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CHANGE 157
6010.57-M
FEBRUARY 16, 2016

REMOVE PAGE(S)

CHAPTER 1

Section 3.1, page 3

CHAPTER 4

Section 6.1, pages 1 - 4

Section 21.1, pages 1 and 2

Section 24.1, pages 3 - 6

Section 24.2, pages 3 - 5

Section 24.3, pages 1, 2, 5

CHAPTER 5

Section 3.1, pages 1 - 5

CHAPTER 6

Section 1.1, pages 1-3

INSERT PAGE(S)

Section 3.1, page 3

Section 6.1, pages 1 - 4

Section 21.1, pages 1 and 2

Section 24.1, pages 3 - 6

Section 24.2, pages 3 - 5

Section 24.3, pages 1, 2, 5

Section 3.1, pages 1 - 5

Section 1.1, pages 1 - 3

SUMMARY OF CHANGES

CHAPTER 1

1. Section 3.1. This change establishes Photodynamic Therapy with off-label use of Visudyne for the treatment of Central Serous Chorioretinopathy. EFFECTIVE DATE: 12/01/2014.

CHAPTER 4

2. Section 6.1. This change establishes Meniscal Allograft Transplant of the Knee treatment. EFFECTIVE DATE: 05/01/2015.
3. Section 21.1. This change establishes Photodynamic Therapy with off-label use of Visudyne for the treatment of Central Serous Chorioretinopathy. EFFECTIVE DATE: 12/01/2014.
4. Section 24.1. This change establishes AlloMap® Molecular Expression Testing for Cardiac Transplant Rejection Surveillance. EFFECTIVE DATE: 02/19/2015.
5. Section 24.2. This change establishes AlloMap® Molecular Expression Testing for Cardiac Transplant Rejection Surveillance. EFFECTIVE DATE: 02/19/2015.
6. Section 24.3. This change establishes AlloMap® Molecular Expression Testing for Cardiac Transplant Rejection Surveillance. EFFECTIVE DATE: 02/19/2015.

CHAPTER 5

7. Section 3.1. This change establishes Selective Internal Radiation Therapy with Yttrium-90 Microspheres for the Treatment of Unresectable Liver Tumors from Metastatic Breast Cancer. EFFECTIVE DATE: 07/04/2014.

CHAPTER 6

8. Section 1.1. This change establishes AlloMap® Molecular Expression Testing for Cardiac Transplant Rejection Surveillance. EFFECTIVE DATE: 02/19/2015.

2.13 Effective February 4, 2011, Radiesse® Voice laryngoplasty injections may be cost-shared for the treatment of type 1 laryngeal cleft (also described as supraglottic interarytenoid defects that extend no further than the true vocal folds).

2.14 Effective November 27, 1995, Orthotopic Liver Transplantation (OLT) may be cost-shared for the treatment of Crigler-Najjar Syndrome Type I. OLT may be performed both prior to the onset of neurological symptoms or after the onset of neurological symptoms.

2.15 Effective June 5, 2013, off-label use of intravenous immune globulin for the treatment of Hashimoto's Encephalopathy, may be considered in exceptional circumstances where there is progressive neurologic decline despite appropriate steroid therapy or where steroid therapy is contraindicated.

2.16 Effective January 4, 2013, allogeneic hematopoietic cell transplant (CPT² procedure code 38240) for the treatment of primary plasma cell leukemia.

2.17 Off-label use of Photodynamic Therapy (CPT² procedure code 67221) with Visudyne (HCPCS J3396) may be considered for cost-sharing for the treatment of retinal astrocytic hamartoma in Tuberous Sclerosis. The effective date is February 1, 2008.

2.18 Effective June 25, 2014, intracranial angioplasty with stenting (CPT² procedure code 61635) of the venous sinuses may be considered for cost-sharing for the treatment of pseudotumor cerebri (also known as idiopathic intracranial hypertension and benign intracranial hypertension).

2.19 Effective February 1, 2012, OLT (CPT² procedure code 47135) for the treatment of Acute Intermittent Porphyria.

2.20 Effective December 1, 2014, Photodynamic Therapy for the treatment of Central Serous Chorioretinopathy.

3.0 EXCLUSIONS

3.1 The off-label use of rituximab for the treatment of pediatric linear Immunoglobulin A (IgA) dermatosis is unproven.

3.2 Proton Beam Therapy (PBT)/radiosurgery/radiotherapy for the treatment of thymoma is unproven.

- END -

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Musculoskeletal System

Issue Date: August 26, 1985

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

1.0 CPT¹ PROCEDURE CODES

20005 - 20551, 20555 - 22328, 22510 - 22515, 22532 - 22856, 22861, 22864 - 27138, 27146 - 27178, 27181 - 29861, 29870 - 29913, 29999

2.0 HCPCS CODES

S2325, S2360, S2361

3.0 DESCRIPTION

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

4.0 POLICY

4.1 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.

