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TRICARE  
MANAGEMENT ACTIVITY

MB&RB

CHANGE 93  
6010.54-M  
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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

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): See pages 3 and 4.

EFFECTIVE DATE: As indicated per issuance.

IMPLEMENTATION DATE: Upon direction of the Contracting Officer.



Reta Michak  
Chief, Office of Medical Benefits  
and Reimbursement Branch

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

**REMOVE PAGE(S)**

**INSERT PAGE(S)**

**CHAPTER 4**

Section 6.1, pages 1 and 2

Section 14.1, pages 1 and 2

Section 23.1, pages 7 through 10

Section 6.1, pages 1 and 2

Section 14.1, pages 1 and 2

Section 23.1, pages 7 through 10

**CHAPTER 5**

Section 1.1, pages 1 through 7

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**CHAPTER 6**

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## SUMMARY OF CHANGES

### CHAPTER 4

1. Section 6.1. Paragraph VI. revised the effective date of coverage for percutaneous vertebroplasty and balloon kyphoplasty to February 6, 2006.
2. Section 14.1. Paragraph III.E. deletes CPT code 50542 and replaces it with 50893. Paragraph IV.F. deleted, the exclusion of radiofrequency ablation for renal masses/tumors was removed.
3. Section 23.1. Paragraph III.I. This clarifies the provision for coverage of bone marrow or stem cell transplantation as follows: Bone marrow, peripheral blood stem cell and umbilical cord blood stem cell transplantation is a process which includes mobilization, harvesting, and transplant of bone marrow, peripheral blood stem cell, or umbilical cord blood stem cells and the administration of high dose chemotherapy or radiotherapy prior to the actual transplant. When bone marrow, peripheral blood stem cell or umbilical cord blood stem cell transplantation is covered, all necessary steps are included in coverage. When bone marrow, peripheral stem cell, or umbilical cord blood stem cell transplantation is noncovered, none of the steps are covered. The prophylactic harvesting, cryopreservation and storage of bone marrow, peripheral stem cells, or umbilical cord blood stem cells when proposed for possible future use if not covered. Paragraph IV.Q added exclusion for Immunoablative therapy with bone marrow or peripheral stem cell transplantation is not covered for the treatment of multiple sclerosis.

### CHAPTER 5

4. Section 1.1. Paragraph IV.B.4. corrected to: For presurgical planning to evaluate the presence of multicentric disease in patients with localized or locally advanced breast cancer who are candidates for breast conservation treatment. Paragraph VI.D. revised the effective date of coverage for CPT codes 72291 and 72292 to January 1, 2007.
5. Section 3.1. Paragraph III.J. added, paragraphs IV.D. and E. edited, coverage of high energy neutron radiotherapy for treatment of adenoid cystic carcinoma. Paragraph IV.F. deleted exclusion.

**SUMMARY OF CHANGES (Continued)**

**CHAPTER 5 (continued)**

6. Section 4.1. Paragraph III.A.6 added, coverage of PET and PET/CT for the staging and restaging of PET and PET/CT for differentiated (follicular, papillary, Hurthle cell) thyroid cancer was added. Paragraph IV.C. added, the exclusion of PET and PET/CT for the initial diagnosis of differentiated thyroid cancer and for medullar cell thyroid cancer was added. Paragraph V.J. added, effective date of February 16, 2006 was added for PET and PET/CT for thyroid cancer was added.

**CHAPTER 6**

7. Section 1.1. Paragraph IV.T. deleted CPT code 83701 as an excepted code, thereby allowing coverage for this lab test.

## MUSCULOSKELETAL SYSTEM

ISSUE DATE: August 26, 1985

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

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### I. CPT<sup>1</sup> PROCEDURE CODES

20000 - 22505, 22520 - 22525, 22532 - 22534, 22548 - 28825, 28899 - 29863, 29866, 29867, 29870 - 29999

### II. HCPCS CODES

S2360, S2361

### III. DESCRIPTION

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

### IV. POLICY

A. Services and supplies required in the diagnosis and treatment of illness or injury involving the musculoskeletal system are covered. U.S. Food and Drug Administration (FDA)-approved surgically implanted devices are also covered.

