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TRICARE
MANAGEMENT ACTIVITY

MB&RB

CHANGE 93
6010.54-M
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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)
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CHANGE 93
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CHAPTER 5

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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.