4.2 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.

4.3 Single or multilevel anterior cervical microdiscectomy with allogeneic or autogeneic iliac crest grafting and anterior plating is covered for the treatment of cervical spondylosis.

4.4 Percutaneous vertebroplasty (CPT¹ procedure codes [22510-22512](#), S2360, S2361) and balloon kyphoplasty (CPT¹ procedure codes [22513-22515](#)) are covered for the treatment of painful osteolytic lesions and osteoporotic compression fractures refractory to conservative medical treatment.

4.5 Total Ankle Replacement (TAR) (CPT¹ procedure codes 27702 and 27703) surgery is covered if the device is FDA approved and the use is for an FDA approved indication. However, a medical necessity review is required in case of marked varus or valgus deformity.

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4.6 Core decompression of the femoral head (hip) for early (precollapse stage I or II) avascular necrosis may be considered for cost-sharing (Healthcare Common Procedure Coding System (HCPCS) code S2325).

4.7 Single-level, cervical Total Disc Replacement (TDR) (CPT² procedure code 22856) using an FDA approved cervical artificial intervertebral disc for the treatment of cervical DDD, intractable radiculopathy, and/or myelopathy is covered if the disc is used in accordance with its FDA labeled indications.

4.8 High Energy Extracorporeal Shock Wave Therapy (HE ESWT) for the treatment of plantar fasciitis is covered when all of the following conditions are met:

- Patients have chronic plantar fasciitis of at least six months duration;
- Patients have undergone and failed six months of appropriate conservative therapy; and
- HE ESWT is defined as Energy Flux Density (EFD) greater than 0.12 millijoules per square millimeter (mJ/mm²).

4.9 Meniscal allograft transplant of the knee is covered.

5.0 EXCLUSIONS

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

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

5.3 Trigger point injection (CPT² procedure codes 20552 and 20553) for migraine headaches.

5.4 Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection), cervical, second level (CPT² procedure code 22858) and three or more levels (CPT² procedure code 0375T) is unproven.

5.5 Removal of total disc arthroplasty (artificial disc), anterior approach, cervical, each additional interspace (CPT² procedure code 0095T) is unproven. Also, see [Section 1.1](#).

5.6 Lumbar total disc arthroplasty (lumbar artificial intervertebral disc revision including replacement, lumbar total disc replacement) for degenerative disc disease is unproven (CPT² procedure codes 22857, 22862, 0163T, 0164T, and 0165T).

5.7 Low Energy (LE) or radial ESWT for the treatment of plantar fasciitis is unproven. Any form of ESWT for the treatment of lateral epicondylitis is unproven.

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5.8 XSTOP Interspinous Process Decompression System (CPT³ procedure codes 0171T and 0172T, HCPCS code C1821) for the treatment of neurogenic intermittent claudication secondary to lumbar spinal stenosis is unproven.

5.9 Femoroacetabular Impingement (FAI) open surgery, surgical dislocation (CPT³ procedure codes 27140 and 27179), for the treatment of hip impingement syndrome or labral tear is unproven.

5.10 Hip arthroscopy with debridement of articular cartilage (CPT³ procedure code 29862) for the treatment of FAI is unproven.

5.11 Hip arthroscopy with femoroplasty (CPT³ procedure code 29914) treatment of FAI; cam lesion is unproven.

5.12 Hip arthroscopy with acetabuloplasty (CPT³ procedure code 29915) treatment of FAI; pincer lesion is unproven.

5.13 Hip arthroscopy with labral repair (CPT³ procedure code 29916) for treatment of FAI syndrome is unproven.

5.14 Osteochondral allograft of the humeral head with meniscal transplant and glenoid microfracture in the treatment of shoulder pain and instability is unproven.

5.15 Thermal Intradiscal Procedures (TIPs) (CPT³ procedure codes 22526, 22527, 62287, and Healthcare Common Procedure Coding System (HCPCS) code S2348) are unproven. TIPs are also known as: Intradiscal Electrothermal Annuloplasty (IEA), Intradiscal Electrothermal Therapy (IDET), Intradiscal Thermal Annuloplasty (IDTA), Percutaneous Intradiscal Radiofrequency Thermocoagulation (PIRFT), Coblation Percutaneous Disc Decompression, Nucleoplasty (also known as Percutaneous Radiofrequency (RF) Thermomodulation or Percutaneous Plasma Discectomy), Radiofrequency Annuloplasty (RA), Intradiscal Biacuplasty (IDB), Percutaneous (or Plasma) Disc Decompression (PDD), Targeted Disc Decompression (TDD), Cervical Intradiscal RF Lesioning.

5.16 Total hip resurfacing (HCPCS code S2118) for treatment of degenerative hip disease is unproven.

5.17 Spinal manipulation under anesthesia (CPT³ procedure codes 00640 and 22505) for the treatment of back pain is unproven.

