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TRICARE
MANAGEMENT ACTIVITY

MB&RS

CHANGE 59
6010.54-M
JULY 3, 2007

PUBLICATIONS SYSTEM CHANGE TRANSMITTAL
FOR
TRICARE POLICY MANUAL (TPM)

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

CHANGE TITLE: EVOLVING PRACTICES CHANGE JULY 2007

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): This change addresses several evolving practices to
include intraperitoneal cisplatin, cryoablation for renal cell carcinoma, progesterone
therapy, and liver transplantation for treatment of MSUP.

EFFECTIVE AND IMPLEMENTATION DATE: Upon direction of the Contracting
Officer.

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

Reta Michak
Chief, Office of Medical Benefits
and Reimbursement Systems

ATTACHMENT(S): 43 PAGE(S)
DISTRIBUTION: 6010.54-M

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

REMOVE PAGE(S)

INSERT PAGE(S)

CHAPTER 1

Section 2.1, pages 3 and 4

Section 2.1, pages 3 and 4

CHAPTER 4

Section 6.1, pages 1 and 2

Section 6.1, pages 1 and 2

Section 8.1, page 1

Section 8.1, page 1

Section 9.1, pages 1 through 3

Section 9.1, pages 1 through 4

Section 14.1, pages 1 and 2

Section 14.1, pages 1 and 2

Section 18.1, pages 1 and 2

Section 18.1, pages 1 and 2

Section 21.1, pages 1 and 2

Section 21.1, pages 1 and 2

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CHAPTER 5

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Section 2.7, pages 1 and 2

INDEX

pages 17, 18, 21, and 22

pages 17, 18, 21, and 22

SUMMARY OF CHANGES

CHAPTER 1

1. Section 2.1, page 4. A recently published randomized controlled trial established the safety and efficacy of intraperitoneal (IP) cisplatin in patients with optimally debulked Stage III ovarian cancer. Therefore, the general exclusion for IP cisplatin therapy as unproven must be modified so that payment may be made for this group of patients.

CHAPTER 4

2. Section 6.1, page 2. Added hip core decompression and XSTOP to the list of EXCLUSIONS.
3. Section 8.1, page 1. Added Pillar Palatal Implant Systems to EXCLUSIONS.
4. Section 9.1.
 - a. Pages 2 - 4. Adds coverage of endovascular radiofrequency ablation/obliteration (CPT¹ procedure codes 36475 and 36476) for the treatment of saphenous venous reflux with symptomatic varicose veins as this treatment is now proven.
 - b. Page 3. Adds pulmonary vein antrum isolation/ablation for the treatment of atrial fibrillation to EXCLUSIONS.
5. Section 14.1, pages 1 and 2. Deleted HCPCS code for Peri-urethral Teflon injection. Adds cryoablation coverage for renal cell carcinoma.
6. Section 18.1, pages 1 and 2. Adds coverage of progesterone therapy for the prevention of preterm birth under certain conditions.
7. Section 21.1, page 1. Adds CPT¹ procedure codes for Transpupillary Thermotherapy, a proven technology.
8. Section 23.1, pages 3 and 10. Adds coverage of tandem autologous peripheral stem cell transplantation for high-risk neuroblastoma.
9. Section 24.5, page 2. Adds coverage of liver transplantation for MSUD as a proven technology.

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SUMMARY OF CHANGES (Continued)

CHAPTER 5

10. Table of Contents, page i. Added Section 5.1.
11. Section 1.1, pages 2 through 4. Adds covered indications for breast MRI and revises the EXCLUSIONS to MRIs.
12. Section 4.1, page 3. Adds PET for the diagnosis and monitoring of treatment of Alzheimer's disease, fronto-temporal dementia or other forms of dementia to EXCLUSIONS.
13. Section 5.1, page 1. New issuance on Thermography, an unproven technology.

CHAPTER 8

14. Table of Contents, page i. Adds Section 2.7, Pulsed Irrigation Evacuation (PIE).
15. Section 2.7. Adds coverage for PIE as a proven technology for treatment of patients with neurogenic bowel.

TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 1, SECTION 2.1

UNPROVEN DRUGS, DEVICES, MEDICAL TREATMENTS, AND PROCEDURES

l. The following is a partial list of drugs, devices, medical treatments, or procedures considered to be unproven. Other drugs, devices, medical treatments, or procedures also considered to be unproven are listed as specific exclusions in relevant sections of the TRICARE Policy Manual. For example, Cardiomyoplasty for treatment of heart failure is considered unproven and is listed as a specific exclusion in [Chapter 4, Section 9.1](#) (Cardiovascular System). Neither the partial list below nor the exclusions cited in other sections of the TRICARE Policy Manual provide an all inclusive list of unproven drugs, devices, medical treatments, or procedures. Other unproven drugs, devices, medical treatments, or procedures are also excluded although they do not appear in the TRICARE Policy Manual.