B. Effective August 25, 1997, autologous chondrocyte implantation (ACI) surgery for the repair of clinically significant, symptomatic, cartilaginous defects of the femoral condyle (medial, lateral or trochlear) caused by acute or repetitive trauma is a covered procedure. The autologous cultured chondrocytes must be approved by the FDA.

C. Single or multilevel anterior cervical microdiscectomy with allogenic or autogenic iliac crest grafting and anterior plating is covered for the treatment of cervical spondylosis.

D. Percutaneous vertebroplasty (CPT<sup>1</sup> procedure codes 22520-22522, S2360, S2361) and balloon kyphoplasty (CPT<sup>1</sup> procedure codes 22523-22525) are covered for the treatment of painful osteolytic lesions and osteoporotic compression fractures refractory to conservative medical treatment.

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CHAPTER 4, SECTION 6.1

MUSCULOSKELETAL SYSTEM

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V. EXCLUSIONS

- A. Meniscal transplant (CPT<sup>2</sup> procedure code 29868) for meniscal injury is unproven.
- B. Ligament replacement with absorbable copolymer carbon fiber scaffold is unproven.
- C. Prolotherapy, joint sclerotherapy and ligamentous injections with sclerosing agents (HCPCS procedure code M0076) are unproven.
- D. Trigger point injection (CPT<sup>2</sup> procedure codes 20552, 20553) for migraine headaches.
- E. IDET (Intradiscal Electrothermal Therapy) for Chronic Discogenic Pain (CPT<sup>2</sup> procedure codes 0062T and 0063T) is unproven.
- F. Botox (chemodenervation) for migraine headaches is unproven.
- G. Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace, cervical; single interspace (CPT<sup>2</sup> procedure code 0090T) each additional interspace (CPT<sup>2</sup> procedure code 0092T) is unproven.
- H. Removal of total disc arthroplasty anterior approach cervical; single interspace (0093T) each additional interspace (CPT<sup>2</sup> procedure code 0095T). Also see [Chapter 4, Section 1.1](#).
- I. Artificial intervertebral disc replacement for degenerative disc disease is unproven (CPT<sup>2</sup> procedure codes 0090T - 0098T).
- J. Extracorporeal shock wave, high energy involving the plantar fascia (CPT<sup>2</sup> procedure code 28890).
- K. X STOP Interspinous Process Decompression System for the treatment of neurogenic intermittent claudication secondary to lumbar spinal stenosis is unproven.
- L. Hip core decompression is unproven.

VI. EFFECTIVE DATE

**February 6, 2006**, for percutaneous vertebroplasty and balloon kyphoplasty.

- END -

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## URINARY SYSTEM

ISSUE DATE: August 26, 1985

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

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### I. CPT<sup>1</sup> 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 (CPT<sup>1</sup> procedure codes 50250 and **50593**) may be considered for coverage under the Rare Disease policy ([Chapter 1, Section 3.1](#)) on a case-by-case basis. Effective June 1, 2006.

F. Under the provisions for the treatment of rare diseases, coverage of laparoscopic radiofrequency ablation (CPT<sup>1</sup> procedure code 50542) and percutaneous radiofrequency

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ablation (CPT<sup>2</sup> procedure code 50592) may be considered on a case-by-case basis for the treatment of Renal Cell Carcinoma (RCC) and genetic syndromes associated with RCC including von Hippel-Lindau syndrome, hereditary papillary cell carcinoma, or hereditary clear-cell carcinoma for patients who are not appropriate candidates for surgical intervention.

IV. EXCLUSIONS

A. Peri-urethral Teflon injection is unproven.

B. Silastic gel implant.

C. Acrylic prosthesis (Berry prosthesis).

D. Bladder stimulators, direct or indirect, such as spinal cord, rectal and vaginal electrical stimulators, or bladder wall stimulators. Payment for any related service or supply, including inpatient hospitalization primarily for surgical implementation of a bladder stimulator.