5.18 Minimally Invasive Lumbar Decompression (mild[®]) for the treatment of Degenerative Disc Disease (DDD) and/or spinal stenosis is unproven.

5.19 ACI surgery for the repair of patellar cartilage lesions is unproven.

5.20 iFuse Implant System (CPT³ procedure code 27279) for treatment of sacroiliac joint pain is unproven.

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TRICARE Policy Manual 6010.57-M, February 1, 2008

Chapter 4, Section 6.1

Musculoskeletal System

5.21 Athletic pubalgia surgery is unproven.

6.0 EFFECTIVE DATES

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

6.2 May 1, 2008, for TAR.

6.3 May 1, 2008, for core decompression of the femoral head.

6.4 December 24, 2012, for single-level, cervical TDR using an FDA approved cervical artificial intervertebral disc.

6.5 December 2, 2013, for HE ESWT for plantar fasciitis.

6.6 May 1, 2015, for meniscal allograft transplant of the knee.

- END -

Chapter 4

Section 21.1

Eye And Ocular Adnexa

Issue Date: August 26, 1985

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

1.0 CPT¹ PROCEDURE CODES

0192T, 65091 - 65755, 65772 - 66172, 66180 - 68899, 77600 - 77615

2.0 DESCRIPTION

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

3.0 POLICY

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

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

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

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

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

3.6 Intrastromal Corneal Ring Segments (Intacs®) is covered for U.S. Food and Drug Administration (FDA) approved indications for beneficiaries with keratoconus who meet all of the following criteria: (1) are unable to achieve adequate vision using lenses or spectacles; and (2) for whom corneal transplant is the only remaining option. Coverage allowed effective July 17, 2005.

3.7 Optonal ExPRESS Mini glaucoma Shunt (CPT¹ procedure code 0192T) to reduce Intraocular Pressure (IOP) in the treatment of glaucoma, that cannot be controlled effectively with medications.

3.8 Off-label use of Photodynamic Therapy (CPT¹ procedure code 67221) with Visudyne (HCPCS J3396) may be considered for cost-sharing for the treatment of retinal astrocytic hamartoma in Tuberous Sclerosis. The effective date is February 1, 2008.

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3.9 Transpupillary thermotherapy (CPT² procedure code 67299) with Plaque Radiotherapy (Brachytherapy) is covered for the treatment of choroidal melanoma. See also [Chapter 5, Section 3.2](#).

3.10 Photodynamic Therapy for the treatment of Central Serous Chorioretinopathy in accordance with the TRICARE provisions for the treatment of rare diseases.

4.0 EXCLUSIONS

4.1 Refractive corneal surgery except as noted in [paragraph 3.4](#) (CPT² procedure codes 65760, 65765, 65767, 65770, 65771).

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

4.3 Orthokeratology.

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

4.5 Epikeratophakia for treatment of aphakia and myopia is unproven.

4.6 Transpupillary thermotherapy (CPT² procedure code 67299) as primary treatment of choroidal melanoma is unproven.

4.7 Canaloplasty for the treatment of glaucoma (CPT² procedure codes 66174 and 66175).

4.8 Autologous serum eye drops for the treatment of dry eye syndrome, keratitis, or ocular hypertension is unproven.

5.0 EFFECTIVE DATES

5.1 April 1, 2011, coverage for Optonal ExPRESS Mini Glaucoma Shunt.

5.2 December 1, 2014, coverage for Photodynamic Therapy for Central Serous Chorioretinopathy.

- END -

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3.6.7 Cachexia, even in the absence of major end organ failure (because of the significantly less favorable survival of these patients).

3.6.8 Obesity, with weight being an increasingly severe adverse factor as the patient exceeds by 20% of ideal weight for height and sex (because of more difficult post-operative mobilization and impaired diaphragmatic function, as well as the difficulty of weight control once corticosteroid immunosuppressant is instituted).

3.6.9 A history of a behavior pattern or psychiatric illness considered likely to interfere significantly with compliance with a disciplined medical regimen (because a lifelong medical regimen is necessary requiring multiple drugs several times a day, with serious consequences in the event of their interruption of excessible consumption).

3.6.10 Active cigarette smoking (abstinence of a minimum of four months prior to transplantation is recommended).

3.6.11 Previous thoracic or cardiac surgery or other bases for pleural adhesions may be a serious adverse factor depending upon site of thoracotomy/sternotomy, the degree of adhesions and the type of transplant anticipated (because of scar tissue and the propensity for inadequately controlled bleeding).

3.6.12 Recent or current history of gastrointestinal problems (because of common post-operative gastrointestinal problems and hemorrhage).

3.6.13 Chronic corticosteroid therapy that cannot be tapered and discontinued prior to transplantation has been considered a serious adverse factor by many (because of the increased risk of tracheal or bronchial dehiscence in the early post-operative period).

