



OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
HEALTH AFFAIRS

16401 EAST CENTRETECH PARKWAY
AURORA, COLORADO 80011-9066

TRICARE
MANAGEMENT ACTIVITY

MB&RS

CHANGE 68
6010.54-M
JANUARY 15, 2008

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: OUTPATIENT PROSPECTIVE PAYMENT SYSTEM (OPPS)
PHASE II - SYSTEM UPDATE

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): This change implements coding changes for the
January 2008 OPSS update.

EFFECTIVE DATE: January 1, 2008.

IMPLEMENTATION DATE: Upon direction of the Contracting Officer.

This change is made in conjunction with Aug 2002 TSM, Change No. 53.

Reta Michak
Chief, Office of Medical Benefits
and Reimbursement Systems

ATTACHMENT(S): 15 PAGE(S)
DISTRIBUTION: 6010.54-M

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

CHANGE 68
6010.54-M
JANUARY 15, 2008

REMOVE PAGE(S)

INSERT PAGE(S)

CHAPTER 1

Section 17.1, page 1

Section 17.1, page 1

CHAPTER 4

Section 17.1, pages 1 and 2

Section 17.1, pages 1 and 2

Section 18..5, pages 1 and 2

Section 18..5, pages 1 and 2

Section 24.4, pages 1 through 5

Section 24.4, pages 1 through 5

Section 24.7, pages 1 through 5

Section 24.7, pages 1 through 5

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

ISSUE DATE: November 6, 2007

AUTHORITY:

I. CPT LEVEL II "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 prior to the 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 34, paragraph III.B](#).

B. Under TRICARE, "S" codes are not reimbursable, with the exception of S9122, S9123, and S9124 for the ECHO respite care benefit and the ECHO Home Health Care (EHHC) benefit; [S0812](#), [S1030](#), [S1031](#), [S1040](#), [S2066](#), [S2067](#), [S2068](#), [S2075](#), [S2076](#), [S2077](#), [S2083](#), [S2202](#), [S2400](#), [S2401](#), [S2402](#), [S2403](#), [S2405](#), [S2411](#), [S3818](#), [S3819](#), [S3820](#), [S3822](#), [S3823](#), [S8185](#), [S8265](#), [S8270](#), and S9430 for all beneficiaries.

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 -

FEMALE GENITAL SYSTEM

ISSUE DATE: August 26, 1985

AUTHORITY: 32 CFR 199.4(c)(2), (c)(3), (e)(3), and (g)(34)

I. CPT¹ PROCEDURE CODES

11975 - 11977, 55980, 56405 - 58301, 58340, 58345, 58346, 58350, 58353, 58356, 58400 - 58671, 58679, 58700 - 58740, 58800 - 58960, 58999, 59001

II. DESCRIPTION

The female genital system includes the female organs of reproduction.

III. POLICY

A. Services and supplies required in the diagnosis and treatment of illness or injury involving the female genital system are covered. Infertility testing and treatment, including correction of the physical cause of infertility, are covered under this provision. This does not include artificial insemination, which is excluded from coverage.

B. Uterine suspension; parametrial fixation as treatment for uterine prolapse may be cost-shared only to retain the uterus for biologic purposes.

C. Intersex surgery (CPT¹ procedure code 55980) is limited to surgery performed to correct sex gender confusion/ambiguous genitalia which is documented to have been present at birth.

NOTE: For policy on prophylactic mastectomy, prophylactic oophorectomy, and prophylactic hysterectomy, see [Chapter 4, Section 5.3](#).

IV. POLICY CONSIDERATION

Benefits are payable for Uterine Artery Embolization (UAE), as an alternative treatment (CPT¹ procedure code 37210) to hysterectomy or myomectomy, for those individuals with confirmed, symptomatic uterine fibroids who are premenopausal and who do not wish to preserve their childbearing potential.

¹ CPT codes, descriptions and other data only are copyright 2005 American Medical Association. All rights reserved. Applicable FARS/DFARS Restrictions Apply to Government use.

TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 4, SECTION 17.1

FEMALE GENITAL SYSTEM

V. EXCLUSIONS

- A. Prophylactics (condoms).
- B. Over-the-counter spermicidal products.
- C. Reversal of a surgical sterilization procedure (CPT² procedure codes 58672, 58673, 58750-58770).
- D. Artificial insemination, including any costs related to donors and semen banks (CPT² procedure codes 58321-58323).
- E. In-Vitro Fertilization (IVF), Gamete Intrafallopian Transfer (GIFT) and all other non-coital reproductive procedures, including all services and supplies related to, or provided in conjunction with, those technologies (CPT² procedure codes 58970-58976).
- F. Hysterectomy (CPT² procedure codes 58150-58285, 58550, 59525) performed solely for purposes of sterilization in the absence of pathology.
- G. Subtotal hysterectomy performed exclusively to preserve sexual function and/or to prevent postoperative complications (e.g., urinary incontinence; vaginal prolapse).
- H. Cervicography (CPT² category III procedure code 0003T) is unproven.
- I. Uterine Artery Embolization (UAE) for individuals with specific contraindications, including such conditions as pelvic malignancy and pelvic inflammatory disease, and premenopausal patients who wish to preserve their childbearing potential.

