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TRICARE
MANAGEMENT ACTIVITY

MB&RB

CHANGE 86
6010.54-M
AUGUST 29, 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: ADMINISTRATIVE CHANGES - AUGUST 2008

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): This administrative change corrects publication errors to the TRICARE Policy Manual for Change 83; revises the exclusion to Cranial Orthosis and Cranial Molding Helmets; revises the CPT Procedure Code Ranges in Chapters 3, 5, and 7; and corrects the website reference for Enteral Nutrition Product Classification.

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

Reta Michak
Chief, Office of Medical Benefits
and Reimbursement Branch

ATTACHMENT(S): 10 PAGE(S)
DISTRIBUTION: 6010.54-M

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

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REMOVE PAGE(S)

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ANESTHESIA

ISSUE DATE:

AUTHORITY: [32 CFR 199.4\(b\)\(2\)\(viii\)](#), [\(c\)\(2\)\(vii\)](#), [\(c\)\(3\)\(viii\)](#), and [\(g\)\(15\)](#)

I. CPT¹ PROCEDURE CODES

00100 - 01999, 99100, 99116, 99135, 99140

II. POLICY

- A. Anesthesia services and supplies are covered.
- B. See [Chapter 3, Section 1.2](#) for conscious sedation.

See the TRICARE Reimbursement Manual (TRM), [Chapter 1, Section 9](#) for information on reimbursement of anesthesia.

III. EXCLUSIONS

- A. Hypnotherapy.
- B. A separate benefit is not payable for anesthesia administered by the attending physician (surgeon or obstetrician) or dentist, or by the surgical, obstetrical or dental assistant. This exclusion does not apply to cases involving administration of local or regional anesthesia such as local anesthesia administered by a surgeon in the surgeon's office, by an obstetrician in a delivery room, or by an orthopedic surgeon in an operating room.

- END -

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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 - 72292, 73000 - 76083, 76086 - 76394, 76400, 76496 - 76499, 95965 - 95967, 0145T - 0151T

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:

A. 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.

B. 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.

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CHAPTER 5, SECTION 1.1

DIAGNOSTIC RADIOLOGY (DIAGNOSTIC IMAGING)

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

NOTE: For policy on breast MRI to screen for breast cancer in high risk women, see [Chapter 7, Sections 2.1 and 2.2](#).

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.)

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CHAPTER 5, SECTION 1.1

DIAGNOSTIC RADIOLOGY (DIAGNOSTIC IMAGING)

F. TRICARE considers three-dimensional (3D) rendering (CPT³ procedure codes 76376 and 76377) medically necessary under certain circumstances (see [Chapter 5, Section 2.1](#)).

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.

L. Radiological supervision and interpretation, percutaneous vertebroplasty or vertebral augmentation including cavity creation, per vertebral body; under fluoroscopic guidance (CPT³ procedure code 72291) or under CT guidance (CPT³ procedure code 72292) is covered.

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M. Multislice or multidetector row CT angiography (CPT⁴ codes 0145T - 0151T) is covered for the following indications:

1. Evaluation of heart failure of unknown origin when invasive coronary angiography +/- Percutaneous Coronary Intervention (PCI) is not planned, unable to be preformed or is equivocal.
2. In an Emergency Department (ED) for patients with acute chest pain, but no other evidence of cardiac disease (low-pretest probability), when results would be used to determine the need for further **testing** or observation.
3. Acute chest pain or unstable angina when invasive coronary angiography or a PCI cannot be performed or is equivocal.
4. Chronic stable angina and chest pain of uncertain etiology or other cardiac findings prompting evaluation for Coronary Artery Disease (CAD) (for example: new or unexplained heart failure or new bundle branch block).
 - a. When invasive coronary angiography or PCI is not planned, unable to be performed, or is equivocal; AND
 - b. Exercise stress test is unable to be performed or is equivocal; AND
 - c. At least one of the following non-invasive tests were attempted and results could not be interpreted or where equivocal or none of the following tests could be performed:
 - (1) Exercise stress echocardiography
 - (2) Exercise stress echo with dobutamine
 - (3) Exercise myocardial perfusion (Single Photon Emission Computed Tomography (SPECT))
 - (4) Pharmacologic myocardial perfusion (SPECT)
5. Evaluation of anomalous native coronary arteries in symptomatic patients when conventional angiography is unsuccessful or equivocal and when results would impact treatment.
6. Evaluation of complex congenital anomaly of coronary circulation or of the great vessels.
7. Presurgical evaluation prior to biventricular pacemaker placement.
8. Presurgical evaluation of coronary anatomy prior to non-coronary surgery (valve placement or repair; repair of aortic aneurysm or dissection).