1. Adoptive immunotherapy using either tumor-infiltrating lymphocytes (TIL) or lymphokine-activated killer (LAK) cells, activated in vitro by recombinant or natural IL-2 or other lymphokines, for the treatment of cancer.

2. Adrenal tissue transplant to brain.

3. Autolymphocyte therapy (ALT).

4. Calcium EAP/calcium orotate and selenium (also known as Nieper therapy) - involves inpatient care and use of calcium compounds and other non-FDA approved drugs and special diets. Used for cancer, heart disease, diabetes, multiple sclerosis -- Not a proven treatment for any indication.

5. Services related to the candidiasis hypersensitivity syndrome, yeast syndrome, or gastrointestinal candidiasis are unproven (i.e., allergenic extracts of *Candida albicans* for immunotherapy and/or provocation/neutralization). Disseminated systemic candidiasis (ICD-9-CM 112.5) is a recognized diagnosis, and medically necessary treatment is covered.

6. Cellular therapy (HCPCS procedure code M0075).

7. Chelation therapy, except when using FDA-approved chelators for FDA-approved indications.

8. Diaphanography (Transillumination Light Scanning).

9. Dynamic Posturography (both static and computerized) (CPT¹ procedure code 92548).

10. Electric reflex salivary stimulation (Salitron® Electrostimulation System) in the treatment of xerostomia (dry mouth) secondary to Sjogren's syndrome (HCPCS procedure code E0755).

11. Eye movement desensitization and reprocessing therapy (EMDR) for treatment of psychiatric and behavioral disorders.

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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 1, SECTION 2.1

UNPROVEN DRUGS, DEVICES, MEDICAL TREATMENTS, AND PROCEDURES

12. Growth factor, including platelet-derived growth factors, for treating non-healing wounds. This includes Procuren®, a platelet-derived wound-healing formula.
13. Hand transplant from a cadaver donor.
14. Histamine therapy.
15. Holding therapy - involves holding the patient in an attempt to achieve interpersonal contact, and to improve the patient's ability to concentrate on learning tasks.
16. Hyperosmotic blood-brain barrier disruption produced by infusion of Manitol to increase drug delivery to brain tumors.
17. Hyperventilation Provocation Test (HVPT) for diagnosing hyperventilation syndrome.
18. Immunotherapy for malignant disease except when using drugs approved by the FDA for this purpose.
19. Intracavitary administration of cisplatin for malignant disease, **except for patients with optimally debulked Stage III ovarian cancer.**
20. Iridology (links flaws in eye coloration with disease elsewhere in the body).
21. Light therapy for Seasonal Depression (also known as seasonal affective disorder (SAD)). This therapy uses varying degrees of light to treat depression.
22. Neurofeedback.
23. All organ transplants not listed as covered in the TRICARE Policy Manual or [32 CFR 199.4\(e\)\(5\)](#).
24. Portable nocturnal hypoglycemia monitors.
25. Pupillometry.
26. Sensory afferent stimulation (SAS) devices for relief of nausea (e.g., Relief Band®).
27. Spinoscopy. Use of a Spinoscope with skin markers to assess the function of the spine.
28. Synaptic 2000 for acute and chronic pain.
29. Tinnitus Masker.
30. Transdermal nicotine therapy used to treat ulcerative colitis.

MUSCULOSKELETAL SYSTEM

ISSUE DATE: August 26, 1985

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

I. CPT¹ PROCEDURE CODES

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

II. DESCRIPTION

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

III. POLICY

A. Services and supplies required in the diagnosis and treatment of illness or injury involving the musculoskeletal system are covered. 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 Food and Drug Administration.

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.

IV. EXCLUSIONS

A. Percutaneous vertebroplasty (CPT¹ procedure codes 22520-~~22525~~) is unproven.

B. Percutaneous kyphoplasty (CPT¹ procedure codes 22523-22525) for the treatment of vertebral fractures is unproven.

C. Meniscal transplant (CPT¹ procedure code 29868) for meniscal injury is unproven.

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

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CHAPTER 4, SECTION 6.1

MUSCULOSKELETAL SYSTEM

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

F. Trigger point injection (CPT² procedure codes 20552, 20553) for migraine headaches.

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

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

I. Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace, cervical; single interspace (CPT² procedure code 0090T) each additional interspace (CPT² procedure code 0092T) is unproven.