- END -

² CPT codes, descriptions and other data only are copyright 2005 American Medical Association. All rights reserved. Applicable FARS/DFARS Restrictions Apply to Government use.

FETAL SURGERY

ISSUE DATE:

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

I. HCPCS PROCEDURE CODES

[S2400](#), [S2401](#), [S2403](#), [S2405](#), [S2411](#)

II. DEFINITION

Fetal surgery is defined as an intervention consisting of opening of the gravid uterus (by either a traditional cesarean surgical incision or through single or multiple fetoscopic port incisions), surgically correcting a fetal abnormality, and either returning the fetus to the uterus (or restoring uterine closure, if the intervention has been accomplished without removal of the fetus) for completion of gestational development.

III. POLICY

A. Fetal surgery is covered for the following indications:

1. Prenatal surgical intervention consisting of vesicoamniotic shunting in fetuses with hydronephrosis due to bilateral urinary tract obstruction together with evidence of progressive oligohydramnios and evidence of adequate renal function as generally defined by normal urinary electrolytes, and with no other lethal abnormalities or chromosomal defects.
2. Prenatal surgical intervention of temporary tracheal occlusion of congenital diaphragmatic hernia (CDH) for fetuses with a prenatal diagnosis of CDH, gestational age of less than 25 weeks at time of diagnosis, and with evidence of liver herniation, and other indicators of poor prognosis, such as a low lung-to-head ratio.
3. Prenatal intervention of either an open in-utero resection of malformed pulmonary tissue or placement of a thoraco-amniotic shunt in cases of hydrothorax or large cystic lesions for fetuses congenital cystic adenomatoid malformation or extralobar pulmonary sequestration, who are of less than 32 weeks' gestation and who have evidence of progressive hydrops, placentomegaly and/or the beginnings of maternal mirror syndrome.
4. Twin-twin transfusion syndrome, gestation age of less than 25 weeks' gestation at the time of diagnosis.

TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 4, SECTION 18.5

FETAL SURGERY

5. Sacrococcygeal teratoma in the presence of fetal hydrops and/or placentomegaly in fetuses with less than 28 weeks of gestation.

B. Other conditions when determined by medical review to be medically necessary and appropriate treatment for the patient's medical condition and that reliable evidence has established in-utero surgery as safe and effective treatment.

IV. CONSIDERATION

█ The Department of Defense (DoD) In-Utero Fetal Surgical Repair of Myelomeningocele Clinical Trial Demonstration Project can be referenced in the TRICARE Operations Manual (TOM), Chapter 20, Section 3.

V. EXCLUSIONS

█ A. The in-utero repair for myelomeningocele (HCPCS S2404) and aqueductal stenosis.

B. In-utero surgery for other conditions for which the safety and effectiveness has not been established.

- END -

SMALL INTESTINE, COMBINED SMALL INTESTINE-LIVER, AND MULTIVISCERAL TRANSPLANTATION

ISSUE DATE: December 3, 1997

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

I. CPT¹ PROCEDURE CODES

44132, 44133, 44135, 44136

II. POLICY

A. Benefits are allowed for small intestine (SI), small intestine-liver (SI/L), and multivisceral transplantation.

NOTE: Multivisceral transplantation includes the en bloc graft of the stomach, pancreaticoduodenal complex, and small intestine. The liver is included for patients with irreversible liver disease. The kidney(s) is included for patients with renal failure.

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 transplant-related services from non-network civilian providers without the required PCM referral and contractor authorization, Managed Care Support (MCS) contractors shall reimburse charges for the services on a Point of Service (POS) basis. Special cost-sharing requirements apply to POS claims.

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

B. SI, SI/L, and multivisceral transplantation are covered for pediatric and adult patients who meet the following criteria:

1. Are suffering from irreversible intestinal failure. Intestinal failure is defined as the loss of absorptive capacity of the small bowel secondary to severe, primary gastrointestinal disease or surgically-induced short bowel syndrome.

¹ CPT codes, descriptions and other data only are copyright 2005 American Medical Association. All rights reserved. Applicable FARS/DFARS Restrictions Apply to Government use.

2. Have failed total parenteral nutrition (TPN). Indicators of failed TPN are liver failure, thrombosis, frequency of infection, and dehydration as demonstrated in the following clinical situations:

- a. Impending or overt liver failure due to TPN induced liver injury.
- b. Thrombosis of the major central venous channels, jugular, subclavian, and femoral veins.
- c. Frequent line infection and sepsis.
- d. Frequent episodes of severe dehydration despite intravenous fluid supplement in addition to TPN.