3.6.14 With chronic pulmonary infection (as with bronchiectasis, chronic or cystic fibrosis), single lung transplantation is contraindicated (because of the great likelihood of the infection extending from the contaminated native lung into the transplanted lung) and the patient must meet the criteria and benefit/risk considerations of double lung or heart-lung transplantation.

3.6.15 With significant heart disease (for example, substantial irreversible right ventricular disease or significant coronary artery disease) the patient must meet the criteria and benefit/risk considerations for heart-lung transplantation; lung transplantation and concurrent repair of the cardiac abnormality may be appropriate in unusual circumstances, as in some situations with Eisenmenger's syndrome.

3.6.16 Primary or metastatic malignancies of the lung.

3.7 Services and supplies related to heart-lung or lung transplantation are covered for:

3.7.1 Evaluation of potential candidate's suitability for heart-lung or lung transplantation, whether or not the patient is ultimately accepted as a candidate for transplantation.

3.7.2 Pre- and post-transplant inpatient hospital and outpatient services.

3.7.3 Pre- and post-operative services of the transplant team.

- 3.7.4** 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.
- 3.7.5** The maintenance of the viability of the donor organ after all existing legal requirements for excision of the donor organ have been met.
- 3.7.6** Donor costs.
- 3.7.7** Blood and blood products.
- 3.7.8** U.S. Food and Drug Administration (FDA) approved immunosuppression drugs to include off-label uses when reliable evidence documents that the off-label use is safe, effective and in accordance with nationally accepted standards of practice in the medical community (proven).
- 3.7.9** Complications of the transplant procedure, including inpatient care, management of infection and rejection episodes.
- 3.7.10** Periodic evaluation and assessment of the successfully transplanted patient.
- 3.7.11** Cardiac rehabilitation.
- 3.7.12** Pulmonary rehabilitation for pre- and post-lung and heart-lung transplants
- 3.7.13** Transportation of the patient by air ambulance and the services of a certified life support attendant.
- 3.7.14** Deoxyribonucleic Acid-Human Leucocyte Antigen (DNA-HLA) tissue typing in determining histocompatibility.
- 3.8** TRICARE may cost-share for epoprostenol (FLOLAN®) for the management of severe secondary pulmonary hypertension, including those for patients with pulmonary hypertension secondary to the scleroderma spectrum of diseases, whether or not they have been authorized for and are awaiting lung transplantation.

3.9 AlloMap® molecular expression testing for cardiac transplant rejection surveillance.

4.0 POLICY CONSIDERATION

4.1 In those cases where the beneficiary fails to obtain preauthorization, benefits may be extended if the services of 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 heart-lung or lung 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.

4.2 Benefits will only be allowed for transplants performed at a TRICARE or Medicare-certified heart, heart-lung or lung transplantation center. Benefits are also allowed for transplants

TRICARE Policy Manual 6010.57-M, February 1, 2008

Chapter 4, Section 24.1

Heart-Lung And Lung Transplantation

performed at a pediatric facility that is TRICARE-certified as a heart, heart-lung, or lung 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.

4.3 Heart-lung, and lung transplantation will be paid under the DRG.

4.4 Claims for transportation of the donor organ and transplant 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.

4.5 Charges made by the donor hospital will be cost-shared on an inpatient basis and must be fully itemized and billed by the transplant center in the name of the TRICARE patient.

4.6 Acquisition and donor costs are not considered to be components of the services covered under the DRG. These costs must be billed separately on a standard Centers for Medicare and Medicaid Services (CMS) 1450 UB-04 claim form in the name of the TRICARE patient.

4.7 When a properly preauthorized transplant 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.

4.8 Heart-lung and lung transplants performed on an emergency basis in an unauthorized heart-lung or lung transplant facility may be cost-shared only when the following conditions have been met:

4.8.1 The unauthorized center must consult with the nearest TRICARE or Medicare-certified heart-lung or lung transplantation center regarding the transplantation case; and

4.8.2 It must be determined and documented by the transplant team physician(s) at the certified heart-lung or lung transplantation center that transfer of the patient (to the certified heart-lung or lung transplantation center) is not medically reasonable, even though transplantation is feasible and appropriate.

5.0 EXCLUSIONS

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

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

5.3 Administration of an unproven immunosuppressant drug that is not FDA approved or has not received approval as an appropriate "off label" drug indication.

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

TRICARE Policy Manual 6010.57-M, February 1, 2008

Chapter 4, Section 24.1

Heart-Lung And Lung Transplantation

5.5 Transportation of an organ donor.

6.0 EFFECTIVE DATES

6.1 February 28, 1991, for heart-lung and lung transplantation.

6.2 May 1, 1996, for epoprostenol.

6.3 June 1, 1997, for living donor lobar lung transplantation.

6.4 February 19, 2015, for AlloMap® molecular expression test.

- END -

TRICARE Policy Manual 6010.57-M, February 1, 2008

Chapter 4, Section 24.2

Heart Transplantation

2.3.14 Insulin-requiring diabetes mellitus (because the diabetes is often accompanied by occult vascular disease and because the diabetes and its complications are exacerbated by chronic corticosteroid therapy).