J. Removal of total disc arthroplasty anterior approach cervical; single interspace (0093T) each additional interspace (CPT² procedure code 0095T). Also see [Chapter 4, Section 1.1](#).

K. Artificial intervertebral disc replacement for degenerative disc disease is unproven (CPT² procedure codes 0090T - 0098T).

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

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

N. **Hip core decompression is unproven.**

- END -

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RESPIRATORY SYSTEM

ISSUE DATE: August 26, 1985
AUTHORITY: [32 CFR 199.4\(c\)\(2\)](#)

I. CPT¹ PROCEDURE CODES

30000 - 32488, 32491, 32500 - 32999, 96570, 96571

II. DESCRIPTION

The respiratory system is comprised of the tubular and cavernous organs and structures by means of which pulmonary ventilation and gas exchange between ambient air and the blood are brought about.

III. POLICY

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

B. Resection of pneumatoceles is a covered procedure.

C. Lung Volume Reduction Surgery (LVRS) is a covered procedure, see [Chapter 4, Section 8.2](#).

IV. EXCLUSIONS

A. Endoscopic thoracic sympathectomy for the treatment of hyperhidrosis is excluded.

B. Pillar palatal implant system for the treatment of Obstructive Sleep Apnea (OSA) is unproven.

- END -

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CARDIOVASCULAR SYSTEM

ISSUE DATE: August 26, 1985

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

I. CPT¹ PROCEDURE CODES

33010 - 33130, 33140, 33141, 33200 - 37183, 37195 - 37785, 92950 - 93272, 93303 - 93581, 93600 - 93745, 93770, 93797 - 93799

II. DESCRIPTION

The cardiovascular system involves the heart and blood vessels, by which blood is pumped and circulated through the body.

III. POLICY

A. Medically necessary services and supplies required in the diagnosis and treatment of illness or injury involving the cardiovascular system are covered.

B. Ventricular assist devices (VADs) (external and implantable) are covered if the device is FDA approved and used in accordance with FDA approved indications. VADs as destination therapy (CPT¹ 33979) are covered if they have received approval from the FDA for that purpose and are used according to the FDA-approved labeling instructions. Benefits are authorized when the procedure is performed at a TRICARE-certified heart transplantation center, a TRICARE-certified pediatric consortium heart transplantation center, or a Medicare facility which is approved for VAD implantation as destination therapy, for patients who meet all of the following conditions:

1. The patient has chronic end-stage heart failure (New York Heart Association Class IV end-stage left ventricular failure for at least 90 days with a life expectancy of less than 2 years).

2. The patient is not a candidate for heart transplantation.

3. The patient's Class IV heart failure symptoms have failed to respond to optimal medical management, including a dietary salt restriction, diuretics, digitalis, beta-blockers, and ACE inhibitors (if tolerated) for at least 60 of the last 90 days.

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4. The patient has **Left Ventricular Ejection Fraction (LVEF)** less than 25%.

5. The patient has demonstrated functional limitation with a peak oxygen consumption of less than 12 ml/kg/min; or the patient has a continued need for intravenous inotropic therapy owing to symptomatic hypotension, decreasing renal function, or worsening pulmonary congestion.

6. The patient has the appropriate body size (by device per FDA labeling) to support the VAD implantation.

C. Gamma and beta intracoronary radiotherapy (brachytherapy) is covered for the treatment of in-stent restenosis in native coronary arteries.

D. Transmyocardial **Revascularization (TMR)** (CPT² procedures codes 33140 and 33141).

1. Coverage is available for patients with stable class III or IV angina which has been found refractory to standard medical therapy, including drug therapy at the maximum tolerated or maximum safe dosages. In addition, the angina symptoms must be caused by areas of the heart not amenable to surgical therapies such as percutaneous transluminal coronary angioplasty, stenting, coronary atherectomy or coronary bypass.

2. Coverage is limited to those uses of the laser used in performing the procedure which have been approved by the FDA for the purpose for which they are being used.

E. TMR as an adjunct to **Coronary Artery Bypass Graft (CABG)** is covered for patients with documented areas of the myocardium that are not amenable to surgical revascularization due to unsuitable anatomy.

