



OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
HEALTH AFFAIRS

16401 EAST CENTRETECH PARKWAY
AURORA, COLORADO 80011-9066

TRICARE
MANAGEMENT ACTIVITY

MB&RB

**CHANGE 164
6010.54-M
AUGUST 15, 2012**

**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 PRACTICE 12-001

CONREQ: 16104

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): See page 3.

EFFECTIVE DATE: As indicated in the change.

IMPLEMENTATION DATE: Upon direction of the Contracting Officer.

**Ann N. Fazzini
Chief, Medical Benefits and
Reimbursement Branch**

**ATTACHMENT(S): 16 PAGE(S)
DISTRIBUTION: 6010.54-M**

CHANGE 164
6010.54-M
AUGUST 15, 2012

REMOVE PAGE(S)

INSERT PAGE(S)

CHAPTER 1

Section 3.1, pages 1 and 2

Section 3.1, pages 1 and 2

CHAPTER 4

Section 2.1, page 3

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Section 6.1, page 3

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Section 21.1, pages 1 and 2

Section 21.1, pages 1 and 2

CHAPTER 5

Section 4.1, pages 1 - 4

Section 4.1, pages 1 - 4

SUMMARY OF CHANGES

CHAPTER 1

1. Section 3.1. Off-label use of rituximab for pediatric Immunoglobulin A (IgA) is unproven.

CHAPTER 4

2. Section 2.1. Maxillary transplant, face transplant, and facial Composite Tissue Allotransplantation (CTA) is unproven.
3. Section 6.1. Minimally Invasive Lumbar Decompression (mild®) for the treatment of Degenerative Disc Disease and/or spinal stenosis is unproven.
4. Section 20.1. Allows for off-label use of the vagus nerve stimulator for children with Lennox Gastaut Syndrome (LGS) (a rare disorder) refractory to medical treatment. Minimally Invasive Lumbar Decompression (mild®) for the treatment of Degenerative Disc Disease and/or spinal stenosis is unproven.
5. Section 21.1. Autologous serum eye drops for the treatment of dry eye syndrome, keratitis, or ocular hypertension is unproven.

CHAPTER 5

6. Section 4.1. Allows cost-sharing for the restaging of gastrointestinal stromal tumor (a rare disease).

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.

G. External Infusion Pumps (EIPs) for insulin may be considered for cost-sharing when the diagnosis is Cystic Fibrosis-Related Diabetes (CFRD) with fasting hyperglycemia. See [Chapter 8, Section 2.3](#) for policy regarding EIPs. Effective January 21, 2009.

H. Post-operative proton beam radiosurgery/radiotherapy (CPT¹ procedure codes 77520, 77522, 77523, and 77525) may be considered for cost-sharing when the diagnosis is sacral chordoma. See [Chapter 5, Section 3.1](#) for policy regarding proton beam radiosurgery/radiotherapy.

I. Extracorporeal photopheresis (CPT¹ procedure code 36522) may be considered for cost-sharing when the diagnosis is Bronchiolitis Obliterans Syndrome (BOS) that is refractory to immunosuppressive drug treatment. See [Chapter 4, Section 9.2](#) for policy regarding photopheresis.

III. EXCLUSIONS

A. 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.

B. Off-label use of rituximab for pediatric Immunoglobulin A (IgA) is unproven.

- END -

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CHAPTER 4, SECTION 2.1

COSMETIC, RECONSTRUCTIVE AND PLASTIC SURGERY - GENERAL GUIDELINES

- J. Rhinoplasties (except when performed to restore function).
- K. Chemical peeling (exfoliation) for the following:
 - 1. Treatment or removal of facial wrinkles, and
 - 2. Treatment of acne or of acne scars.
- L. Revision of scars resulting from surgery and/or a disease process, except disfiguring and extensive scars resulting from neoplastic surgery.
- M. Dermabrasion of the face (except when performed as part of surgery to restore body form following accidental injury or revision of disfiguring and extensive scars resulting from neoplastic surgery).
- N. Removal of tattoos.
- O. Hair transplants.
- P. Electrolysis.
- Q. Penile implant procedure for psychological impotency, transsexualism, or other such conditions as gender dysphoria.
- R. Insertion of prosthetic testicles for transsexualism, or such other conditions as gender dysphoria.
- S. Liposuction for body contouring.
- T. Rhytidectomy (CPT¹ procedure codes 15824 - 15826, 15828, and 15829) except for treatment of significant burns or other significant major facial trauma.
- U. Face transplant, maxillary transplant, and facial Composite Tissue Allotransplantation (CTA).
- V. When it is determined that a cosmetic, reconstructive and/or plastic surgery procedure does not qualify for benefits, all related services and supplies are excluded, including any institutional costs.