E. Transurethral balloon dilation of the prostate (CPT<sup>2</sup> procedure code 52510) is unproven.

V. EFFECTIVE DATE

A. Transurethral Needle Ablation (TUNA) of the prostate is proven (CPT<sup>2</sup> procedure code 53852). Effective June 1, 2004.

B. March 28, 2007, for laparoscopic radiofrequency ablation or percutaneous radiofrequency ablation for the treatment of RCC and genetic syndromes associated with RCC, including von Hippel-Lindau syndrome, hereditary papillary cell carcinoma, or hereditary clear-cell carcinoma.

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

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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.

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. Bone marrow, peripheral blood stem cell and umbilical blood stem cell transplantation is a process which includes mobilization, harvesting, and transplant of bone marrow, peripheral blood stem cell, or umbilical cord blood stem cells and the administration of high dose chemotherapy or radiotherapy prior to the actual transplant. When bone marrow, peripheral blood stem cell or umbilical cord blood stem cell transplantation is covered, all necessary steps are included in coverage. When bone marrow, peripheral stem cell, or umbilical cord blood stem cell transplantation is noncovered, none of the steps are covered. The prophylactic harvesting, cryopreservation and storage of bone marrow, peripheral blood stem cells, or umbilical cord blood stem cells when proposed for possible future use is not covered. 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. 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.

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

M. 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 Diagnostic Related Group (DRG) payment system. Outpatient institutional facility charges will be paid as billed. Professional services are reimbursed under the CHAMPUS Maximum Allowable Charge (CMAC) Methodology.

N. 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.

O. 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. 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.

Q. Immunoablative therapy with bone marrow or peripheral stem cell transplantation is not covered for the treatment of multiple sclerosis

V. 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.

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- 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.
- 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.
- Y. January 1, 2006, for HDC with ABMT or PSCT for desmoplastic small round cell tumor.

- END -

## 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)

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### I. CPT<sup>1</sup> 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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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. (CPT<sup>2</sup> 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 (CPT<sup>2</sup> 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 **localized or** advanced **breast** 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. (CPT<sup>2</sup> procedure codes 70544-70549, 71555, 72159, 72198, 73225, 73725, and 74185.)

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DIAGNOSTIC RADIOLOGY (DIAGNOSTIC IMAGING)

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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. (CPT<sup>3</sup> 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 (CPT<sup>3</sup> 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 (CPT<sup>3</sup> procedure codes 71010-71035) are covered.

I. Diagnostic mammography (CPT<sup>3</sup> 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 (CPT<sup>3</sup> 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.

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- 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 (CPT<sup>4</sup> procedure code 72291) or under CT guidance (CPT<sup>4</sup> procedure code 72292) is covered.
  
- M. Multislice or multidetector row CT angiography (CPT<sup>4</sup> 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.

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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).
9. Presurgical cardiovascular evaluation for patients with equivocal stress study prior to kidney or liver transplantation.
10. Presurgical evaluation prior to electrophysiologic procedure to isolate pulmonary veins for radiofrequency ablation of arrhythmia focus.

#### V. EXCLUSIONS

- A. Bone density studies for the routine screening of osteoporosis.
- B. Ultrafast CT (electron beam CT (HCPCS code S8092)) to predict asymptomatic heart disease is preventive.
- C. MRIs (CPT<sup>5</sup> procedure codes 77058 and 77059) to screen for breast cancer in asymptomatic women considered to be at low or average risk of developing breast cancer; for diagnosis of suspicious lesions to avoid biopsy, to evaluate response to neoadjuvant chemotherapy, to differentiate cysts from solid lesions.
- D. MRIs (CPT<sup>5</sup> procedure codes 77058 and 77059) to assess implant integrity or confirm implant rupture, if implants were not originally covered or coverable.
- E. 3D rendering (CPT<sup>5</sup> procedure codes 76376 and 76377) for monitoring coronary artery stenosis activity in patients with angiographically confirmed CAD is unproven.
- F. 3D rendering (CPT<sup>5</sup> procedure codes 76376 and 76377) for evaluating graft patency in individuals who have undergone revascularization procedures is unproven.
- G. 3D rendering (CPT<sup>5</sup> 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.
- H. CT angiography (CPT<sup>5</sup> procedure codes 76376 and 76377) for acute ischemic stroke is unproven.
- I. CT angiography (CPT<sup>5</sup> procedure codes 76376 and 76377) for intracerebral aneurysm and subarachnoid hemorrhage is unproven.
- J. CT, heart, without contrast, including image post processing and quantitative evaluation of coronary calcium (ultra fast or electron beam CT) (CPT<sup>5</sup> procedure code 0144T,