F. FDA approved IDE clinical trials. See [Chapter 8, Section 5.1, paragraph D.](#) and [F.](#) for policy.

G. **Endovenous radiofrequency ablation/obliteration (CPT² procedure codes 36475 and 36476) for the treatment of saphenous venous reflux with symptomatic varicose veins is covered when:**

1. **One of the following indications is present:**

a. **Persistent symptoms interfering with activities of daily living in spite of conservative/non-surgical management. Symptoms include aching, cramping, burning, itching and/or swelling during activity or after prolonged standing.**

b. **Significant recurrent attacks of superficial phlebitis.**

c. **Hemorrhage from a ruptured varix.**

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d. Ulceration from venous stasis where incompetent varices are a contributing factor.

e. Symptomatic incompetence of the great or small saphenous veins (symptoms as in paragraph III.G.1.a.).

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

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

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

1. There is no evidence of end-organ damage;

2. Office blood pressure greater than 140/90 mm Hg on at least three separate clinic/office visits with two separate measurements made at each visit; and

3. At least two blood pressure measurements taken outside the office which are less than 140/90 mm Hg.

IV. EXCLUSIONS

A. Thermogram; cephalic (CPT³ procedure code 93760); peripheral (CPT³ 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 carotid, vertebral and cerebral arteries is unproven.

F. Signal-Average Electrocardiography (CPT³ procedure code 93278) is unproven.

G. Primary percutaneous transluminal mechanical thrombectomy (CPT³ procedure code 37184) with or without second and all subsequent vessel(s) with the same vascular family (CPT³ procedure code 37185) is unproven.

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CHAPTER 4, SECTION 9.1

CARDIOVASCULAR SYSTEM

H. Secondary percutaneous transluminal thrombectomy (CPT⁴ procedure code 37186) is unproven.

I. Percutaneous transluminal mechanical thrombectomy vein(s) including intraprocedural pharmacological thrombolytic injections and fluroscopic guidance (CPT⁴ procedure code 37187) is unproven.

J. Percutaneous transluminal mechanical thrombectomy, vein(s) including intraprocedural pharmacological thrombolytic injections and fluroscopic guidance, repeat treatment on subsequent day during course of thrombolytic therapy (CPT⁴ procedure code 37188) is unproven.

K. Pulmonary vein antrum isolation/ablation for treatment of atrial fibrillation is unproven.

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 ventricular assist devices as destination therapy.

D. December 1, 2003, for endovenous radiofrequency ablation/obliteration.

E. January 1, 2005, for ABPM.

- 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 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 50542) 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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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. Laparoscopic radiofrequency ablation (CPT² procedure code 50542) and percutaneous radiofrequency ablation (CPT² procedure code 50592) for renal masses/tumors are unproven.

V. EFFECTIVE DATE

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

- END -

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MATERNITY CARE

ISSUE DATE: August 26, 1985

AUTHORITY: 32 CFR 199.4(c)(2)(i), (e)(16), (g)(5), (g)(34), and (g)(36)

I. CPT¹ PROCEDURE CODES

59000 - 59899, 82105, 82106, 82731, 84702

II. DESCRIPTION

Maternity care is the medical services related to conception, delivery and abortion, including prenatal and postpartum care (generally through the sixth post-delivery week), and treatment of complications of pregnancy.

III. POLICY

A. Services and supplies associated with antepartum care (including well-being of the fetus), childbirth, postpartum care, and complications of pregnancy may be cost-shared.

B. The mother and child hospital length-of-stay benefit may not be restricted to less than 48 hours following a normal vaginal delivery and 96 hours following a cesarean section. The decision to discharge prior to those minimum length-of-stays must be made by the attending physician in consultation with the mother.

C. Maternity care for pregnancy resulting from noncoital reproductive procedures may be cost-shared.

D. Services and supplies associated with antepartum care, childbirth, postpartum care and complications of pregnancy may be cost-shared where the surrogate mother is a TRICARE beneficiary.

E. Progesterone therapy for the prevention of preterm birth is covered only when the following criteria are met:

1. Weekly injections of 17 alpha-hydroxyprogesterone caproate between 16 and 36 weeks of gestation for pregnant women with a documented history of a previous spontaneous birth at less than 37 weeks of gestation.

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2. Oral progesterone therapy or injections of 17 alpha-hydroxyprogesterone caproate are **NOT** covered for other high risk factors for preterm birth, including, but not limited to multiple gestations, short cervical length, or positive fetal tests for cervicovaginal fetal fibronectin.

IV. EXCLUSIONS

A. Services and supplies related to noncoital reproductive procedures.

B. Home Uterine Activity Monitoring (HUAM), telephonic transmission of HUAM data, or HUAM-related telephonic nurse or physician consultation for the purpose of monitoring suspected or confirmed pre-term labor is unproven.