- END -

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CHAPTER 4, SECTION 6.1

MUSCULOSKELETAL SYSTEM

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

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

N. Thermal Intradiscal Procedures (TIPs) (CPT³ procedure codes 22526, 22527, 62287, and HCPCS code S2348) are unproven. TIPs are also known as: Intradiscal Electrothermal Annuloplasty (IEA), Intradiscal Electrothermal Therapy (IDET), Intradiscal Thermal Annuloplasty (IDTA), Percutaneous Intradiscal Radiofrequency Thermocoagulation (PIRFT), Coblation Percutaneous Disc Decompression, Nucleoplasty (also known as percutaneous radiofrequency (RF) thermomodulation or percutaneous plasma discectomy), Radiofrequency Annuloplasty (RA), Intradiscal Biacuplasty (IDB), Percutaneous (or Plasma) Disc Decompression (PDD), Targeted Disc Decompression (TDD), Cervical Intradiscal RF Lesioning.

O. Total hip resurfacing (HCPCS code S2118) for treatment of degenerative hip disease is unproven.

P. Spinal manipulation under anesthesia (CPT³ procedure codes 00640 and 22505) for the treatment of back pain is unproven.

Q. Minimally Invasive Lumbar Decompression (mild®) for the treatment of Degenerative Disc Disease (DDD) and/or spinal stenosis is unproven.

VI. EFFECTIVE DATES

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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NERVOUS SYSTEM

ISSUE DATE: August 26, 1985

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

I. CPT¹ PROCEDURE CODES

61000 - 61626, 61680 - ~~62264~~, ~~62268~~ - 62284, 62290 - 63048, 63055 - 64484, 64505 - 64560, 64565 - 64580, 64595, 64600 - 64650, 64680 - 64999, 95961, 95962, 95970 - 95975, 95978, 95979

II. DESCRIPTION

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

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

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

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

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

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

III. POLICY

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

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

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

C. Implantation of depth electrodes is covered. Implantation of a U.S. Food and Drug Administration (FDA) approved vagus nerve stimulator **may be covered for the following indications:**

1. As adjunctive therapy in reducing the frequency of seizures in adults and adolescents over 12 years of age, which are refractory to anti-epileptic medication.
2. As therapy for children 12 years of age or younger who have a diagnosis of medically refractory Lennox-Gastaut Syndrome (LGS) (a rare disease).

NOTE: Battery replacement is also covered.

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

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

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

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

G. Non-pulsed Radiofrequency (RF) denervation (CPT³ procedure codes 64622, 64623, 64626, 64627) for the treatment of chronic cervical and lumbar facet pain is covered when the following criteria are met:

1. No prior spinal fusion surgery in the vertebral level being treated, and
2. Low back (lumbosacral) or neck (cervical) pain, suggestive of facet joint origin as evidenced by absence of nerve root compression as documented in the medical record on history, physical and radiographic evaluations; and the pain is not radicular, and
3. Pain has failed to respond to three months of conservative management which may consist of therapies such as nonsteroidal anti-inflammatory medications, acetaminophen, manipulation, physical therapy, and a home exercise program, and
4. A trial of controlled diagnostic medial branch blocks under fluoroscopic guidance has resulted in at least a 50% reduction in pain; and
5. If there has been a prior successful RF denervation, a minimum time of six months has elapsed since prior RF treatment (per side, per anatomical level of the spine).

H. Endoscopic laminotomy (CPT³ procedure code 63030) is covered for the treatment of lumbar spinal stenosis. The endoscopic spinal system used in the procedure must be FDA approved.

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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 (CPT⁴ 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).
- 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.