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PULMONARY SERVICES

ISSUE DATE: April 19, 1983

AUTHORITY: [32 CFR 199.4\(b\)\(2\)\(xviii\)](#)

I. CPT¹ PROCEDURE CODES

94002 - ~~94004~~, 94010 - 94799

II. DESCRIPTION

Services provided for the diagnosis or treatment of conditions involving the lungs.

III. POLICY

A. Pulmonary services including pulmonary services provided as part of a treatment program on an inpatient or outpatient basis are covered.

B. For an indication to be covered the efficacy of the pulmonary services must be proven.

NOTE: Examples of proven indications are: cardiopulmonary or pulmonary rehabilitation for pre- and post-lung transplant patients when preauthorized by the appropriate preauthorizing authority as outlined in the Policy on heart-lung and lung transplantation; effective September 13, 1999, severe Chronic Obstructive Pulmonary Disease (COPD) on an inpatient basis; and moderate and severe COPD on an outpatient basis.

- END -

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ORTHOTICS

ISSUE DATE: September 20, 1990

AUTHORITY: [32 CFR 199.4\(d\)\(3\)\(viii\)](#)

I. DESCRIPTION

Orthotics is the field of knowledge relating to the making of an appliance or apparatus used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body.

II. POLICY

A. Orthotic devices are covered.

B. For individuals with diabetes, extra-depth shoes with inserts or custom molded shoes with inserts are covered.

C. Orthopedic braces including shoes which are an integral part of the brace--neither the shoe nor the brace is usable separately--are covered.

III. EXCLUSIONS

The following types of orthoses are excluded from TRICARE coverage:

A. Orthopedic shoes (except for orthopedic shoes which are an integral part of a brace).

B. Arch supports.

C. Shoe inserts.

D. Other supportive devices of the feet, such as, wedges, specialized fillers, heels straps, pads, shanks, etc.

E. Cranial orthosis (Dynamic Orthotic Cranioplasty Band) and cranial molding helmets for nonsynostotic positional plagiocephaly (deformational plagiocephaly, plagiocephaly without synostosis) (HCPCS S1040). **The use of this device for all other indications is excluded on the basis that this is off-label use of a device. For policy provisions on the use of**

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CHAPTER 8, SECTION 3.1

ORTHOTICS

this device for Extended Care Health Option (ECHO) beneficiaries, see Chapter 1, Section 17.1.

- END -

NUTRITIONAL THERAPY

ISSUE DATE: April 19, 1983

AUTHORITY: 32 CFR 199.4(a)(1)(i), (d)(3)(iii), (g)(57), and 32 CFR 199.5(c)

I. HCPCS PROCEDURE CODES

B4034 - B9999

II. DESCRIPTION

Nutritional therapy provides medically necessary nutrient intake for individuals with inborn errors of metabolism, medical conditions of malabsorption, pathologies of the alimentary or gastrointestinal tract, and neurological or physiological conditions which require enteral tube feedings.

III. POLICY

A. When used as the primary source of nutrition, TRICARE may cost-share medically necessary supplies and nutritional products for:

1. Enteral nutritional therapy.
2. Parenteral nutritional therapy.
3. Oral nutritional therapy.
4. Medically necessary vitamins and minerals added to the nutritional solution.
5. Intraperitoneal Nutrition (IPN) therapy when determined to be medically necessary treatment for individuals suffering from malnutrition as a result of end stage renal disease.
6. Ketogenic diet if it is part of a medically necessary admission for epilepsy. Services and supplies will be reimbursed under the DRG payment methodology.

B. Medically necessary nutritional products which are provided under [paragraph III.A.](#) and which are on the "Enteral Nutrition Product Classification List" are eligible for TRICARE cost-sharing. The list is maintained by [Noridian Administrative Services](#) and is currently available online at: <http://www.dmepdac.com/dmecsapp/do/search>.

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CHAPTER 8, SECTION 7.1

NUTRITIONAL THERAPY

C. Medical supplies and equipment required to provide the therapy are covered.

D. Nutritional therapy may be provided in the inpatient or outpatient setting.

IV. EXCLUSIONS

A. Food and food substitutes.

B. Vitamins or mineral preparations, except as provided in POLICY above or by [Chapter 8, Section 9.1](#).

C. Nutritional supplements administered solely to boost protein or caloric intake or in the absence of a medical condition for which the accepted treatment consists of or includes administration of nutritional supplements.

D. The above exclusions apply also to prenatal care.

E. For children less than one year of age who require enteral nutritional therapy, usual and customary infant formulas are excluded.

F. Except as provided in [paragraph III.A.6](#). above, services and supplies related to a ketogenic diet, including nutritional counseling, calculation of a ketogenic formula, and food substitutes.

- END -