C. Off-label use of FDA-approved drugs to induce or maintain tocolysis.

D. Lymphocyte or paternal leukocyte immunotherapy in the treatment of recurrent spontaneous fetal loss is unproven.

E. Salivary estriol test for preterm labor is unproven (CPT² procedure code 82677).

- END -

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EYE AND OCULAR ADNEXA

ISSUE DATE: August 26, 1985

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

I. CPT¹ PROCEDURE CODES

65091 - 65755, 65772 - 68899, [77600 - 77615](#)

II. DESCRIPTION

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

III. POLICY

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

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

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

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

E. Transpupillary thermotherapy (laser hyperthermia, [CPT¹ procedure codes 77600 - 77615](#)), with chemotherapy, is covered for the treatment of retinoblastoma. [See also Chapter 5, Section 5.1.](#)

IV. EXCLUSIONS

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

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

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CHAPTER 4, SECTION 21.1

EYE AND OCULAR ADNEXA

C. Orthokeratology.

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

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

- END -

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CHAPTER 4, SECTION 23.1
HIGH DOSE CHEMOTHERAPY AND STEM CELL TRANSPLANTATION

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

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

3. Neuroblastoma.

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

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

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

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

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

7. Glioblastoma multiforme.

8. Posterior fossa teratoid brain tumors.

9. Rhabdomyosarcoma and undifferentiated sarcomas.

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

11. Chronic myelogenous leukemia.

12. Waldenstrom's macroglobulinemia.

13. AL (Amyloid Light-Chain) Amyloidosis.

14. Wilms'tumor.

15. Trilateral retinoblastoma/pineoblastoma.

16. Osteosarcoma (osteogenic sarcoma).

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

C. Allogeneic bone marrow or allogeneic peripheral stem cell transplantation, with or without HDC, is covered in the treatment of the following disease processes when either a related or unrelated donor is used. The list of indications is not all inclusive. Other

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

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

14. Hyperesinophilic Syndrome.
15. Multiple myeloma when HCD with ABMT or PSCT has failed.
16. X-linked hyper-IgM Syndrome.
17. Chediak-Higashi Syndrome.
18. Langerhans Cell Histiocytosis, refractory to conventional treatment.
19. Hodgkin's disease.

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

1. Is in relapse following an adequate trial of HDC with allogeneic BMT of CML;
and
2. Qualified (or would have qualified) for authorization for HDC with allogeneic BMT according to the provisions set forth in this policy.

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

1. Aplastic anemia.
2. Acute lymphocytic or non-lymphocytic leukemias.
3. Chronic myelogenous leukemia.
4. Severe combined immunodeficiency.
5. Wiskott-Aldrich syndrome.
6. Infantile malignant osteopetrosis.
7. Blackfan-Diamond anemia.
8. Fanconi anemia.
9. Neuroblastoma.
10. X-linked lymphoproliferative syndrome.

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

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

G. TRICARE will reimburse costs for donor searches.

1. Charges for donor searches must be fully itemized and billed by the transplant center.
2. Costs for donor searches will be cost-shared in accordance with established reimbursement guidelines for outpatient diagnostic testing.
3. Donor search costs may be billed at any time. There is no limit on how many searches a transplant center may request from the search printout.

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

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

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

I. Benefits will not be allowed for stem cell harvesting and/or cryopreservation and umbilical cord blood stem cell harvesting and/or cryopreservation until the stem cell reinfusion has been completed. In the event that the patient expires prior to the stem cell reinfusion being completed, benefits for the harvesting may be allowed.

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

K. Benefits may be allowed for DNA-HLA tissue typing in determining histocompatibility.

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

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

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

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

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

IV. EXCEPTION

A demonstration project is being conducted wherein the DoD will participate in cancer treatment clinical trials under approved National Cancer Institute (NCI) protocols to include High Dose Chemotherapy with Stem Cell Rescue (HDC/SCR). Refer to the TRICARE Operations Manual, [Chapter 20, Section 2](#) for additional information regarding the demonstration project.

V. EXCLUSIONS

Benefits will not be paid for:

A. HDC with ABMT or Autologous PSCT, Allogeneic BMT or Allogeneic PSCT, with or without HDC, or Allogeneic Umbilical Cord Blood transplantation, with or without HDC, if the patient has a concurrent condition (other existing illness) that would jeopardize the achievement of successful transplantation.