2.3.15 Asymptomatic severe peripheral or cerebrovascular disease (because of accelerated progression in some patients after cardiac transplantation and chronic corticosteroid treatment).

2.3.16 Peptic ulcer disease (because of the likelihood of early postoperative exacerbation); and

2.3.17 Current or recent history of diverticulitis (considered as a source of active infection which may be exacerbated with the initiation of immunosuppressant therapy).

2.4 Services and supplies related to heart transplantation are covered for:

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

2.4.2 Pre- and post-transplant inpatient hospital and outpatient services.

2.4.3 Pre- and post-operative services of the transplant team.

2.4.4 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.

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

2.4.6 Blood and blood products.

2.4.7 U.S. Food and Drug Administration (FDA) approved immunosuppression drugs to include off-label uses when reliable evidence documents the off-label use is safe, effective, and provided in accordance with nationally accepted standards of practice in the medical community (proven).

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

2.4.9 Periodic evaluation and assessment of the successfully transplanted patient.

2.4.10 Cardiac rehabilitation.

2.4.11 Deoxyribonucleic Acid-Human Leucocyte Antigen (DNA-HLA) tissue typing in determining histocompatibility.

2.4.12 Donor costs.

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

2.5 Ventricular assist devices are covered if the device is FDA approved and used in accordance with FDA approved indications.

2.6 The SynCardia temporary Total Artificial Heart (TAH) for the treatment of end-stage biventricular heart failure is covered when used as a bridge to heart transplantation.

2.7 TAHs as destination therapy may be covered if the device has received a Humanitarian Device Exemption (HDE) from the FDA, and the device is used in accordance with FDA approved indications. See [Chapter 8, Section 5.1](#) for the policy regarding HDEs.

2.8 AlloMap® molecular expression testing for cardiac transplant rejection surveillance.

3.0 POLICY CONSIDERATIONS

3.1 For beneficiaries who reside in TRICARE regions but fail to obtain preauthorization for heart transplantation, 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 heart transplant. 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.

3.2 Benefits will only be allowed for transplants performed at a TRICARE or Medicare approved heart transplantation center. Benefits are also allowed for transplants performed at a pediatric facility that is TRICARE-certified as a heart transplantation center on the basis that the center belongs to a pediatric consortium program whose combined experience and survival data meet the TRICARE criteria for certification. The contractor in whose jurisdiction the center is located is the certifying authority for TRICARE authorization as a heart transplantation center. Refer to [Chapter 11, Section 7.1](#) for organ transplant center certification requirements.

3.3 Heart transplantation will be paid under the Diagnostic Related Group (DRG).

3.4 Claims for transportation of the donor organ and transplant 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.

3.5 Charges made by the donor hospital will be cost-shared on an inpatient basis and must be fully itemized and billed by the transplant center in the name of the TRICARE patient.

3.6 Acquisition and donor costs are not considered to be components of the services covered under the DRG. These costs must be billed separately on a standard Centers for Medicare and Medicaid Services (CMS) 1450 UB-04 claim form in the name of the TRICARE patient.

3.7 When a properly preauthorized transplant 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.

TRICARE Policy Manual 6010.57-M, February 1, 2008

Chapter 4, Section 24.2

Heart Transplantation

3.8 Heart transplantations performed on an emergency basis in an unauthorized heart transplant facility may be cost-shared only when the following conditions have been met:

3.8.1 The unauthorized center must consult with the nearest TRICARE or Medicare-approved center regarding the transplantation case; and

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

4.0 EXCLUSIONS

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

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

4.3 Administration of an unproven immunosuppressant drug that is not FDA approved or has not received approval as an appropriate "off-label" drug indication.

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

4.5 Transportation of an organ donor.

4.6 Prolonged extracorporeal circulation for cardiopulmonary insufficiency (CPT² procedure codes 33960 and 33961).

5.0 EFFECTIVE DATES

5.1 November 7, 1986, for heart transplants.

5.2 The date of FDA approval for ventricular assist devices.

5.3 July 18, 2005, for the SynCardia temporary TAH as a bridge to heart transplantation.

5.4 The date of FDA approval for TAHs as destination therapy.

5.5 February 19, 2015, for AlloMap[®] molecular expression testing for cardiac transplant rejection surveillance.

- END -

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Combined Heart-Kidney Transplantation (CHKT)

Issue Date: May 7, 1999

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

1.0 POLICY

1.1 Combined Heart-Kidney Transplantation (CHKT) is a TRICARE benefit that requires preauthorization.

1.1.1 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 Contractors (MCSCs) shall reimburse charges for the services on a Point of Service (POS) basis. Special cost-sharing requirements apply to POS claims.