3. Pediatric patients have a parent or legal guardian who have a realistic understanding of the range of clinical outcomes that may be encountered for pediatric patients. Adult patients have a realistic understanding of the range of clinical outcomes that may be encountered.

4. Plans for long-term adherence to a disciplined medical regimen are feasible and realistic.

5. The transplant is performed at a TRICARE-certified SI transplantation center or TRICARE-certified pediatric consortium SI transplantation center or Medicare-certified SI transplantation center.

C. Services and supplies related to SI, SI/L, and multivisceral transplantation are covered for:

1. Evaluation of a potential candidate's suitability for SI, SI/L, and multivisceral 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. Surgical services and related pre- and postoperative services of the transplantation team.

4. Blood and blood products.

5. FDA approved immunosuppression drugs to include off-label uses when determined to be medically necessary for the treatment of the condition for which it is administered, according to accepted standards of medical practice.

6. Complications of the transplant procedure, including inpatient care, management of infection and rejection episodes.

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

8. 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.

9. The maintenance of the viability of the donor organ after all existing legal requirements for excision of the donor organ have been met.

10. Donor costs.

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

12. DNA-HLA tissue typing in 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 fail to obtain preauthorization for SI, SI/L, or multivisceral transplantation, TRICARE 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 SI, SI/L, or multivisceral transplantation benefit. Charges for transplant and transplant-related services provided to TRICARE Prime enrollees who failed to obtain PCM referral and contractor authorization will be reimbursed only under POS rules.

B. Benefits will only be allowed for transplants performed at a TRICARE-certified SI or Medicare-certified SI transplantation center. Benefits are also allowed for transplants performed at a pediatric facility that is TRICARE-certified as an SI 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 is the certifying authority for transplant centers within its region. Refer to [Chapter 11, Section 7.1](#) for organ transplant center certification requirements.

C. Effective for admissions on or after October 1, 2001, SI, SI/L, and multivisceral transplantations shall be reimbursed under the assigned DRG based on the patient's diagnosis. Claims for admissions prior to October 1, 2001, shall be reimbursed based on billed charges.

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.

TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 4, SECTION 24.4

SMALL INTESTINE, COMBINED SMALL INTESTINE-LIVER, AND MULTIVISCERAL TRANSPLANTATION

F. Acquisition and donor costs are not considered to be components of the services covered under the DRG and will be reimbursed based on billed charges. 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. SI, SI/L, or multivisceral transplants performed on an emergency basis in an unauthorized SI facility may be cost shared only when the following conditions have been met:

1. The unauthorized center must consult with the nearest TRICARE-certified or Medicare-certified SI transplantation center regarding the transplantation case; and
2. It must be determined and documented by the transplant team physician(s) at the certified SI transplantation center that transfer of the patient (to the certified SI transplantation center) is not medically reasonable, even though transplantation is feasible and appropriate.

IV. EXCLUSIONS

A. SI, SI/L, or multivisceral transplantation is excluded when any of the following contraindications exist:

1. Ability to ingest oral nutrition.
2. Serious, uncontrolled psychiatric illness that would hinder compliance with any stage of the transplant process.
3. Significant cardiopulmonary insufficiency.
4. History or presence of aggressive and/or incurable malignancy.
5. Persistent abdominal or systemic infection.
6. Severe autoimmune disease.
7. Severe immunodeficiency disease.
8. Active alcohol or chemical dependency that interferes with compliance to strict treatment regimen.
9. Inability or unwillingness of the patient or legal guardian to give signed consent and to comply with regular follow-up requirements.

TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 4, SECTION 24.4

SMALL INTESTINE, COMBINED SMALL INTESTINE-LIVER, AND MULTIVISCERAL TRANSPLANTATION

B. Also excluded are:

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.

V. EFFECTIVE DATES

- A. January 1, 1996, for small intestine alone transplants for patients under the age of 16 and combined small intestine-liver transplants for pediatric and adult patients.
- B. February 1, 1998, for multivisceral transplants.
- C. October 4, 2000, for small intestine alone transplants for patients age 16 and older.

- END -

SIMULTANEOUS PANCREAS-KIDNEY, PANCREAS-AFTER-KIDNEY, AND PANCREAS-TRANSPLANT-ALONE

ISSUE DATE: February 5, 1996

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

I. CPT¹ PROCEDURE CODES

48550 - 48556

II. POLICY

A. Benefits are allowed for simultaneous pancreas-kidney transplantation (SPK), pancreas-after-kidney transplantation (PAK), and pancreas-transplantation-alone (PTA).

