

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D. RFA for treatment of liver metastases from primary sites other than colorectal metastases is unproven (CPT³ procedure codes 47370, 47380, and 47382).

V. EFFECTIVE DATES

A. RFA (CPT³ procedure codes 47370, 47380, and 47382) for treatment of unresectable hepatocellular carcinoma or unresectable liver metastases from colorectal cancer is proven and covered, effective April 28, 2004.

B. IPHC (CPT³ procedure codes 77600, 77605, and 96445) in conjunction with cytoreductive surgery or peritonectomy for treatment of pseudomyxoma peritonei arising from appendiceal carcinoma may be covered under the Rare Diseases policy on a case-by-case basis for adult patients, effective May 13, 2009.

C. TEM (CPT³ procedure code 0184T) for treatment of benign lesions or malignant T1 tumors is covered effective June 2, 2009.

- END -

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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 **U.S. Food and Drug Administration (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.

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F. Under the provisions for the treatment of rare diseases, coverage of laparoscopic Radiofrequency Ablation (RFA) (CPT² procedure code 50542) and Percutaneous Radiofrequency Ablation (PRFA) (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.

G. Posterior Tibial Nerve Stimulation (PTNS) for treatment of overactive bladder, to include urinary frequency, urge, and incontinence (CPT² procedure code 64555), 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 RFA or PRFA 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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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.

F. Thoracic epidural steroid injections for the treatment of pain due to symptomatic thoracic disc herniations may be considered for cost-sharing when a patient meets all of the following criteria:

1. Pain is radicular; and
2. Pain is unresponsive to conservative treatment.

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

I. Neuromuscular Electrical Stimulation (NMES) for the treatment of denervated muscles is unproven.

J. Stereotactic cingulotomy is unproven.

K. 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).

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L. Laminoplasty, cervical with decompression of the spinal cord, two or more vertebral segments with reconstruction of the posterior bony elements (CPT⁴ procedure codes 63050 and 63051).

M. Balloon angioplasty, intracranial, percutaneous (CPT⁴ procedure code 61630) is unproven.

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

O. 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.

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

Q. Radiofrequency Ablation (RFA) (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 RFA for spinal pain is unproven.

R. Implantation of Occipital Nerve Stimulator for the treatment of chronic intractable migraine headache is unproven.

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

T. 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.

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F. June 10, 2008, for thoracic epidural steroid injections.

- END -

determine whether the beneficiary's condition meets the clinical criteria for the transplantation. TRICARE Prime enrollees who failed to obtain preauthorization will be reimbursed only under Point of Service rules.

B. Benefits will only be allowed for transplantations performed at a TRICARE or Medicare-certified liver transplantation center. Benefits are also allowed for transplants performed at a pediatric facility that is TRICARE-certified as a liver 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 in whose jurisdiction the center is located is the certifying authority for TRICARE authorization as a liver transplantation center. Refer to [Chapter 11, Section 7.1](#) for organ transplantation center certification requirements.

C. Liver transplantation will be paid under the DRG.

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. 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 transplantation 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 transplantation 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. Liver or LDLT performed on an emergency basis in an unauthorized liver transplantation 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 liver transplantation center regarding the transplantation case;

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

3. All other TRICARE contractual requirements have been met.

IV. EXCLUSIONS

A. Liver transplantation and LDLT is excluded when any of the following contraindications exist:

1. Significant systemic or multisystemic disease (other than hepatorenal failure) which limits the possibility of full recovery and may compromise the function of the newly transplanted organs.

2. Active alcohol or other substance abuse **that interferes with compliance to strict treatment regimen.**

3. Malignancies metastasized to or extending beyond the margins of the liver.

B. The following are also excluded:

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

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

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

4. 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).

5. Transportation of an organ donor.

C. Artificial assist devices that are not FDA approved and that are not used in compliance with FDA approved indications.

V. EFFECTIVE DATES

A. November 1, 1994, for hepatitis C.

B. December 1, 1996, for hepatitis B.

- END -

TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 4, SECTION 24.6

COMBINED LIVER-KIDNEY TRANSPLANTATION

B. Benefits will only be allowed for transplants performed at a TRICARE or Medicare-certified liver transplantation center. Benefits are also allowed for transplants performed at a pediatric facility that is TRICARE-certified as a liver 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 in whose jurisdiction the center is located is the certifying authority for TRICARE approval as a liver transplantation center. Refer to [Chapter 11, Section 7.1](#) for organ transplant center certification requirements.

C. Claims for services and supplies related to the transplant will be reimbursed based on billed charges. Effective August 1, 2003, CLKTs shall be paid under the assigned DRG based on the patient's diagnosis.

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. 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.

F. When a properly preauthorized candidate is discharged less than 24-hours after admission because of extenuating circumstance, 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.

G. CLKTs performed on an emergency basis in an unauthorized liver 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 liver transplantation center regarding the transplantation case; and

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

H. This policy does not apply to beneficiaries who become eligible for Medicare coverage due to isolated renal disease. This policy applies only to those individuals suffering from concomitant hepatic and renal failure. Coordination of benefits with Medicare is not required for CLKTs.