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

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

D. Administration of an unproven immunosuppressant drug that is not FDA approved.

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

F. Transportation of a donor.

G. Allogeneic bone marrow transplantation for treatment of low grade non-Hodgkin's lymphoma is not a benefit.

H. Autologous umbilical cord blood transplantation therapy as this procedure is considered unproven.

I. Allogeneic bone marrow transplantation for neuroblastoma as this procedure is considered unproven.

J. Allogeneic donor bone marrow transplantation (infusion) performed with or after organ transplants for the purpose of increasing tolerance of the organ transplant is considered unproven.

K. HDC with ABMT or PSCT is not a benefit for treatment of desmoplastic small round-cell tumor.

L. HDC with ABMT or PSCT is not covered for treatment of breast cancer.

M. HDC with allogeneic BMT is not a benefit for treatment of Waldenstrom's macroglobulinemia.

N. HDC with stem cell rescue is not a benefit for the treatment of epithelial ovarian cancer.

O. HDC with allogeneic stem cell transplantation is not covered for the treatment of cold agglutinin disease.

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P Donor lymphocyte infusion if not specifically listed as covered in [paragraph III.D.](#) under POLICY above.

VI. EFFECTIVE DATES

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

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

C. November 1, 1983, for HDC with allogeneic bone marrow transplants using related donors.

D. July 1, 1989, for HDC with allogeneic bone marrow transplants using unrelated donors.

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

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

G. January 1, 1995, for allogeneic umbilical cord blood transplants.

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

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

J. January 1, 1996, for allogeneic bone marrow transplants using related 3 antigen mismatch donors for patients with undifferentiated leukemia, chronic myelogenous leukemia (CML), aplastic anemia, acute lymphocytic leukemia (ALL) or acute myelogenous leukemia (AML).

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

L. January 1, 1995, for allogeneic bone marrow transplant for hypereosinophilic syndrome.

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

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

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

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

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

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- R. July 1, 1999, for HDC with ABMT or PSCT for germ cell tumors in a second or subsequent relapse.
- S. January 1, 1998, for HDC with ABMT or PSCT for osteosarcoma (osteogenic sarcoma).
- T. June 1, 1995, for allogeneic BMT for Chediak-Higashi syndrome.
- U. January 1, 1998, for allogeneic peripheral stem cell transplantation.
- V. June 1, 2003, for Langerhans Cell Histiocytosis, refractory to conventional treatment.
- W. January 24, 2002, for allogeneic stem cell transplant for Hodgkin's disease.
- X. May 19, 2005, for tandem autologous peripheral stem cell transplant for high-risk neuroblastoma.

- END -

LIVER TRANSPLANTATION

ISSUE DATE: September 3, 1986

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

I. CPT¹ PROCEDURE CODES

47133 - 47136, 47140 - 47142

II. POLICY

A. Benefits are allowed for liver and living donor liver transplantations (LDLT).

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

2. For Standard and Extra patients residing in an MCS region, preauthorization is the responsibility of the MCS Medical Director or other designated utilization staff.

B. Liver and LDLT is covered when the transplantation is performed at a TRICARE or Medicare-certified liver transplantation center or TRICARE-certified pediatric consortium liver transplantation center for beneficiaries who:

1. Are suffering from irreversible hepatic disease; and
2. Have exhausted alternative medical and surgical treatments; and
3. Are approaching the terminal phase of their illness.
4. Demonstrate plans for a long-term adherence to a disciplined medical regimen are feasible and realistic.

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CHAPTER 4, SECTION 24.5

LIVER TRANSPLANTATION

C. Liver and LDLT transplants performed for beneficiaries suffering from irreversible hepatic disease resulting from hepatitis B or C is covered.

D. Liver transplantation for severe classical Maple Syrup Urine Disease (MSUD) not controlled by dietary restriction may be considered on a case-by-case basis under the TRICARE provisions for the treatment of rare diseases.

E. Services and supplies related to liver and LDLTs are covered for:

1. Evaluation of a potential candidate's suitability for liver transplantation whether or not the patient is ultimately accepted as a candidate for transplantation.

2. Pre- and post-transplantation inpatient hospital and outpatient services.

3. Pre- and postoperative services of the transplantation 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 transplantation procedure, including inpatient care, management of infection and rejection episodes.