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HCPCS code S8092) is excluded for symptomatic patients and for screening asymptomatic patients for CAD.

K. CT, heart, without contrast material followed by contrast, material(s) and further sections, including cardiac gating and 3D image post processing; cardiac structure and morphology (CPT<sup>6</sup> procedure code 0145T) is excluded for patients with typical anginal chest pain with high suspicion for CAD; patients with acute Myocardial Infarction (MI); and for screening asymptomatic patients for CAD.

L. Computed tomographic angiography of coronary arteries (including native and anomalous coronary arteries, coronary bypass grafts) without quantitative evaluation of coronary calcium (CPT<sup>6</sup> procedure code 0146T) is excluded for patients with typical anginal chest pain with high suspicion for CAD; patients with acute MI; and for screening asymptomatic patients for CAD.

M. Computed tomographic angiography of coronary arteries (including native and anomalous coronary arteries, coronary bypass grafts) with quantitative evaluation of coronary calcium (CPT<sup>6</sup> procedure code 0147T) is excluded for patients with typical anginal chest pain with high suspicion for CAD; patients with acute MI; and for screening asymptomatic patients for CAD.

N. 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 (CPT<sup>6</sup> procedure code 0148T) is excluded for patients with typical anginal chest pain with high suspicion for CAD; patients with acute MI; and for screening asymptomatic patients for CAD.

O. Cardiac structure and morphology and computed tomographic angiography of coronary arteries (including native and anomalous coronary arteries, coronary bypass grafts) with quantitative evaluation of coronary calcium (CPT<sup>6</sup> procedure code 0149T) is excluded for patients with typical anginal chest pain with high suspicion for CAD; patients with acute MI; and for screening asymptomatic patients for CAD.

P. Cardiac structure and morphology in congenital heart disease (CPT<sup>6</sup> procedure code 0150T) is excluded for patients with typical anginal chest pain with high suspicion for CAD; patients with acute MI; and for screening asymptomatic patients for CAD.

Q. CT, heart, without contrast material followed by contrast material(s) and further sections, including cardiac gating and 3D image post processing, function evaluation (left and right ventricular function, ejection fraction and segmental wall motion (CPT<sup>6</sup> procedure code 0151T)) is excluded for patients with typical anginal chest pain with high suspicion for CAD; patients with acute MI; and for screening asymptomatic patients for CAD.

R. Multislice or multidetector row CT angiography of less than 16 slices per sec and 1mm or less resolution is excluded.

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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 5, SECTION 1.1

DIAGNOSTIC RADIOLOGY (DIAGNOSTIC IMAGING)

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S. Dual Energy X-Ray Absorptiometry (DXA) composition study (CPT<sup>7</sup> procedure code 0028T) is unproven. |

VI. EFFECTIVE DATES

A. The effective date for MRIs with contrast media is dependent on the U.S. Food and Drug Administration (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.

C. March 31, 2006, for coverage of multislice or multidetector row CT angiography.

D. **January** 1, 2007, for CPT<sup>7</sup> procedure codes 72291 and 72292. |

E. January 1, 2007, for coverage of multislice or multidetector row CT angiography performed for presurgical evaluation prior to electrophysiological procedure to isolate pulmonary veins for radiofrequency ablation of arrhythmia focus.