1.1.2 For non-enrolled TRICARE beneficiaries residing in a Managed Care Support (MCS) region, preauthorization authority is the responsibility of the MCS Medical Director or other designated utilization staff.

1.2 The designated preauthorizing authority shall only use the criteria contained in this policy when preauthorizing simultaneous heart-kidney transplantation.

1.3 CHKT is covered when the transplantation is performed at a center certified by TRICARE or Medicare for heart transplantation or TRICARE-certified pediatric consortium heart transplantation center and Medicare-approved for renal transplantation, for patients who:

1.3.1 Are suffering from end stage heart disease and irreversible or end stage renal disease; and

1.3.2 Have exhausted more conservative medical and surgical treatments.

1.3.3 Have a realistic understanding of the range of clinical outcomes that may be encountered.

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

TRICARE Policy Manual 6010.57-M, February 1, 2008

Chapter 4, Section 24.3

Combined Heart-Kidney Transplantation (CHKT)

1.4 Services and supplies related to CHKT is covered for:

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

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

1.4.3 Surgical services and related pre- and postoperative services of the transplantation team.

1.4.4 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.

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

1.4.6 Donor costs.

1.4.7 Blood and blood products.

1.4.8 U.S. Food and Drug Administration (FDA) approved immunosuppression drugs to include off-label uses when determined to be medically necessary and generally accepted practice within the general medical community (i.e., proven).

1.4.9 Complications of the transplantation procedure, including inpatient care, management of infection and rejection episodes.

1.4.10 Periodic evaluation and assessment of the successfully transplanted patient.

1.4.11 Hepatitis B and pneumococcal vaccines for patients undergoing transplantation are covered under TRICARE.

1.4.12 Deoxyribonucleic Acid-Human Leucocyte Antigen (DNA-HLA) tissue typing in determining histocompatibility are covered under TRICARE.

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

1.4.14 AlloMap® molecular expression testing for cardiac transplant rejection surveillance.

2.0 POLICY CONSIDERATIONS

3.0 For beneficiaries who fail to obtain preauthorization for CHKT, TRICARE benefits may be extended if the services or supplies otherwise would qualify for coverage but for the failure to obtain preauthorization. If preauthorization is not received, the appropriate preauthorizing authority as outlined in [paragraph 1.1](#), is responsible for reviewing the claims to determine whether the beneficiary's condition meets the clinical criteria for the CHKT 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.

TRICARE Policy Manual 6010.57-M, February 1, 2008

Chapter 4, Section 24.3

Combined Heart-Kidney Transplantation (CHKT)

4.2.4 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).

4.2.5 Transportation of an organ donor.

5.0 EFFECTIVE DATES

5.1 March 27, 1997.

5.2 February 19, 2015, AlloMap® molecular expression testing for cardiac transplant rejection surveillance.

- END -

Radiation Oncology

Issue Date: March 27, 1991

Authority: [32 CFR 199.4\(b\)\(2\)](#), [\(b\)\(2\)\(x\)](#), [\(c\)\(2\)\(viii\)](#), and [\(g\)\(15\)](#)

1.0 CPT¹ PROCEDURE CODES

[37243](#), 61793, 61795, 77261 - 77421, 77427 - 77799, 0073T

2.0 HCPCS PROCEDURE CODES

G0339, G0340

3.0 DESCRIPTION

3.1 Radiation therapy is also known as radiotherapy, radiation treatment, x-ray therapy, cobalt therapy, and proton beam therapy. The primary purpose of radiation therapy is to eliminate or shrink localized cancers (as opposed to cancers that have spread to distant parts of the body).

3.2 Stereotactic radiosurgery/radiotherapy is a method of delivering ionizing radiation to small intracranial targets. Stereotactic radiosurgery entails delivering a high dose in a single session. Stereotactic radiotherapy entails fractionating the dose over a number of treatments.

3.2.1 There are three main variations of stereotactic radiosurgery/radiotherapy: gamma beam or gamma knife, linear accelerator (linac), and charged particle beam (proton or helium ion). The three radiation delivery devices differ technically in several ways: source of radiation, size and shape of the radiation field, and range of radiation dosages.

3.2.2 The radiosurgical/radiotherapy procedure is preceded by a process of localizing the target, which can be performed with one or more of the following techniques: skull x-ray, cerebral angiography, Computerized Tomography (CT), or Magnetic Resonance Imaging (MRI).

4.0 POLICY

4.1 Radiation therapy (fast neutron, hyperfractionated, and radioactive chromic phosphate synoviorthesis) is covered for those indications documented by reliable evidence as safe, effective and comparable or superior to standard care (proven). For coverage on brachytherapy/radiation therapy, see [Section 3.2](#).

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4.2 Gamma knife 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).