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 transplant-related services from non-network civilian providers without the required PCM referral and contractor authorization. Managed Care Support (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 a Managed Care Support (MCS) region, preauthorization authority is the responsibility of the MCS Medical Director or other designated utilization staff.

B. Simultaneous pancreas-kidney transplantation (SPK) and pancreas-after-kidney transplantation (PAK) are covered when the transplantation is performed at a Medicare-approved renal transplantation center, for patients who:

1. Are suffering from concomitant, Type I Diabetes Mellitus that is resistant to exogenous therapy and end stage chronic renal disease; and

2. Have exhausted more conservative medical and surgical treatments for Type I Diabetes Mellitus and renal disease.

¹ CPT codes, descriptions and other data only are copyright 2005 American Medical Association. All rights reserved. Applicable FARS/DFARS Restrictions Apply to Government use.

3. Have a realistic understanding of the range of clinical outcomes that may be encountered.
4. Plans for long-term adherence to a disciplined medical regimen are feasible and realistic.

C. Pancreas-transplantation-alone (PTA) is covered when performed at a Medicare approved renal transplantation center, for patients who:

1. Are suffering from Type I Diabetes Mellitus;
 - a. Patient with diabetes must be beta cell autoantibody positive; or
 - b. Patient must demonstrate insulinopenia defined as a fasting C-peptide level that is less than or equal to 110% of the lower limit of normal of the laboratory's measurement method. Fasting C-peptide levels will only be considered valid with a concurrently obtained fasting glucose less than or equal to 225 mg/Dl;
2. Patients must have a history of medically-uncontrollable labile (brittle) insulin-dependent diabetes mellitus with documented recurrent, severe, acutely life-threatening metabolic complications that require hospitalization. Aforementioned complications include frequent hypoglycemia unawareness or recurring severe ketoacidosis, or recurring severe hypoglycemic attacks;
3. Patients must have been optimally and intensively managed by an endocrinologist for at least 12 months with the most medically-recognized advanced insulin formulations and delivery systems;
4. Patients must have the emotional and mental capacity to understand the significant risks associated with surgery and to effectively manage the lifelong need for immunosuppression
5. Patients must otherwise be a suitable candidate for transplantation.

D. Services and supplies related to SPK, PAK, and PTA are covered for:

1. Evaluation of a potential candidate's suitability for SPK, PAK, and PTA whether or not the patient is ultimately accepted as a candidate for transplantation.
2. Pre- and post-transplantation inpatient hospital and outpatient services.
3. Surgical services and related 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 the national standards of practice in the medical community (proven). Mycophenolate Mofetil (Cellcept) and Tacrolimus (Prograf) for the prophylaxis of organ rejection in patients receiving SPK, PAK, and PTA are covered.
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 in 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 fail to obtain preauthorization for SPK, PAK, and PTA 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 SPK transplantation benefit. Charges for transplant and transplant-related services provided to TRICARE Prime enrollees who failed to obtain PCM referral and contractor authorization will be reimbursed only under Point of Service rules.

B. Benefits for SPK, PAK, or PTA transplantation will only be allowed for transplants performed at a Medicare-approved renal transplantation center.

C. Effective for admissions on or after October 1, 1999, SPK, PAK, and PTA transplantations shall be reimbursed under the assigned DRG. Claims for admissions prior to October 1, 1999, shall be reimbursed based on billed charges.

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.

TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 4, SECTION 24.7

SIMULTANEOUS PANCREAS-KIDNEY, PANCREAS-AFTER-KIDNEY, AND PANCREAS-TRANSPLANT-ALONE

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 and will be reimbursed based on billed charges. 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 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 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.

H. SPKs, PAKs, or PTAs performed on an emergency basis in an unauthorized renal transplant facility may be cost-shared only when the following conditions have been met:

1. The unauthorized center must consult with the nearest Medicare-certified renal transplant center regarding the transplantation case; and

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

IV. EXCLUSIONS

A. SPKs, PAKs, and PTAs are excluded when any of the following contraindications exist:

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

2. Active alcohol or other substance abuse.

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

4. Significant coronary artery disease.

B. The following are also excluded:

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

TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 4, SECTION 24.7

SIMULTANEOUS PANCREAS-KIDNEY, PANCREAS-AFTER-KIDNEY, AND PANCREAS-TRANSPLANT-ALONE

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 TRICARE 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.
6. Autologous islet cell transplantation (CPT² procedure code 48160) for the treatment of chronic pancreatitis. Allogeneic islet cell transplantation for the treatment of diabetes mellitus.

V. EFFECTIVE DATES

- A. October 1, 1995, for SPK transplants.
- B. January 1, 1996, for PAK and PTA transplants.

- END -

² CPT codes, descriptions and other data only are copyright 2005 American Medical Association. All rights reserved. Applicable FARS/DFARS Restrictions Apply to Government use.