- END -

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5. Prostate cancer.
6. Meningioma.
7. Low grade glioma (astrocytoma, grade I-II).
8. Glioblastoma multiforme.
9. Soft tissue sarcoma (liposarcoma).
10. Hodgkin's disease when conventional radiotherapy is contraindicated.
11. Acoustic neuromas.

F. Helium ion beam radiosurgery/radiotherapy is covered for the following indications. This 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. As primary therapy for patients with melanoma of the uveal tract, with no evidence of metastasis or extrascleral extension, and with tumors up to 24 mm in largest diameter and 14 mm in height.

2. As postoperative therapy in patients who have undergone biopsy or partial resection of the chordoma or low grade (I or II) chondrosarcoma of the basisphenoid region (skull-base chordoma or chondrosarcoma) or cervical spine.

G. Extracranial stereotactic radiosurgery/radiotherapy is covered for the following indication. This 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. Primary and metastatic lung carcinoma.

H. Frameless stereotaxy (neuronavigation) is covered for the following indications. This 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. Localization, surgical planning and guidance for intracranial tumors, skull base tumors, metastatic brain tumors, AVMs, cavernomas, chordomas, and pituitary adenomas.

2. Biopsy guidance.
3. Cerebrospinal fluid shunt placement.
4. Surgery for intractable epilepsy.
5. Spinal surgery.

I. The frameless stereotaxy device must be FDA-approved. The following devices are FDA-approved: StealthStation System, The Operating Arm, ISG Viewing Wand, MKM System, and Philips Easyguide. Other systems which are FDA-approved are also covered.

J. High energy neutron radiation treatment (CPT<sup>2</sup> procedure codes 77422 and 77423) is covered for adenoid cystic carcinoma for the following indications:

1. Unresectable, inoperable or recurrent tumors.
2. Locally advanced disease.
3. In situations where surgical extirpation would cause considerable morbidity.

#### IV. EXCLUSIONS

A. Whole body hyperthermia in the treatment of cancer is unproven. Hyperthermia for recurrent breast cancer is unproven.

B. Helium ion beam radiosurgery/radiotherapy for arteriovenous malformations and ependymoma is unproven.

C. Intra-Operative Radiation Therapy (IORT) is unproven.

D. High energy neutron radiation treatment delivery, single treatment area using a single port or parallel-opposed ports with no blocks or simple blocking (CPT<sup>2</sup> procedure code 77422) is unproven (except for treatment of adenoid cystic carcinoma, see paragraph III.J.).

E. High energy neutron radiation treatment delivery, single treatment area using a single port or parallel-opposed ports with no blocks or simple blocking one or more isocenter(s) with coplanar or non-coplanar geometry with blocking and/or wedge, and/or compensator(s) (CPT<sup>2</sup> procedure code 77423) is unproven (except for treatment of adenoid cystic carcinoma, see paragraph III.J.).

#### V. EFFECTIVE DATES

A. February 26, 1986, for proton beam radiosurgery/radiotherapy for arteriovenous malformations.

B. March 1, 1988, for proton beam radiosurgery/radiotherapy for patients with Cushing's disease or acromegaly caused by pituitary microadenoma.

C. October 6, 1988, for gamma beam (gamma knife) radiosurgery/radiotherapy for treatment of arteriovenous malformation, benign brain tumors, acoustic neuromas, pituitary adenomas, craniopharyngiomas, other tumors of the posterior fossa and pineal region tumors.