- Arteriovenous Malformations (AVMs).
- Benign brain tumors.
- Acoustic neuromas (vestibular Schwannomas).
- Pituitary adenomas.
- Craniopharyngiomas.
- Other tumors of the skull base.
- Pineal region tumors.
- Metastatic brain tumors.
- High grade gliomas (glioblastoma multiforme, anaplastic astrocytomas).

4.3 Linear accelerator 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).

- AVMs.
- Acoustic neuromas (vestibular Schwannomas).
- Metastatic brain tumors.

4.4 Proton 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).

- AVMs.
- Cushing's disease or acromegaly caused by pituitary microadenomas.
- 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.
- As primary therapy for patients with uveal melanoma, with no evidence of metastasis or extrascleral extension, and with tumors up to 22 mm in largest diameter and 14 mm in height.
- Prostate cancer.
- Meningioma.
- Low grade glioma (astrocytoma, grade I-II).
- Glioblastoma multiforme.
- Soft tissue sarcoma (liposarcoma).
- Hodgkin's disease when conventional radiotherapy is contraindicated.
- Acoustic neuromas.
- As post-operative therapy for sacral chordoma under the rare disease policy as described in [Chapter 1, Section 3.1](#).

4.5 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).

4.5.1 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.

4.5.2 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.

4.6 Extracranial stereotactic radiosurgery/radiotherapy including image-guided robotic linear accelerator-based stereotactic body radiotherapy (SBRT) (CPT² procedure codes 77435, 77373 and HCPCS codes G0339, G0340) and all related medically necessary services and supplies (CPT² procedure code 55876) are covered for the following indications.

- Primary and metastatic lung carcinoma.
- Prostate cancer.

4.7 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).

- Localization, surgical planning and guidance for intracranial tumors, skull base tumors, metastatic brain tumors, AVMs, cavernomas, chordomas, and pituitary adenomas.
- Biopsy guidance.
- Cerebrospinal fluid shunt placement.
- Surgery for intractable epilepsy.
- Spinal surgery.

4.8 The frameless stereotaxy device must be U.S. Food and Drug Administration (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.

4.9 High energy neutron radiation treatment (CPT² procedure codes 77422 and 77423) is covered for adenoid cystic carcinoma for the following indications:

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

4.10 The off-label use of Selective Internal Radiation Therapy (SIRT), also known as radioembolization, with yttrium-90 microspheres (resin or glass) for the treatment of unresectable liver tumors from metastatic breast cancer is safe, effective, and in accordance with nationally accepted standards of practice in the medical community.

5.0 EXCLUSIONS

5.1 Helium ion beam radiosurgery/radiotherapy for AVMs and ependymoma is unproven.

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

5.3 High energy neutron radiation treatment delivery, single treatment area using a single port or parallel-opposed ports with no blocks or simple blocking (CPT³ procedure code 77422) is unproven (except for treatment of adenoid cystic carcinoma, see [paragraph 4.9](#)).

5.4 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) (CPT³ procedure code 77423) is unproven (except for treatment of adenoid cystic carcinoma, see [paragraph 4.9](#)).

5.5 Proton Beam Therapy (PBT)/radiosurgery/radiotherapy for the treatment of thymoma is unproven.

6.0 EFFECTIVE DATES

6.1 February 26, 1986, for proton beam radiosurgery/radiotherapy for AVMs.

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

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

6.4 January 1, 1990, for proton beam radiosurgery/radiotherapy for soft tissue sarcoma (liposarcoma).

6.5 June 18, 1990, for proton beam radiosurgery/radiotherapy for chordomas or chondrosarcomas.

6.6 January 1, 1994, for gamma beam (gamma knife) and linear accelerator radiosurgery/radiotherapy for metastatic brain tumors.

6.7 January 1, 1996, for proton beam radiosurgery/radiotherapy for uveal melanoma.

6.8 January 1, 1996, for helium ion beam radiosurgery/radiotherapy for uveal melanoma and chordomas or chondrosarcomas.

6.9 April 1, 1996, for linear accelerator radiosurgery/radiotherapy for AVMs and acoustic neuromas.

6.10 April 26, 1996, for proton beam radiosurgery/radiotherapy for prostate cancer.

6.11 October 1, 1997, for gamma knife radiosurgery/radiotherapy for high grade gliomas (glioblastoma multiforme, anaplastic astrocytomas).

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TRICARE Policy Manual 6010.57-M, February 1, 2008

Chapter 5, Section 3.1

Radiation Oncology

6.12 January 1, 1998, for extracranial stereotactic radiosurgery/radiotherapy for lung carcinoma.

6.13 The date of FDA approval for frameless stereotaxy.

6.14 October 24, 2014, for image-guided robotic linear accelerator-based stereotactic body radiation therapy (SBRT) and all related medically necessary services and supplies for the treatment of prostate cancer.