10. Periodic evaluation and assessment of the successfully transplanted patient.

11. Hepatitis B and pneumococcal vaccines for patients undergoing transplantation.

12. DNA-HLA tissue typing determining histocompatibility.

13. Transportation of the patient by air ambulance and the services of a certified life support attendant.

III. POLICY CONSIDERATIONS

A. For beneficiaries who reside in TRICARE regions but fail to obtain preauthorization for liver or LDLT, benefits may be extended if the services or supplies otherwise would qualify for benefits but for the failure to obtain preauthorization. If preauthorization is not received, the appropriate preauthorizing authority is responsible for reviewing the claims to

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 UB-92 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.

a. Benefits may be allowed if:

(1) The patient has been abstinent (for at least six months prior to the transplantation is recommended); and

(2) There is no evidence of other major organ debility (e.g., cardiomyopathy); and

(3) There is evidence of ongoing participation in a social support group such as Alcoholics Anonymous; and

(4) There is evidence of a supportive family/social environment.

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.

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LIVER TRANSPLANTATION

V. EFFECTIVE DATES

A. November 1, 1994, for hepatitis C.

B. December 1, 1996, for hepatitis B.

- END -

RADIOLOGY

SECTION	SUBJECT
1.1	Diagnostic Radiology (Diagnostic Imaging)
2.1	Diagnostic Ultrasound
3.1	Radiation Oncology
4.1	Nuclear Medicine
5.1	Thermography



DIAGNOSTIC RADIOLOGY (DIAGNOSTIC IMAGING)

ISSUE DATE: March 7, 1986

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

I. CPT¹ PROCEDURE CODES

70010 - 76083, 76086 - 76394, 76400, 76496 - 76499, 95965 - 95967

II. HCPCS PROCEDURE CODES

G0204 - G0207

III. DESCRIPTION

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

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

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

A Computerized Tomography (CT)/Computerized Axial Tomography (CAT) scan is

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

IV. POLICY

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

B. Breast MRI (CPT² procedure codes 77058 and 77059) is covered for the following indications:

1. To detect breast implant rupture (the implantation of the breast implants must have been covered by TRICARE).
2. For detection of occult breast cancer in the setting of axillary nodal adenocarcinoma with negative physical exam and negative mammography.
3. For presurgical planning for locally advanced breast cancer before and after completion of neoadjuvant chemotherapy, to permit tumor localization and characterization.
4. For presurgical planning to evaluate the presence of multicentric disease in patients with locally advanced cancer who are candidates for breast conservation treatment.
5. Evaluation of suspected cancer recurrence.
6. To determine the presence of pectoralis major muscle/chest wall invasion in patients with posteriorly located tumor.

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

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

E. CT scans are covered when medically necessary, appropriate and the standard of care and all criteria stipulated in 32 CFR 199.4(e) are met. (CPT² procedure codes 70450-70498, 71250-71275, 72125-72133, 72191-72194, 73200-73206, 73700-73706, 74150-74175, 75635, and 76355-76380.)

F. TRICARE considers three-dimensional (3D) rendering (CPT² procedure codes 76376 and 76377) medically necessary under certain circumstances (see [Chapter 5, Section 2.1](#)).

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CHAPTER 5, SECTION 1.1

DIAGNOSTIC RADIOLOGY (DIAGNOSTIC IMAGING)

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

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

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

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

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

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

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

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

b. Individuals who have vertebral abnormalities.

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

d. Individuals with primary hyperparathyroidism.

e. Individuals with positive family history of osteoporosis.

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

V. EXCLUSIONS

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

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DIAGNOSTIC RADIOLOGY (DIAGNOSTIC IMAGING)