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CHAPTER 5, SECTION 3.1

RADIATION ONCOLOGY

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- D. January 1, 1990, for proton beam radiosurgery/radiotherapy for soft tissue sarcoma (liposarcoma).
- E. June 18, 1990, for proton beam radiosurgery/radiotherapy for chordomas or chondrosarcomas.
- F. January 1, 1994, for gamma beam (gamma knife) and linear accelerator radiosurgery/radiotherapy for metastatic brain tumors.
- G. January 1, 1996, for proton beam radiosurgery/radiotherapy for uveal melanoma.
- H. January 1, 1996, for helium ion beam radiosurgery/radiotherapy for uveal melanoma and chordomas or chondrosarcomas.
- I. April 1, 1996, for linear accelerator radiosurgery/radiotherapy for arteriovenous malformations and acoustic neuromas.
- J. April 26, 1996, for proton beam radiosurgery/radiotherapy for prostate cancer.
- K. October 1, 1997, for gamma knife radiosurgery/radiotherapy for high grade gliomas (glioblastoma multiforme, anaplastic astrocytomas).
- L. January 1, 1998, for extracranial stereotactic radiosurgery/radiotherapy for lung carcinoma.
- M. The date of FDA approval for frameless stereotaxy.

- END -



## NUCLEAR MEDICINE

ISSUE DATE: June 30, 1993

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

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### I. CPT<sup>1</sup> PROCEDURE CODE RANGE

78000 - 79999

### II. DESCRIPTION

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

### III. POLICY

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

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

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

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

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

1. Myocardial perfusion imaging utilizing SPECT.
2. Brain imaging utilizing SPECT for the evaluation of seizure disorder.
3. Prostatic radioimmunoscinigraphy imaging utilizing SPECT for the following indications:
  - a. Metastatic spread of prostate cancer and for use in post-prostatectomy patients in whom there is a high suspicion of undetected cancer recurrence.
  - b. Newly diagnosed patients with biopsy-proven prostate cancer at high risk for spread of their disease to pelvic lymph nodes.
4. Indium<sup>111</sup> - for detecting the presence and location of myocardial injury in patients with suspected myocardial infarction.
5. Indium<sup>111</sup> - labeled anti-TAG72 for tumor recurrence in colorectal and ovarian cancer.
6. SPECT for other indications is covered when documented by reliable evidence as safe, effective, and comparable or superior to standard care (proven).

C. Indium<sup>111</sup> Pentetreotide (Octreoscan) Scintigraphy is covered for:

1. The localization and monitoring of treatment of primary and metastatic neuroendocrine tumors.
2. Other indications when documented by reliable evidence as safe, effective, and comparable or superior to standard care (proven).

D. Bone Density Studies (CPT<sup>2</sup> procedure codes 78350, 78351) are covered for:

1. The diagnosis and monitoring of osteoporosis.
2. The diagnosis and monitoring of osteopenia.
3. Patients must present with signs and symptoms of bone disease or be considered at high-risk for developing osteoporosis. High-risk factors which have been identified as the

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standard of care by the American College of Obstetricians and Gynecologists (ACOG) include:

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

b. Individuals who have vertebral abnormalities.

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

d. Individuals with primary hyperparathyroidism.

e. Individuals with positive family history of osteoporosis.

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

#### IV. EXCLUSIONS

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

B. PET for the diagnosis and monitoring of treatment of Alzheimer's disease, fronto-temporal dementia or other forms of dementia is unproven.

C. PET and PET/CT for the initial diagnosis of differentiated thyroid cancer and for medullary cell thyroid cancer.

#### 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 <sup>111</sup>In-Capromab Pendetide, CyT 356 (ProstaScint™).

F. June 1, 1994, for Octreoscan Scintigraphy.

G. May 26, 1994, for bone density studies.

H. January 1, 2007, for PET and PET/CT for lymphoma.

I. January 1, 2006, for PET and PET/CT for pancreatic cancer.

TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 5, SECTION 4.1

NUCLEAR MEDICINE

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J. February 16, 2006, for PET and PET/CT for thyroid cancer.

- END -

**TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002**

CHAPTER 6, SECTION 1.1

GENERAL

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R. Thawing of cryopreserved, reproductive tissue, testicular/ovarian (CPT<sup>3</sup> procedure code 89354).

S. Thawing of cryopreserved, oocytes, each aliquot (CPT<sup>3</sup> procedure code 89356).

T. CPT<sup>3</sup> procedure code 83704 not covered for Low Density Lipoprotein (LDL) subclass testing.

U. Allo Map<sup>™</sup> for molecular testing is unproven for use in cardiac transplant rejection surveillance.

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