IV. EXCLUSIONS

A. Combined liver-kidney transplantation is excluded when the following contraindications exist:

TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 4, SECTION 24.6

COMBINED LIVER-KIDNEY TRANSPLANTATION

1. Significant systemic or multisystemic disease (other than hepatorenal failure) which limits the possibility of full recovery and may compromise the function of the newly transplanted organs.

2. Active alcohol or other substance abuse **that interferes with compliance to strict treatment regimen.**

3. Malignancies metastasized to or extending beyond the margins of the liver and/or kidney.

B. The following are also excluded:

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

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

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

4. 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).

5. Transportation of an organ donor.

V. EFFECTIVE DATES

A. November 12, 1992.

B. November 1, 1994, for hepatitis C.

C. December 1, 1996, for hepatitis B.

- END -

NUCLEAR MEDICINE

ISSUE DATE: June 30, 1993

AUTHORITY: 32 CFR 199.4(b)(2)(vii) and (c)(2)(ix)

I. CPT¹ PROCEDURE CODE RANGE

78000 - 79999

II. DESCRIPTION

Nuclear Medicine uses very small amounts of radioactive materials or radiopharmaceuticals to diagnose and treat disease. Radiopharmaceuticals are substances that are attracted to specific organs, bones, or tissues. The radiopharmaceutical used in nuclear medicine emit gamma rays that can be detected externally by gamma or PET cameras. These cameras work in conjunction with computers used to form images that provide data and information about the area of body being imaged. The following techniques are used in the diagnosis, management, treatment, and prevention of disease: (1) Planar, Single Photon Emission Computed Tomography (SPECT); (2) Positron Emission Tomography (PET); (3) Tomography; (4) Nuclear Medicine Scan; (5) Radiopharmaceutical; (6) Gamma Camera; (7) In Vitro done in test tubes; and (8) In Vitro done in patients.

III. POLICY

A. Positron emission tomography (PET) is covered for:

1. The diagnosis and management of seizure disorders.
2. Evaluation of ischemic heart disease.
3. The diagnosis and management of lung cancer.
4. PET and PET/CT for the diagnosis, staging, restaging, and monitoring of treatment of lymphoma.
5. PET and PET/CT for the diagnosis, staging, restaging, and monitoring of treatment of pancreatic cancer.

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6. PET and PET/CT for the staging and restaging of differentiated (follicular, papillary, Hürthle cell) thyroid cancer.

7. PET and PET/CT for ruling out recurrence of ovarian cancer.

8. PET and PET/CT for staging, restaging, and detection of recurrence of colorectal cancer.

9. PET scans for other indications are covered when documented by reliable evidence as safe, effective and comparable or superior to standard care (proven).

B. Single Photon Emission Computed Tomography (SPECT) is covered for:

1. Myocardial perfusion imaging utilizing SPECT.

2. Brain imaging utilizing SPECT for the evaluation of seizure disorder.

3. Prostatic radioimmunoscintigraphy imaging utilizing SPECT for the following indications:

a. Metastatic spread of prostate cancer and for use in post-prostatectomy patients in whom there is a high suspicion of undetected cancer recurrence.

b. Newly diagnosed patients with biopsy-proven prostate cancer at high risk for spread of their disease to pelvic lymph nodes.

4. Indium¹¹¹ - for detecting the presence and location of myocardial injury in patients with suspected myocardial infarction.

5. Indium¹¹¹ - labeled anti-TAG72 for tumor recurrence in colorectal and ovarian cancer.

6. SPECT for other indications is covered when documented by reliable evidence as safe, effective, and comparable or superior to standard care (proven).

C. Indium¹¹¹ Pentetreotide (Octreoscan) Scintigraphy is covered for:

1. The localization and monitoring of treatment of primary and metastatic neuroendocrine tumors.

2. Other indications when documented by reliable evidence as safe, effective, and comparable or superior to standard care (proven).

D. Bone Density Studies (CPT² procedure codes 78350, 78351) are covered for:

1. The diagnosis and monitoring of osteoporosis.

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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 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.
- E. PET and PET/CT for the diagnosis, staging, restaging, and monitoring of treatment of gastric cancer is unproven.
- F. PET and PET/CT for the initial diagnosis, staging, and monitoring of treatment of ovarian cancer is unproven.
- G. PET and PET/CT for the initial diagnosis and monitoring of treatment of colorectal cancer is unproven.

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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 5, SECTION 4.1

NUCLEAR MEDICINE

H. Scintimammography (HCPCS code S8080), Breast-Specific Gamma Imaging (BSGI) (CPT⁴ procedure codes 78800, 78801), and Molecular Breast Imaging (MBI) are unproven for all indications.

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.

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.

K. December 1, 2008, for PET and PET/CT for ruling out recurrence of ovarian cancer.

L. May 1, 2007, for PET and PET/CT for staging, restaging, and detection of recurrence of colorectal cancer.

- END -

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