6.15 July 4, 2014, for the off-label use of SIRT, also known as radioembolization, with yttrium-90 microspheres (resin or glass) for the treatment of unresectable liver tumors from metastatic breast cancer.

- END -

Chapter 6

Section 1.1

General

Issue Date:

Authority: 32 CFR 199.4(a)(1)(i), (b)(2)(ix), (b)(2)(xviii), (b)(3)(vi), (b)(3)(xv), (c)(2)(ix), (c)(2)(x), and (g)(60)

1.0 CPT¹ PROCEDURE CODES

80048 - 87622, 87640, 87641, 87650 - 87999, 88104 - 89264, 89330 - 89399

2.0 DESCRIPTION

2.1 Pathology is the medical science and specialty practice that deals with all aspects of disease, but with special reference to the essential nature, the causes, and development of abnormal conditions, as well as the structural and functional changes that result from disease processes.

2.2 The surgical pathology services include accession, examination, and reporting for a specimen which is defined as tissue that is submitted for individual and separate attention, requiring individual examination and pathologic diagnosis. These codes require gross and microscopic examination.

3.0 POLICY

3.1 Pathology and laboratory services are covered except as indicated.

3.2 Surgical pathology procedures, billed by a pathologist, are covered services.

3.3 If the operating surgeon bills for surgical pathology procedures, they will be denied as incidental, since the definitive (microscopic) examination will be performed later, after fixation of the specimen, by the pathologist who will bill separately.

3.4 Dermatologists are qualified to perform surgical pathology services. Therefore, if a dermatologist bills for both the surgical procedure (e.g., CPT¹ procedure code 11100, skin biopsy) as well as the surgical pathology, both procedures are covered in full.

3.5 Human papillomavirus testing (CPT¹ procedure codes 87620 - 87622) is covered as a **diagnostic test** for the assessment of women with Atypical Squamous Cells of Undetermined Significance (ASCUS) detected **during a Pap smear**.

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3.6 The Nuclear magnetic Resonance (NMR) LipoProfile-2 test, used with the NMR Profiler (CPT² procedure codes 83701 and 83704) is proven and covered for the management of lipoprotein disorders associated with cardiovascular disease.

3.7 For transfusion services, refer to [Section 2.1](#).

3.8 AlloMap[®] for molecular testing is proven for use in cardiac transplant rejection surveillance.

4.0 EXCLUSIONS

4.1 Autopsy and postmortem (CPT² procedure codes 88000 - 88099).

4.2 Sperm penetration assay (hamster oocyte penetration test or the zona-free hamster egg test) is excluded for In vitro Fertilization (IVF) (CPT² procedure code 89329).

4.3 In-vitro chemoresistance and chemosensitivity assays (stem cell assay, differential staining cytotoxicity assay and thymidine incorporation assay) are unproven.

4.4 Hair analysis to identify mineral deficiencies from the chemical composition of hair is unproven. Hair analysis testing (CPT² procedure code 96902) may be reimbursed when necessary to determine lead poisoning.

4.5 Insemination of oocytes (CPT² procedure code 89268).

4.6 Extended culture of oocyte(s) embryo(s) four to seven days (CPT² procedure code 89272).

4.7 Assisted oocyte fertilization, microtechnique; less than or equal to 10 oocytes (CPT² procedure code 89280). Assisted oocyte fertilization, microtechnique; greater than 10 oocytes (CPT² procedure code 89281).

4.8 Biopsy oocyte polar body or embryo blastomere (CPT² procedure code 89290). Biopsy oocyte polar body or embryo blastomere; greater than four embryos (CPT² procedure code 89291).

4.9 Cryopreservation reproductive tissue, testicular (CPT² procedure code 89335).

4.10 Storage (per year) embryo(s) (CPT² procedure code 89342). Storage (per year) sperm/semen (CPT² procedure code 89343). Storage (per year) reproductive tissue, testicular/ovarian (CPT² procedure code 89344). Storage (per year) oocyte (CPT² procedure code 89346).

4.11 Thawing of cryopreserved, embryo(s) (CPT² procedure code 89352). Thawing of cryopreserved, sperm/semen, each aliquot (CPT² procedure code 89353). Thawing of cryopreserved, reproductive tissue, testicular/ovarian (CPT² procedure code 89354). Thawing of cryopreserved, oocytes, each aliquot (CPT² procedure code 89356).

4.12 Oncotype Dx (S3854) is not covered due to the lack of U.S. Food and Drug Administration (FDA) status.

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4.13 OVA1™ test for ovarian cancer.

4.14 The Pathwork® Tissue of Origin Test is unproven to assist in identifying the origin of poorly differentiated, undifferentiated, or metastatic tumors.

5.0 EFFECTIVE DATES

5.1 July 23, 2008, for NMR LipoProfile-2 test, used with the NMR Profiler.

5.2 February 19, 2015, for AlloMap® molecular expression testing for cardiac transplant rejection surveillance.

- END -