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O. Balloon dilation of intracranial vasospasm, initial vessel (CPT⁵ procedure code 61640) each additional vessel in same family (CPT⁵ procedure code 61641) or different vascular family (CPT⁵ procedure code 61642) is unproven.

P. Sphenopalatine ganglion block (CPT⁵ procedure code 64505) for the treatment of chronic migraine headaches and neck pain is unproven.

Q. RF denervation (CPT⁵ procedure codes 64626, 64627) for the treatment of thoracic facet pain is unproven. Pulsed Radiofrequency Ablation (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 (CPT⁵ 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.

U. Thermal Intradiscal Procedures (TIPs) (CPT⁵ procedure codes 22526, 22527, 62287, and Healthcare Common Procedure Coding System (HCPCS) code S2348) are unproven. TIPs are also known as: Intradiscal Electrothermal Annuloplasty (IEA), Intradiscal Electrothermal Therapy (IDET), Intradiscal Thermal Annuloplasty (IDTA), Percutaneous Intradiscal Radiofrequency Thermocoagulation (PIRFT), Coblation Percutaneous Disc Decompression, Nucleoplasty (also known as Percutaneous RF Thermomodulation or Percutaneous Plasma Discectomy), Radiofrequency Annuloplasty (RA), Intradiscal Biacuplasty (IDB), Percutaneous (or Plasma) Disc Decompression (PDD), Targeted Disc Decompression (TDD), Cervical Intradiscal RF Lesioning.

V. Laser ablation of paravertebral facet joint nerves (CPT⁵ procedure codes 64622 and 64623) is unproven. **(This applies only to laser ablation and should not be applied to RFA.)**

W. Minimally Invasive Lumbar Decompression (mild[®]) for the treatment of Degenerative Disc Disease (DDD) and/or spinal stenosis 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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CHAPTER 4, SECTION 20.1

NERVOUS SYSTEM

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

G. January 1, 2009, for non-pulsed RF denervation for the treatment of chronic cervical and lumbar facet pain.

H. January 1, 2009, for endoscopic laminotomy for the treatment of lumbar spinal stenosis.

I. October 1, 2011, for vagus nerve stimulator for treatment of LGS in children 12 years of age or younger.

- END -

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

0192T, 65091 - 65755, 65772 - **66172, 66180** - 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](#).

F. Intrastromal Corneal Ring Segments (Intacs®) is covered for U.S. Food and Drug Administration (FDA) approved indications for beneficiaries with keratoconus who meet all of the following criteria: (1) are unable to achieve adequate vision using lenses or spectacles; and (2) for whom corneal transplant is the only remaining option.

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CHAPTER 4, SECTION 21.1

EYE AND OCULAR ADNEXA

G. Optonal ExPRESS Mini Glaucoma Shunt (CPT² procedure code 0192T) to reduce Intraocular Pressure (IOP) in the treatment of glaucoma, that cannot be controlled effectively with medications.

IV. EXCLUSIONS

A. Refractive corneal surgery except as noted in [paragraph III.D.](#) (CPT² procedure codes 65760, 65765, 65767, 65770, 65771).

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

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. Canaloplasty for the treatment of glaucoma (CPT² procedure code 66174 and 66175).

H. Autologous serum eye drops for the treatment of dry eye syndrome, keratitis, or ocular hypertension is unproven.

V. EFFECTIVE DATE

April 1, 2011, Coverage for Optonal ExPRESS Mini Glaucoma Shunt.

- END -

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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/CT for metastatic bladder cancer.

10. Restaging of gastrointestinal stromal tumor (a rare disease).

11. 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.
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 for osteoporosis are those identified as the standard of care by the American College of Obstetricians and Gynecologists (ACOG).

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 uterine fibroids) with Magnetic Resonance Imaging (MRI) guidance (CPT² 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.

H. PET for the diagnosis of renal mass or possible Renal Cell Carcinoma (RCC) recurrence.

I. Scintimammography (HCPCS code S8080), Breast-Specific Gamma Imaging (BSGI) (CPT² 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.

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CHAPTER 5, SECTION 4.1

NUCLEAR MEDICINE

- 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.
- M. January 1, 2010, for PET/CT for metastatic bladder cancer.
- N. January 1, 2010, for PET for gastrointestinal stromal tumor (a rare disease).**

- END -