- B. Ultrafast CT (electron beam computed tomography (HCPCS code S8092)) to predict asymptomatic heart disease is preventive.
- C. MRIs (CPT⁴ procedure codes 76058 and 77059) to screen for breast cancer, for diagnosis of suspicious lesions to avoid biopsy, to evaluate response to neoadjuvant chemotherapy, to differentiate cysts from solid lesions.
- D. 3D rendering (CPT⁴ procedure codes 76376 and 76377) for monitoring coronary artery stenosis activity in patients with angiographically confirmed CAD is unproven.
- E. 3D rendering (CPT⁴ procedure codes 76376 and 76377) for evaluating graft patency in individuals who have undergone revascularization procedures is unproven.
- F. 3D rendering (CPT⁴ 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.
- G. Computed tomography angiography (CPT⁴ procedure codes 76376 and 76377) for acute ischemic stroke is unproven.
- H. Computed tomography angiography (CPT⁴ procedure codes 76376 and 76377) for intracerebral aneurysm and subarachnoid hemorrhage is unproven.
- I. Computed tomography, heart, without contrast, including image post processing and quantitative evaluation of coronary calcium (CPT⁴ procedure code 0144T) is unproven.
- J. Computed tomography, heart, without contrast material followed by contrast, material(s) and further sections, including cardiac gating and 3D image post processing; cardiac structure and morphology (CPT⁴ procedure code 0145T) is unproven.
- K. Computed tomographic angiography of coronary arteries (including native and anomalous coronary arteries, coronary bypass grafts) without quantitative evaluation of coronary calcium (CPT⁴ procedure code 0146T). Computed tomographic angiography of coronary arteries (including native and anomalous coronary arteries, coronary bypass grafts) with quantitative evaluative of coronary calcium (CPT⁴ procedure code 0147T) is unproven.
- L. Cardiac structure and morphology and computed tomographic angiography of coronary arteries (including native and anomalous coronary arteries, coronary bypass grafts) without quantitative evaluation of coronary calcium (CPT⁴ procedure code 0148T). Cardiac structure and morphology and computed tomographic angiography of coronary arteries (including native and anomalous coronary arteries, coronary bypass grafts) with quantitative evaluative of coronary calcium (CPT⁴ procedure code 0149T) is unproven.
- M. Cardiac structure and morphology in congenital heart disease (CPT⁴ procedure code 0150T). Computed tomography, heart, without contrast material followed by contrast material(s) and further sections, including cardiac gating and 3D image post processing,

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DIAGNOSTIC RADIOLOGY (DIAGNOSTIC IMAGING)

function evaluation (left and right ventricular function, ejection fraction and segmental wall motion (CPT⁵ procedure code 0152T)) is unproven.

VI. EFFECTIVE DATE

A. The effective date for MRIs with contrast media is dependent on the 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.

- END -

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CHAPTER 5, SECTION 4.1

NUCLEAR MEDICINE

- 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.

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.

- END -

THERMOGRAPHY

ISSUE DATE: October 12, 1994

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

I. DESCRIPTION

Thermography is a procedure which relies upon measurement of infrared radiation from the body for diagnostic purposes. It is used for pathology of the female breast, peripheral vascular disease, musculoskeletal injuries and for detecting cervical lesions. Thermography can include various types of the telethermographic infrared detectors/imagers or heat sensitive cholesteric liquid crystal systems that are applied to the skin.

II. POLICY

All claims for thermography should be denied on the basis of its status as unproven.

- END -

OTHER SERVICES

SECTION	SUBJECT
1.1	Ambulance Service
2.1	Durable Medical Equipment: Basic Program
2.2	Infantile Apnea Cardiorespiratory Monitor
2.3	Implantable Infusion Pump
2.4	Cold Therapy Devices For Home Use
2.5	Home Prothrombin Time (PT) International Normalized Ratio (INR) Monitor
2.6	Breast Pumps
2.7	Pulsed Irrigation Evacuation (PIE)
3.1	Orthotics
4.1	Prosthetic Devices And Supplies
5.1	Medical Devices
5.2	Neuromuscular Electrical Stimulation (NMES) Devices
6.1	Medical Supplies And Dressings (Consumables)
7.1	Nutritional Therapy
7.2	Liquid Protein Diets
8.1	Diabetes Outpatient Self-Management Training Services
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PULSED IRRIGATION EVACUATION (PIE)

ISSUE DATE: July 3, 2007

AUTHORITY: [32 CFR 199.2](#) and [32 CFR 199.4\(d\)\(3\)\(iii\)](#)

I. CPT¹ PROCEDURE CODES

91123, 99511

II. HCPCS CODES

E0350, E0352

III. DESCRIPTION

Pulsed Irrigation Evacuation (PIE) is an automated enema in which small pulses of warm tap water are delivered into the rectum, serving to rehydrate feces and promote peristalsis. The system consists of a speculum, tubing, a disposable collection container, and an electrical unit that delivers positive and negative air pressure through the tubing.

IV. POLICY

PIE may be covered for the treatment of patients with neurogenic bowel who have failed conservative therapy with bowel retraining (e.g., suppositories, digital stimulation, abdominal massage, enemas).

V. EXCLUSIONS

PIE is excluded when any of the following contraindications exist:

- A. Abdominal surgeries in the past 12 months.
- B. Renal insufficiency.
- C. Acute diverticulitis.
- D. Impactions not in the colon, i.e., ileus.

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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

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PULSED IRRIGATION EVACUATION (PIE)

E. Integrity of the colon is suspect (suspected perforation).

VI. EFFECTIVE DATE

January 1, 1997.

- END -

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